OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 12 September 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 12 September 2017

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HEALTH AND SPORT COMMITTEE
19th 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)
*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)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rachel Cackett (Royal College of Nursing Scotland)
Ross Greer (West Scotland) (Green) (Committee Substitute)
Councillor Peter Johnston (Convention of Scottish Local Authorities)
Dr Miles Mack (Royal College of General Practitioners Scotland)
Julie Murray (East Renfrewshire Health and Social Care Partnership)
Judith Proctor (Aberdeen City Health and Social Care Partnership)
Elaine Tait (Royal College of Physicians of Edinburgh)
Jill Vickerman (British Medical Association Scotland)
Dave Watson (Unison Scotland)
Sharon Wearing (Chartered Institute of Public Finance and Accountancy Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 12 September 2017

[The Convener opened the meeting at 10:00]

Interests

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 19th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not photograph or film proceedings.

We have received apologies from Alison Johnstone, for whom Ross Greer is substituting. I invite him to declare any interests.

Ross Greer (West Scotland) (Green): Thank you for having me, convener. I have no relevant interests to declare.

The Convener: Thank you very much, Ross. You are very welcome at the committee.

Subordinate Legislation

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2017 (SSI 2017/231)

10:00

The Convener: The second item on our agenda is subordinate legislation. We have to consider one instrument, which is subject to negative procedure: the National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2017.

No motion to annul the instrument has been lodged, and the Delegated Powers and Law Reform Committee has not made any comments on the regulations. Do members agree that we have no comments to make on the instrument?

Members *indicated agreement.*

Draft Budget 2018-19

10:01

The Convener: Agenda item 3 is the draft budget 2018-19, on which we will have two evidence sessions today. I welcome to the committee Sharon Wearing, who is the chief finance and resources officer in the Chartered Institute of Public Finance and Accountancy's integration joint board chief finance officers—or CIPFAIJBCFO, which is a big acronym—section; Judith Proctor, who is chief officer in the Aberdeen health and social care partnership; Julie Murray, who is chief officer in the East Renfrewshire health and social care partnership; and Councillor Peter Johnston, who is health and wellbeing spokesperson for the Convention of Scottish Local Authorities.

We will move directly to questions. Will you reflect on the budget situation in which partnerships find themselves?

Judith Proctor (Aberdeen City Health and Social Care Partnership): We could go alphabetically by organisation. I will have a stab at that question.

From conversations that we had outside the committee room, it seems that the picture across Scotland is very varied. Each health and social care partnership started from a different place, they all have different configurations of services delegated to them and, obviously, they all have different local circumstances in which they work.

In Aberdeen, we managed to achieve a balanced budget overall at the close of the year; in fact, we posted a surplus in relation to the transformation funds. That was largely as a result of our ability to spend that funding quickly. However, all that funding has now been allocated to transformation projects.

We find ourselves in a challenging position this year, but we are working hard to achieve a balanced budget by the end of this financial year.

Julie Murray (East Renfrewshire Health and Social Care Partnership): East Renfrewshire has a long-standing partnership. We have been integrated since 2006, and we made management savings through integration fairly early on. As chief officer and, previously, director, I have been responsible for integrated budgets since 2007.

Part of our difficulty is that we have made easy savings over the years from picking the low-hanging fruit, but we are getting to the stage at which things are getting much more difficult. We project that we will be on budget for 2017-18, but we are using about £900,000 of reserves. As with Judith Proctor's situation, that was planned so that we could have a bit more time to create a transitional fund to redesign and restructure. The low-hanging fruit is gone, so we have to look at customer—or patient—pathways, we have to manage demand in different ways, and we have to make savings through restructuring, and look at the skills mix. As Judith Proctor's partnership will, we will manage 2017-18, but we are very concerned about future years, given the parent bodies' potential budget settlements and what they are projecting. We are managing by the skin of our teeth at the moment, but we are nervous for the future.

Sharon Wearing (Chartered Institute of Public Finance and Accountancy Scotland): I am happy to give the committee an update on the overall position across Scotland.

The situation is very much as Judith Proctor said, but each IJB has a different delegated budget: they are not consistent. For example, some IJBs have children and families and homelessness in their delegated schemes, but others look only at adult services within what has been delegated to them. There is a variety of outturn positions across the country.

We go from one extreme, at which a partnership has had to have a loan from the local authority to assist its financial position, which it is due to repay in future years, to the other, in which some partnerships have planned well and have been able to deliver the savings targets and to consider putting money into the reserves. Indeed, all are required to consider doing that as part of the reserves policies that we should all have in place. There is a mixed picture across Scotland; we are all looking at significant savings and efficiency programmes for the coming year, so that we will maintain our balanced budgets, where possible.

Councillor Peter Johnston (Convention of Scottish Local Authorities): First, you cannot look at the credibility of the health and social care budget in isolation. We need to understand the detail of the budget, but we must also understand the wider context within which it sits.

The local government budget is a key driver of preventative activity that seeks to address inequality and increased demand for other services across the system, including—vitally—our health and social care system. Simply to protect the national health service, for example, while cutting local government budgets is counterproductive to our overall objectives; to our objectives, as a country, for health and social care in the longer run. It would also lead inevitably to more pressures being built up, more problems and more expenditure from the public purse.

Ultimately, investment in local government will reduce demand for health and social care

services. We accept that every government—local and national—faces the same problems in funding the current service level and in the shift in the balance of care that we are so desperate to achieve.

Initially, we must see a far greater focus on investing in services that deliver the best outcomes for our communities. A short-term input-focused budget process is an inhibitor to genuine reform. IJBs need to be supported to obtain the maximum flexibility in their use of their budgets to meet the demands of the local communities. Any new commitments must be funded, but the core budget must be sufficient, too. Funding additionality being offered while the core budget is being significantly cut does not work.

The Convener: COSLA's submission is very good; it is also robust. Paragraph 5 provides a summary, identifying short-termism, centralisation and the lack of an evidence base, combined with budget cuts, as the issues. That seems to summarise the situation. However, the last bullet point—which is the point that Peter Johnson has just made—is key. It is:

> "reductions to core local government budgets with no cognisance of the interrelationship between all that local authorities do to reduce inequalities, build community capacity, resilience and assets and decrease demand for services in other parts of the system".

Are the services that are being provided by the partnerships being impacted by the cuts to the core local government budget? That is the front line in the fight against inequality. Is that happening in the panellists' areas?

Sharon Wearing: I will start off and talk about the 2017-18 budget settlement and its impact across all partnerships. Additional funding of £107 million for IJBs was agreed, but a budget reduction of £80 million across Scotland's IJBs was also agreed. We saw a reduction in services because we had to find savings and efficiencies to cover that reduction.

The additional funding was to provide for the Scottish living wage, to waive the financial assessment for war pensions and to help pre-implementation of the new carers funds. Therefore, the money could not be used to offset the £80 million savings challenge. That was on the local authority side.

On the health side, we had a flat-cash budget settlement. We had a big debate about what "flat cash" would mean. It was expected that it would mean continuation of the 2016-17 budget, with the IJBs picking up the inflationary pressures. Those included staffing and other cost pressures.

The biggest pressure that we faced was probably in the prescribing budget. We were happy to fund the uplift in that budget, which for a lot of partnerships last year was an increase of about 5 per cent. NHS Greater Glasgow and Clyde's partnership tried to reduce a £16 million pressure across the six partners; we put in a lot of spend to save and worked with the pharmacists to bring the amount down, so we are managing within our existing budget. New funding has gone in, but there was also a requirement for partnerships to find significant savings that could be redirected to fund their pressures.

Judith Proctor: Aberdeen city health and social care partnership had to find £5.2 million for inflationary pressures, which we absorbed from within the budget. Aberdeen City Council decided to take the full share of £80 million, which meant that we had to find further savings to the tune of about £3.1 million. That has been significantly challenging for us to do at the same time as we try to transform our services.

We are now thinking about budget setting for the coming financial year—what the decisions of local government and the NHS on budgets will mean, and what the impact will be on the health and social care partnership. We are planning ahead prudently, but until we know the impact of the budgets of our partner organisations, we will not know the full extent of the challenges that we will face.

Julie Murray: Councils' core budgets are our partnership's core budgets, and any impact obviously has an impact on us—our council funds £45 million of our core budget for front-line services. We had to make significant savings last year, and this year our savings total is £4.2 million, I think.

However, with regard to inequalities and preventative work, East Renfrewshire Council has protected an element of money for the early years change fund. We have used it across what we call the East Renfrewshire family, which includes the health and social care partnership, the East Renfrewshire Culture and Leisure Trust and the various council departments, to focus on prevention and early years around such things as housing, the environment and nursery education.

Councillor Johnston: From a COSLA perspective, the major issues in the 2017-18 budget are threefold. Is the quantum—the core budget—sufficient to deliver current day-to-day services? Is it sufficient to allow us to fund transformation? Do we have the flexibility to make local decisions that are best suited to the needs of local communities?

As colleagues have said, the health and care budget is suffering from the same tensions as the local government budget, in which there are significant questions about whether the quantum is appropriate to deliver the immediate needs of day-

to-day services. The key thing is that standing still is not good enough for us to meet the demographic challenges that are coming in our direction, which everybody knows about. We cannot afford to stand still: we have to move forward and innovate to find new ways to deliver services that best meet the needs of people in the community. That is the major challenge that we have with the budget.

The Convener: In summary, the answer to the question is no: the budget is not sufficient.

Councillor Johnston: It is not a case of yes or no: we have to look at the issue in the round. We have major concerns about whether the budget can meet our ambitions for health and social care.

Colin Smyth (South Scotland) (Lab): Good morning to the panel. My question is about the way that partnerships are funded, and how that impacts on the challenges that you have commented on—in particular, the fact that your partnerships are funded by your two main constituent parts, which are local authorities and health boards.

Julie Murray said in her evidence about East Renfrewshire that funding is not losing its identity. What did you mean? Do the other panellists agree?

Julie Murray: The intention is that when funding from our parent bodies comes into the IJB, that funding loses its identity. We decide our strategic priorities and direct back to the council and the health board. The challenge for us is that we have to continue to report the spend through two different reporting systems. We move budgets around at the margins.

I do not have evidence for this, but my gut feeling and my anxiety are that if we were to decide to disinvest significantly in, for example, social work and to invest in physiotherapy, I might have trouble persuading the council the following year to give me additional funding to meet demographic pressures, because it would think that it was subsidising NHS budgets—and, potentially, vice versa. As I have said, I have no evidence for that, because we have not really tried such an approach, but it does not feel as though the funding is losing its identity, as was intended.

I do not know whether colleagues have anything to add.

10:15

Sharon Wearing: I want to add to Julie Murray's comments by pointing out that we are working with two ledgers and two sources of funding, and we are having to report back under those two arrangements. The best way forward would be for the funding to operate under one ledger for the IJB, because that would allow the board to make better decisions with regard to how the funding loses its identity and where it is at just now. Because the current system encourages the funding to work through both the local authority ledger and the health board ledger, the funding does not lose its identity as was intended by the legislation. That could be changed, however, if there were one direct funding allocation to IJBs and if the two elements from the two partners were removed.

Colin Smyth: So, do you support direct funding from central Government?

Sharon Wearing: As we have set out in our submission, we support further exploration of the option of funding allocations going directly to IJBs.

Councillor Johnston: You will not be surprised to hear that COSLA and Scottish local government do not support that proposition. We think that an essential ingredient in the success of health and social care is the on-going partnership between the NHS and local government, and that the connection between the health and social care bodies, the IJBs and local government services is vital. After all, integration does not just happen within the boundaries of an IJB. For example, in my home council, West Lothian Council, the chief officer of the IJB is also a deputy chief executive of the council, and the IJB is wholly integrated. As we have been arguing, front-line council services are essential for tackling inequality and meeting our preventative agenda issues, and they are all joined up and working together to achieve those aims. That is happening not just in West Lothian but across Scotland.

As for the budget itself, there are issues with timescales. Local government and the NHS prepare their budgets to different timescales, so it would be helpful if they could be brought more into line. A key element that is causing concern is the NHS's attitude to set-aside budgets, which is a technical term meaning unscheduled-care budgets. The Public Bodies (Joint Working) (Scotland) Act 2014 states that those moneys must be transferred to IJBs, but there have been some issues in that respect. For us, it is fairly fundamental that the NHS follows the law and transfers those set-aside budgets.

I point out that the IJBs were created to ensure an integrated care pathway from the community into the acute hospital setting and back into the community, so the NHS being unwilling, at times, to transfer those budgets into the IJB domain will hinder integration. That transfer has already been agreed by Parliament, so we hope that colleagues here make sure that it happens across the country.

Colin Smyth: Technically, there is nothing to stop an IJB making those changes. It seems to me that the legislation is very clear on that. I am not suggesting that you are inventing reasons for not doing something, but I have to say that IJBs' funding by the two constituent partners is not really the issue, here. The issue is more likely to do with the facts that IJBs are relatively new, and that you are having to deal with the funding pressures that you have already mentioned. The bigger challenge is in making transformational change at the same time as managing funding pressure and looking for other cuts in order to transfer money. Is it correct to say that there is nothing to stop you making transformational change and changing how you spend the money, even though you are funded by two constituent partners?

Julie Murray: I simply echo what I said at the beginning. My anxiety is that if we substantially change the way in which we fund services, or if there is a substantial shift in resource from a council budget to an NHS budget—or vice versa—that might create problems in the future. The council would very much resist subsidising what it sees as a lack of core NHS budget—and, potentially, vice versa, if the money should go to social care.

We have not tested that properly, so you might be right that it might not be an issue at all. However, my experience makes me suspect that it would be.

Colin Smyth: Can I ask a little technical question on the presentation of the budget? One of the criticisms last year involved an accusation about double counting by the Government in the budget. Parliament's independent information service—the Scottish Parliament information centre—said that the £107 million that was allocated to social care was, in effect, already included in the health budget totals and also alluded to in the section on local government. In effect, ministers were using the same £107 million to cite growth in both budgets. I think that the Fraser of Allander institute said that that was highly controversial and, frankly, not right. Was that a fair criticism? From a presentational point of view, where in the budget should those allocations sit?

Sharon Wearing: From the finance officers' perspective, the funding was allocated to health and then transferred across to the IJBs and spent on the social care side of our budget. Again, we come back to how budgets are allocated. Our view is that that funding could have been directly allocated to the IJBs. That would be a different response, but I think that it would probably have been a better reflection of what was intended for the funding and how it was to be allocated. Additional challenges are created for us in bringing that money across and having to bill for that funding coming across. It goes back to my point that we are working within two systems and two ledgers—council and health board ledgers—and that we put that money back through the two. The funding does not necessarily lose its identity and we will see it as expenditure on both the health side and the local authority side, having been directed back by the IJB.

The Convener: From a public finance point view, is that not the way in which it should be done?

Sharon Wearing: Our view is that we need to look at allocating funds directly to the IJBs rather than having quite a convoluted way of allocating funding to them, with all the additional work that that involves. We are looking to try to improve and be more efficient in how funding is allocated.

The Convener: But I am not quite getting to the nub of whether that funding was in two places. Do you agree that it was?

Sharon Wearing: My view is that, yes, it was in two places, because there was expenditure on the health side and there was expenditure on the local authority side as a result of that transfer taking place.

The Convener: And it was the same money.

Sharon Wearing: Yes, it was a transfer from one to the other.

The Convener: Thank you.

Brian Whittle (South Scotland) (Con): Good morning, panel. I welcome COSLA's submission and will quote paragraph 15:

> "Given the Committee's remit which covers sport as well as health, we would also emphasise the benefits sport brings to the preventative agenda. Sport brings undoubted health and wellbeing benefits and encourages healthy active lives, supporting mental as well as physical health and promoting communities."

With that in mind, does the panel think that the current budget allows for effective preventative health planning? Further, how challenging is it to balance planning that spend against the potential future savings resulting from a preventative health budget?

Councillor Johnston: You reinforce the point that is the core of COSLA's argument, which is that we cannot simply look at the health and care budget in isolation. There are many things that contribute to health and wellbeing that are not directly within the IJBs or the NHS.

The point about sport is well made and I can reinforce it with a local example. For almost a decade now in West Lothian, someone who goes to their general practitioner because they are

suffering from depression is not prescribed drugs but is prescribed a six-week course in a local fitness centre run by West Lothian Leisure, which is an arm's-length body of West Lothian Council. That is a recognition that, for some people, physical activity rather than drugs might give a better outcome in curing the illness that they are suffering from. I do not think that there is any argument but that a healthy and well population requires access to those vital facilities. If core budgets are being cut across local government, the stress of maintaining the facilities will clearly be detrimental to the outcome that we are all working together to achieve.

Brian Whittle: In that particular example, which is a pertinent one, there would be a saving to the health service in the non-prescribing of drugs but a cost to the council in having leisure facilities available to the patient. Is that true?

Councillor Johnston: That is very true. Unfortunately, there is no means of accounting for that in the system. What those drugs would have cost does not go into our budget for providing health and fitness facilities. Those facilities are contributing to the overall outcome, which is what is important.

Alex Cole-Hamilton (Edinburgh Western) (LD): I, too, am very interested by the COSLA submission. It is pretty heavy stuff in terms of where the Government is going and what its approach is to budgeting and feeding into the IJB process. In paragraph 5, the submission states that there is

"a disconnect between the public narrative around the level of investment in public services, versus budget pressures".

Before that, it states that there is a

"continued focus on inputs not outcomes".

Over the summer, we saw one outcome of spending decisions in that drug deaths in this country had leapt by as much as a third, making us the worst-performing country in the European Union for substance-related mortality. Such an outcome going wrong is a weather vane, and it should be a weather vane for the budgeting process and decisions on where to prioritise spending.

Could the panel say where the system is broken? Is it the fault of central Government? Is central Government saying that it has passed the money to the boards and, even though there is a cut, the boards can still deliver outcomes by reprioritising? Is it the fault of the boards? Where does the disconnect lie?

Julie Murray: Are you specifically asking about the alcohol and drug partnership allocations?

Alex Cole-Hamilton: If you could focus on those, that would be brilliant.

Julie Murray: On the ADP allocations, reduced funding was passed to health boards. Health boards were asked to reprioritise. There are so many different priorities that it is difficult to see where funding would come from. Our health board gave us the allocation straight through to our budget. That was probably a result of the compliance test that was put in place around budgets and settlements.

We made some savings locally. Our demographic is such that our drug deaths are relatively low but they have risen across Greater Glasgow and Clyde. Different ADPs and health and social care partnerships are targeting their resources in different ways. We target ours on recovery, but I know that Glasgow's are targeted in slightly different ways.

At the end of the day, the health board did pass on the allocation to us.

Alex Cole-Hamilton: So yours is an example of good practice in which the HSCP made do with the money that it was given and prioritised ADP funding to be sure that the service would continue.

Julie Murray: Yes.

Alex Cole-Hamilton: But that is not the universal picture.

Julie Murray: No. That is not to say that we did not make some savings. We made savings in a way that we thought was low risk.

Judith Proctor: In Aberdeen, we had the full effect of the cut to the budget. We have had to focus on how to make efficiencies.

It is difficult to address the full extent of Alex Cole-Hamilton's question, because it is difficult to see a straight-line correlation between a reduction in budget and an increase in the number of drug deaths. Experts in the field would consider the issue to be multifactorial. Such deaths may be attributable to a number of things. Certainly, how we use budgets effectively to meet the priorities that we have with the increasing demand for those services is a significant focus for ADPs. Given that the budgets were allocated to the IJBs, it was obviously a significant focus for them as well.

10:30

Alex Cole-Hamilton: I understand that, as you suggest, the issue is multifactorial. However, when I had meetings over the summer with the senior consultant who was compiling the statistics on drug deaths, he pointed to a direct causal relationship between a 23 per cent cut in ADP funding and the increase in drug deaths. I understand that there are many reasons why

people die of overdoses, but if we are currently withdrawing services that can manage people's lifestyles or get them clear of their behaviours, we can act to address those statistics.

Judith Proctor: I agree. The challenge then is to support meeting those priorities while also finding the savings to balance that or address that gap from elsewhere in the totality of the budget, which is also under pressure from increasing demand.

Councillor Johnston: I will answer on the generality of your question. You are asking what impact the integration of health and social care budgets has had on meeting central Government and local government outcomes. For me, it is clear that IJBs across Scotland are making good progress. We are beginning to see tangible changes in service design and the essential strategic commissioning that goes along with that. However, the key challenge that we face is to get the resource to deliver the pace and scale of change that we need and to do more to support integration and focus on reducing demand and on prevention and early intervention.

There needs to be an acceptance that moving services, for example from an acute setting to the community and delivering them differently is not a cut but is simply an improvement. We have to recognise that reducing the number of hospital beds and investing in our communities is not a bad thing but is the way we can move ahead and achieve the transformation that we are all looking to deliver.

Alex Cole-Hamilton: Sorry. You are saying that what is happening is not a cut and that there is not an element of cuts in this whole process, yet COSLA's own submission disagrees with you on that.

Councillor Johnston: That is not what I said. I am saying that, if we look at the budget as a whole, the difficulty is to meet the day-to-day service requirements and, at the same time, fund the transformational change that we are all looking to deliver. I was trying to put into the discussion the point that we need to accept that moving services from an acute setting into the community is not necessarily a cut but is a change in how we deliver things and may be a better way of delivering the outcomes that we are looking to achieve. We need to accept that a reduced number of hospital beds can deliver better outcomes and that that is a good thing.

Alex Cole-Hamilton: Absolutely—I do not disagree. However, COSLA's own submission refers to

"reductions to core local government budgets with no cognisance of the interrelationship between all that local authorities do to reduce inequalities, build community capacity, resilience and assets and decrease demand for services in other parts of the system such as health and social care".

There is a material reduction in the money that is coming.

Councillor Johnston: I am not contradicting our submission; I am simply giving you a specific example.

Alex Cole-Hamilton: Absolutely. We all know stakeholders—organisations and people who work in the sector—who do miracles with next to nothing and are forced increasingly to do miracles with next to nothing. I accept what you say about service redesign, which has its place, but it is important for the committee to recognise the landscape in which we are operating.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I will follow up on my colleague Brian Whittle's comment on budgets. Councillor Johnston, COSLA states at the start of its submission that we cannot look at the health budget in isolation, and you just spoke about prevention and early intervention. COSLA's submission states:

"If we are to achieve a flourishing Scotland, then we need to deliver on our joint aim of improving Scotland's mental health and wellbeing."

Julie Murray, East Renfrewshire health and social care partnership's submission essentially argues for

"Targeting areas for preventative services including specific waiting times"

and gives CAMHS as an example of that. CAMHS is obviously the far end of the system in terms of mental health provision. In respect of mental health and building resilience, to what extent is there scope for the budget to enable us to get out of our silos and work across other areas, such as education. Within the education system, a whole curriculum area in curriculum for excellence is devoted to health and wellbeing. Given the budget pressures, is there scope for health and education to work together on that?

Councillor Johnston: Yes, there is scope to do that and that is happening. From COSLA's perspective, that was part of the argument for not funding IJBs directly, as missing out the local government-NHS link and removing the parent bodies would be very detrimental to the process.

From a COSLA perspective, it is important that our IJBs retain the flexibility to make local decisions. COSLA worked closely with the Government to put together the Mental Health (Scotland) Act 2015 and the mental health strategy, but we were critical of the Government's decision, which we consider to be an input measure, to provide 800 new mental health

workers and tell us in local government and IJBs exactly where they would have to be located. We do not find that helpful. We would welcome the 800 new workers and the funding for them, but we would like to have the ability to make a local decision about where they would be best located to suit the needs of our communities.

Julie Murray: In East Renfrewshire, we work very closely with education. We have a solid foundation in our children's services planning and the work that we do on early years. We have huge waiting lists for CAMHS because we are not providing the different sorts of tier 2 support. We would not invest in CAMHS; we would invest in something different. For example, we part fund schools counselling.

To see whether it works, we are considering a one-off reinvestment of some of the savings that we have made. We have shifted the balance of care from children's residential services. We are not sending as many children away to school and secure accommodation, so we are investing in a service that is built around GP clusters and family support to prevent inappropriate referrals to CAMHS. Some of the kids who are referred to CAMHS do not need that level of support; they need something different. We are trying to be creative and working with third sector organisations. Children 1st is running that service for us.

The Convener: Did you say that you had long waiting times for CAMHS?

Julie Murray: Our waiting times for CAMHS are on target but it is still a long wait.

The Convener: Will you quantify that?

Julie Murray: It is an 18-week wait. Our CAMH service is under pressure.

The Convener: For what percentage of people do you hit the 18-week target?

Julie Murray: I do not have that figure off the top of my head, I am afraid.

The Convener: Could you provide us with it?

Julie Murray: Certainly. When we looked at our waiting list, we thought that many of the kids who were on it probably needed something other than CAMHS.

Jenny Gilruth: You talked about a tier 2 intervention before children get to the CAMHS waiting list. I am a Fife MSP. NHS Fife is one of the five, I think, health boards in Scotland that have not hit the 18-week target. Is there scope in the budget to get into schools with healthcare provision or with counsellors? You have given examples of that. If that were to happen, could it alleviate budget pressures and, perhaps, reduce waiting times as a result?

Julie Murray: Yes, it would. However, although we know that some of the preventive measures work well, the challenge is protecting that budget. Our budgets get reduced and reduced and we have to consider those at most risk. It is a challenge to protect the preventive element. For us, one of the ways of doing that is to partner with other organisations that can apply for funding, for example.

Jenny Gilruth: Sharon Wearing mentioned having two different reporting bodies: local authorities and health boards. Does that feed into a lack of budget transparency? Does the fact that you report back to two different bodies mean that it is much more difficult to evidence that Government health outcomes have been achieved?

Sharon Wearing: Each IJB has its own budget monitoring arrangements that it takes to its board regularly. A joint budget report is made regularly to inform IJB members what the budget position is in each IJB in the country, so they see that collective budget monitoring report. However, there is still an operational requirement for us to feed into the health board and the council, where we start to see the budget being split. One joined-up budget would be a better way to help that budget lose its identity in future.

Tom Arthur (Renfrewshire South) (SNP): One of the themes that have emerged from the written submissions is the cluttered landscape of performance frameworks. We have already touched on budgets losing their identity. Councillor Johnston touched on the need to meet outcomes. Is there sufficient clarity in the Government's stated priorities for health?

Councillor Johnston: I think that there is clarity in the stated outcomes. I reinforce the point that IJBs need flexibility to deliver on local outcomes. That might be part of the reason why you have raised the question of clarity. We have national outcomes, but the ways of achieving the outcomes will be different in each locality. That is part of the reason why, for example, the Public Bodies (Joint Working) (Scotland) Act 2014 required IJBs not to have only one locality even within their own areas. The act recognised that different localities need different solutions. However, all the localities are working towards the same outcomes. The clarity is absolutely there in the national outcomes, but we need flexibility to get there in different ways.

Judith Proctor: I agree with Councillor Johnston's assessment—I think that there is clarity. We work with a broad range of outcome measures, which can sometimes be challenging. I echo the point about the requirement for local flexibility and the benefit that we can gain from it and from working with communities on good outcomes for them. Because we work with

different geographies, even in a small city such as Aberdeen, there are different health outcomes and different health inequalities across the city and we need to be able to focus on improvements at a local-population level.

There is clarity. We have developed our own performance framework, through which we seek to demonstrate delivery against the nine national health and wellbeing outcomes but, underneath that, we have a range of indicators that reflect local need and local improvement, so that we can see the impact that we are making in communities in Aberdeen.

Julie Murray: I agree with my colleagues. The vision is probably clear—we have clarity through the health and social care delivery plan. We have all just produced our performance reports. Because my partnership includes children's services and community justice, we have brought together the nine outcomes with outcomes for those services and reported against them. The focus should be on outcomes and there should not be prescription on the best way to achieve those outcomes.

Tom Arthur: That is helpful.

There seems to be a perennial dispute over whether there should be direct funding or a continuation of the current mode of funding. Is there a middle ground? If direct funding is not an option, what could be done to improve collaboration between health boards and local authorities in IJBs?

Councillor Johnston: It would be helpful to try to bring together the timetables within which NHS and council budgets are determined and agreed. That would be a significant step forward. It would also be helpful if moneys that are directed into social care did not have to go through the health board route but came directly to local government. That would increase transparency and perhaps deal with some of the issues that colleagues raised earlier.

We have a tremendous vision for the integrated delivery of health and social care, and we are making good progress on it, but the key message that I am trying to convey is that if we are to deliver the transformational change in the necessary timescales, we need to resource IJBs properly. We have major concerns that although IJBs probably have sufficient budget to stand still, they have tremendous challenges in trying to deliver the change that is needed while delivering the services that need to be delivered. That is the key message that we are trying to get over.

The Convener: Julie Murray raised her eyebrows when Peter Johnston said that there is

"sufficient budget to stand still".

Do you disagree with him?

10:45

Julie Murray: I do, actually. To stand still next year, we would probably need an additional £3 million, and our scenario planning suggests that we will probably get £3 million less, so I do not think that we have enough money to stand still.

With regard to doing things the way that we have always done them, because we have been on an integration journey for 10 years, we have probably had quite a lot of innovation and creativity in what we have delivered. We are beginning to get to the end of that line. There is a real challenge for chief officers. What they as the advisers to integration joint boards suggest would be good for the boards, in terms of protected money and direct allocation, might not necessarily be what the boards' parent bodies would like. We are line managed by council and NHS board chief executives, who might have very different views on issues such as set-aside or direct funding.

Although I think that there are some real attractions to direct funding, better timing would take care of some of the issues, as Peter Johnston said, and direct funding would have disadvantages, in that we very much need to be part of the local community planning family. I therefore have mixed feelings, but I think that if there were a sense that, within a context of parent bodies continuing to fund IJBs, their budgets were protected as much as possible to enable them to meet the strategic priorities, that would be fine.

Judith Proctor: In Aberdeen, we have developed a local protocol to support us through the process of budget setting for three organisations. NHS Grampian has strived hard to align its budget-setting process with that of the council, and we have made some real strides in that effort. That was done in anticipation of things getting difficult. Relationships across all our organisations in the north-east and Aberdeen have been very good, but as budget pressures hit the organisations and the IJB seeks to make different decisions, those relationships can become strained and be put under pressure.

The budget protocol sets out, to a degree, the expectations around timelines and how we will work. It also sets out the opportunity for the IJB, against a difficult fiscal background, to make representations to the partner organisations for an increase in budget, if we can demonstrate need, demographic pressure and so on. That is not to say that we will get an increase, but—reflecting the legislation—the protocol allows us that opportunity. That has been a really helpful process.

Like Julie Murray, I have mixed feelings about direct allocation. It seems very straightforward and simple, whereas managing budgets across three organisations is time consuming and hugely complex. However, I absolutely recognise the benefit of being part of the family of public sector organisations in an area and the ability that that gives us to have discussions, particularly with the local authority about some of its other mainstream budgets. We have talked about how budgets for housing, education and children's services, for example, can be brought to bear to support the overall ambition of reducing health inequalities by focusing and targeting our effort on communities that are at particular disadvantage in terms of inequality. That needs to be seen as the overall context. I do not detract from the complexity of managing as chief officers in that context, with the various calls on our time and focus, as well as the regular reporting duties, as my colleague mentioned. It is challenging.

The Convener: Do you have enough to stand still?

Judith Proctor: Our standstill cost is about £8.7 million, according to what we have observed. Our forecast is that it costs us that to stand still.

The Convener: Do you think that you have enough?

Judith Proctor: We are forecasting some significant pressures on the budget. We have reserves that we have put aside for that purpose, but of course using our reserves impacts our ability to transform. That is the real conundrum. In Aberdeen, we are very ambitious to change our services, but we are also realistic about how long it is going to take us to change and the pace at which we can move. The pressures that we face will definitely impact our ability to move at the pace that we want to move at, and we will have to continually look at adjusting our expectations and plans for transformation against our requirement under the legislation to break even.

The Convener: That sounded a bit like a no. We will leave it at that.

Sharon Wearing: I would just like to add that the budget settlement last year included quite a lot of direction from the Scottish Government on IJB budget allocations, and it was quite directive about the maximum level of savings and so on that could be taken from an IJB's budget. That helped to protect a lot of the IJBs from facing what could have been wider savings targets in the current financial year. That was one element of it; on the health side, there was flat-cash guidance, which again was given to help protect the IJBs.

However, that has not taken away from quite a lot of long discussions about what the budget allocations should be. IJBs are still to finalise their budget for 2017-18 and, from a timing perspective, they would ideally want to set their budgets before the end of March. Some of the discussions that we are having about what the budget level for the IJBs should be have taken the timescales well beyond that ideal period, which we need when we are also trying to deliver substantial savings targets.

Tom Arthur: I have a final question for Julie Murray and Judith Proctor. You have outlined what you need if you are to tread water. In an ideal situation, how much would you require to realise the vision of shifting the balance of care?

Julie Murray: I do not have a figure off the top of my head, but what we really require to shift the balance of care is probably some transitional or bridging funding. There are resources within the system. There is quite a complex system in Greater Glasgow and Clyde NHS Board, which covers East Renfrewshire. There are six partnerships. If we work together with the health board and acute services, as we are doing, we could release some significant resource locally to develop community services. However, we probably need some funding up front to develop the services before hospital beds close. I do not have a figure.

Tom Arthur: How long will it take?

Julie Murray: In a system such as the one in Greater Glasgow and Clyde NHS Board, I think that it will probably take five years.

The Convener: We have only about 10 minutes left and four members still want to come in, so I ask everyone to be as snappy as possible.

Miles Briggs (Lothian) (Con): Paragraph 23 in the COSLA paper says that there are a number of

"accountability and audit issues which have become evident as the work of IJBs has progressed."

Will the panel outline in more detail what those issues have been and the steps that you have taken to address them? Also, given the discussion about budgeting and the experience in Northern Ireland, would you support a shift towards single budgeting?

Judith Proctor: Could you repeat the question?

Julie Murray: We are trying to find point 23.

Miles Briggs: I am sorry; I meant to be snappy. Paragraph 23 of the COSLA submission talks about the

"accountability and audit issues which have become evident as the work of IJBs has progressed."

Can you outline what you have seen of those issues in your areas and anything that you have done to rectify them, especially around benchmarking of services?

Judith Proctor: Benchmarking of services can be quite difficult because of the range of services that some IJBs have. Julie Murray referred to the children's social work services in her partnership that do not sit in ours. That can create different dynamics.

Sometimes the length of time for which the partnership has been up and running and the way of working can also reflect differences. Sharon Wearing addressed the complexity of the landscape around accountability and audit—that is particularly true of audit. We are seeking to streamline audit processes and provide assurance and accountability to partner organisations in the IJB without duplicating audit. We are working through that, which remains a work in progress. We are being very clear about doing it but it can be quite complicated.

I am not sure whether that was what you were asking about.

Sharon Wearing: Audit Scotland has highlighted that further work is required around the set-aside, which is the unscheduled care aspect of the acute budget. We all recognise that there has not been the advance that we would like to see in that area of work, and we are definitely doing a lot of work this financial year to look at better arrangements for the set-aside budget.

It is a key area for us in relation to shifting the balance of care. As Julie Murray said, it would be helpful to have some spend-to-save moneys, which would give us bridging finance to move services from the acute system into community settings. It is a complex area but it is one where we need to make progress to demonstrate that shift in the balance of care.

Miles Briggs: My second point was on budgeting. In Northern Ireland, integration has moved things towards single budgeting. Do you think that that is a good idea, given some of the concerns that you have raised this morning?

Judith Proctor: I have not looked at the system in Northern Ireland for some years, but I understand that the structure created a number of single boards. However, the last time that I looked, they were not making some of the progress that we have made in Scotland over particular elements of resettling people with mental health issues and learning disability, so there were still some challenges in delivering outcomes, despite the single structure. I do not know whether that remains the case, because it is a good three or four years since I last looked, but it would certainly be interesting to compare the areas where Northern Ireland has made progress against the outcomes that we are managing to achieve for our population.

Councillor Johnston: I can only reinforce the point that I have made already, which is that COSLA would not support single budgeting if it meant removing budgets and taking money away from local government and from the democratic control of local councils and giving it centrally to a new, nationally funded range of IJBs. We think that that would damage the process and, because of the Public Bodies (Joint Working) (Scotland) Act 2014, it would probably require legislation. The approach is exactly what we should not be contemplating as we face the current challenges of shifting the balance of care and delivering for our communities. It would be a total distraction.

Ross Greer: I would like to go back to the point about the link between expenditure and outcomes. I know that the IJBs have, in the past, found it extremely difficult to provide analysis of that. The Cabinet Secretary for Health and Sport has acknowledged that, and it is mentioned in a number of the submissions to the committee, including the one from East Renfrewshire Council. What progress has been made on making that link and on being able to provide the data and information?

Julie Murray: That is something that everyone is struggling with, so we hope that colleagues from Scottish Government and the chief finance officers can start to work together to develop a national framework, because the difficulty is that we might all try to do things in different ways, which would make things difficult to compare. It is complicated because there are many services that we provide and different bits of our budget contribute to a number of outcomes, so we need some sort of national guidance for that. It should not be a time-consuming piece of work, because we do not know what value it might have.

Sharon Wearing: Let us take as an example the home-care budget. It meets a number of the objectives, so it is difficult to split it up and say how much of that budget helps delayed discharges and compare it to how much helps to maintain people in their own homes. The budgets are there and we know which objectives they support, but it is a challenge to split the money among the outcomes that we are achieving. A different way would be to show the budgets and the outcomes that they support; that would be a step in the right direction, but we have a lot of budgets that support a number of outcomes, which is why we have a challenge.

Ross Greer: If that is required by the legislation, it does not sound ideal or easy to deliver. Julie Murray mentioned the need for frameworks, and I assume that capacity is also a big issue. What else is required to help you move toward delivering that? Is it a question of capacity?

Julie Murray: Capacity is an issue locally. The chief officers have a strong network, as have the chief finance officers and the planners. It would be good if we were able to work together with Scottish Government colleagues. I wondered whether we have guidance; we do not, so we should try to develop it.

11:00

Ivan McKee (Glasgow Provan) (SNP): I want to touch on the preventative spend agenda by referring back to the Christie commission, which floated some big numbers around that, such as there being potentially up to 40 per cent savings for public services if resources were focused on prevention rather than on treating symptoms. The integration joint boards agenda is supposed to move us towards that through more closely integrated work and, in particular, through a shift from acute spending to community spending, and so on.

What should happen is that resources are put into prevention, then at some point down the line money is saved because it is not having to be spent on cures. I want to hear about specific examples. First, have we seen anything like that manifesting itself in savings? I am thinking about the example that Peter Johnston mentioned from West Lothian of doctors prescribing fitness classes. East Renfrewshire has had integrated services for 10 years, so we should, in theory, be seeing an output from that by now—for example, a reduction in the drugs bill compared to other comparable areas and an improvement in health outcomes. Is there any evidence to support that approach? Are there examples of things that you have done in the past five or 10 years whose outcomes have had a beneficial effect on the budget?

To take that to a macro level, if you had a blank bit of paper, what would you spend money on now and when would you expect to see savings from that spend? Would it be five or 10 years down the line? Everyone talks the talk about prevention; the concept is great. Everyone talks about needing the money for double funding just now, but when you push them on where that means they will save money in five or 10 years, they are a bit more vague.

The Convener: That was the short version, was it? [*Laughter*.] Could the answers be a lot more succinct?

Councillor Johnston: It is not easy to give a short answer to that. If the question is whether we see immediate benefits in the budget, the answer is probably no. We have demographic challenges: the population and its needs are changing and demand is increasing. At the same time as reductions are made by doing one thing, demand for other services increases and surpasses that. Standing still is not an option.

On priorities, there is a consensus that we want to move towards being a more equal society, so surely all policy proposals should be challenged about the extent to which they address and target inequalities. That is certainly COSLA's view. We want more investment in testing and financing new models of social care, because we recognise that we cannot stand still.

I spent some time on the board of Healthcare Improvement Scotland and I remember an example that we were given from the 1870s, which was the time when steam ships came in. The sailing ships adapted to the challenge from the steam ships by adding more masts and sails until they eventually turned over and sank. That analogy has stuck with me because it is very powerful. If we continue to do the same things, our health and social care system will simply not cope. We have to find a mechanism to do things differently in order to achieve the outcomes that we want. That requires investment and resources to fund the transformational change that we all agree is absolutely necessary.

The Convener: Does anyone else want to comment on that?

Sharon Wearing: I can give an example. Glasgow city IJB has put a lot of investment into intermediate care and reablement services. We also have direct ordering of home care—hospital nurses can directly order home care in order to allow patients to be discharged within four hours. As a result, we have seen a significant decrease in our unscheduled—lost—bed days. That is part of our trying to shift away from acute services to bringing people back into the community and back home.

We look at how we can focus on prevention. Our first challenge was try to get people back into their community and back home quickly and safely. That has produced dividends. The bed days that have been lost in Glasgow have gone down from 38,152 to 15,557.

Ivan McKee: Has that been quantified in financial terms?

Sharon Wearing: We have done a lot of work on the investment that we have put in, and we know from the figures on bed days lost what the unit cost would be. I do not have an overall figure to hand today, but I can get that for the committee.

Ivan McKee: That would be great. Thank you.

I will go back to Peter Johnston's point. In my question, I was very careful to say "compared with other areas that are not doing the same interventions." I will go back to the question. Is

there any evidence of a cost saving—in either financial or health outcomes, compared with other areas that were not making that intervention—from West Lothian's prescribing of fitness classes rather than medication? If there is not such evidence, although we might think that it is the right thing to do, we have absolutely no evidence that it is. If there is no such evidence, that should make us question the whole preventative agenda, because if it does not save money, we must go back and question whether the Christie report was correct.

Councillor Johnston: I cannot tell you, off the top of my head. I tried to answer your question in principle, but I am happy to go back and ask my colleagues in West Lothian Council for figures that may or may not answer it.

Ivan McKee: Thank you.

Brian Whittle: Following on from our earlier discussion, there is an example from—I think—Manchester, of the education budget and the health budget crossing over, and the ability to move funds about according to need. As my colleague Jenny Gilruth said, education and intervention are important in the health agenda. There are obvious challenges in that example, but is it worth consideration? It might not be confined to health and education: we could bring in the welfare budget as well, where there is crossover and a little bit of movement in funds.

Judith Proctor: That is certainly an interesting area. When, in a partnership such as Aberdeen's, which largely deals with services for adults, we talk about the preventative agenda, we need increasingly to think about the next generation of children and how we create the fittest possible generation for the future. Effort that goes into supporting children and families to have healthy lifestyles, to be resilient and to make good health choices will, ultimately, have a significant impact on the sustainability of budgets, so that needs to be an area of focus for all of us. I do not know how we would achieve that with budgets, but it would be fruitful to consider closer partnerships with schools. In Aberdeen, we have really focused on locality working; the opportunity and potential to work with clusters of schools and with our clusters of health and social care services could definitely give us a step into that.

The Convener: Julie, do you want to ask about that?

Julie Murray: What Brian Whittle described is partners in community planning coming to the table with resources. In the current climate, it is particularly difficult in education—because of protection of teacher numbers, other elements of the budgets are being squeezed a bit. The work that we do is done locally. We come together as community planning partners to look at our resources and where we can best target them.

The Convener: Sharon Wearing mentioned that numbers can be attached to delayed discharges and bed days. In other areas of your work, about which we have heard repeatedly that people cannot put numbers against them, what is being achieved through the partnerships and how do you know how well you are doing?

Sharon Wearing: One area that is being looked at is annual performance reports, the first of which has been produced this year. It allows people to benchmark and to consider where they are relative to one another. A lot of work is going on around that—probably more at the level of heads of planning, across all the partnerships. The work is considering where we can all improve our performance and how to relate that to our investment to ensure that it is giving us the outputs and outcomes that we expect. We all focus on how we will monitor our transformation programmes in terms of whether they are achieving the expectations that we have set for them and what we can do differently if they are not.

The Convener: Be very brief, please.

Judith Proctor: A point that is raised in one of the submissions and with which I would absolutely agree relates to the support that could be provided to boards by the various improvement organisations across the patch in Scotland. In the north of Scotland, for example, we are doing some work with Healthcare Improvement Scotland on the i-hub—the improvement hub—to help us to understand where we might find the best evidence of what works. The evidence is quite sparse for many of the things that we are trying, so it is quite difficult for us to demonstrate improvement and how well we are doing. If we could get the support of the Improvement Service and other such organisations in looking in a concentrated way at cutting-edge evidence and in evaluating some of the tests of change that we are putting in place across Scotland, that would be helpful in strengthening our work and our understanding of what works, and of where savings can be made and sustainability put in place through rigorous application of the evidence base.

The Convener: Thank you very much for your evidence this morning. I suspend the meeting briefly to allow a change of panel.

11:10

Meeting suspended.

11:14

On resuming—

The Convener: I welcome to the meeting our second panel: Rachel Cackett, policy adviser, Royal College of Nursing Scotland; Elaine Tait, chief executive officer, Royal College of Physicians of Edinburgh; Jill Vickerman, national director, British Medical Association Scotland; Dave Watson, head of policy and public affairs, Unison Scotland; and Dr Miles Mack, chair, Royal College of General Practitioners Scotland.

We will move directly to questions, and I ask Maree Todd to open the questioning.

11:15

Maree Todd (Highlands and Islands) (SNP): Thank you, convener, and I thank the panel. I wonder whether we can explore together some of the big-picture issues before drilling down into more of the detail.

We are all aware that hospital care can be harmful for some people. At the weekend, we visited the dementia centre at the University of Stirling and were told that somebody with dementia who is admitted to institutional hospital care almost immediately deteriorates and does not really recover their function. I am also aware that muscle wasting happens within 72 hours of lying still in a hospital bed. Therefore, some harm can come from being admitted to hospital, yet time and again I hear from colleagues out in the community that, in a crisis, it is much easier to admit someone to hospital than to put in a package of care that would help them to stay at home. What would better care look like and, in a crisis, what would happen instead of a hospital admission? How do we get there from where we are now?

The Convener: We are really pressed for time, so be brief on this one—I am looking at Dave Watson in particular.

Dr Miles Mack (Royal College of General Practitioners Scotland): This has been a big struggle. Throughout my career, there have been moves to shift services from hospitals to the community in the expectation that that is the right thing to do. I am delighted that the Scottish Government has followed that up with the 2020 vision, which comes on the back of reports such as the Kerr report. Those have given some cause for hope in the past, but we have really struggled to deliver on them.

The main thing that the Royal College of General Practitioners Scotland wants to ensure is that we have the workforce and the investment in general practice to deliver community care. Patently, that has not been the case, because we have seen a fall in percentage funding to general practice over the past few years that, unfortunately, has continued over the past three years, since I have been in post, despite our loud clamouring to have the issue tackled. The sort of care that my members are able to provide is necessary for people to be looked after at home. The elderly population is a particular challenge for us. Our core values are about long-term continuity and comprehensive care, so being able to co-ordinate people's care throughout is essential.

Whatever we do, we desperately need to invest in general practice and in GP numbers and to ensure that we stick close to the core values that the NHS has had for a long time. However, we are not in isolation, because there is clear evidence that that is just as important for district nursing services. I know that the committee has had evidence from Helen Irvine before, whose work clearly linked GP and district nursing services in our being unable to provide the sort of changes that we are looking for despite an overall rise in the health and social care budget.

We need a nuanced approach. It is about having the basic care in people's communities that we would probably expect. It sounds very traditional, but investing in the way in which we want to deliver that care and seeing that is quite revolutionary.

Rachel Cackett (Royal College of Nursing Scotland): The first thing to say is that there are times when hospital is the right place for people—when they need hospital-based care—and we have staff working in hospitals in Scotland who do an amazing job in providing that care. However, we need to ensure that people are in hospital only when they absolutely have to be and—to back up what Miles Mack said—that requires a fundamental shift in how we distribute our resources and think about how we deliver services.

One of the things is to understand the complexity of the conditions that people are now presenting with. The location in which we are providing care, support and treatment is also changing, so we are looking at delivering far more complex care in the community, which requires decision makers to be in the right place in the community 24/7 in order to ensure that people are getting the care and treatment that they need in their home, a care home or wherever else they happen to be that is outside the hospital setting, and that staff have the right access to clinicians in the acute sector who can make decisions, in the moment, to try to keep them at home, where that is the appropriate thing to do, or to get them out.

Of course, that requires a rethink of how our workforce is configured. The NHS is a people-fuelled economy; it does not work without those people, and that requires us to invest in the right places. This afternoon, Dr Miles Mack, colleagues from across pharmacy and optometry and I are meeting the Scottish Government as part of a primary care vision collective to talk about how we can jointly rethink how we develop primary care across all the professions to make that work and to bring forward the vision that you are talking about and that the Government is talking about in the 2020 vision. However, we are doing that against a backdrop of significant vacancies. In district nursing alone, we are looking at a 5.5 per cent vacancy rate; in health visiting, the vacancy rate is more than 7 per cent. We have gaps.

On numbers, we must be careful to talk about not just how many more staff are needed but—to return to my point about complexity—what we are asking those people to do and what volume of work is coming their way.

This morning, there have been discussions about set-aside funds, which are key when it comes to thinking about how we transfer resource—if that is indeed what we are going to do as complexity gets greater, because there are issues about what our hospitals become as the complexity of need increases and about how expensive that hospital care will be to provide. We need to think through what we are talking about moving in terms of cash and in terms of people. We must ensure that we have the right nursing workforce—with far fewer vacancies—with the right skill level to make the clinical decisions to deliver people's care in the community, where that is the most appropriate thing to do.

Jill Vickerman (British Medical Association Scotland): I am conscious of your comment about the lack of time, convener, so I will not reiterate the many points that Dr Miles Mack and Rachel Cackett have made. BMA members consistently tell me those same things, so there is huge consensus.

A new GP contract is part of the landscape and has a role in trying to help to find a way forward. That is about creating a model in which being a GP is seen as being an attractive profession, so that people want to come to Scotland and to stay here, and being clear about what exactly GPs' role needs to be and how they will work within the wider primary care team. All the other points are right; but there is a need to make it work. We need to pull off a different version of a GP model for the future.

Dave Watson (Unison Scotland): I served on a health board 30 years ago and the number 1 strategy was to shift services from acute to community services. As they say, there is nothing new in politics; the same issues come round.

There are two reasons why we have not made as much progress as we have wanted to. First, the community services to do it must be in place and we have a problem there. The problem is not just in NHS primary care and community services but in the social care sector, which, unlike the NHS, is highly fragmented. If you think that vacancy rates are high in the NHS, you should look at what they and turnover rates are in the social care sector—people are not attracted to work in that sector, employment is fragmented and so on.

The second issue is largely political, and is that it is not easy to close a hospital. Members' post bags are all full to the brim every time a shift in care has to be made. We have to convince people that credible services are in place and then have a dialogue with communities about the best way to use them.

Elaine Tait (Royal College of Physicians of Edinburgh): I reiterate the point about the need to bring communities with us. Doctors are evidence driven, so we must make the arguments and give those who are responsible for dealing with community transfers the leadership skills to be confident to say that the evidence is there that where services are being transferred, that is being done safely and that services delivered in the community are different, not poorer.

One challenge with the lack of transition funding, which several people on the previous panel mentioned, is in ensuring that the services are available in the community to prevent multiple admissions, or readmission, of people who have had care in the hospital sector, been transferred to the community but there is a problem because the community services are not sufficiently well established. That is not a reflection on the ability of our colleagues in the community; rather, it is a reflection on the investment in the services that are present.

Maree Todd: I want to ask a slightly narrower question about bringing the community with us. The Royal College of Physicians of Edinburgh submission says:

> "Care should be taken with technological or pharmaceutical developments which deliver small marginal benefits."

That sentence distils the tension around evidence-based medicine, which undoubtedly favours pharmaceutical-based interventions, as there are not necessarily the same levels of evidence around other interventions. Is it time for a national conversation about some of the very expensive drugs that are coming along that deliver marginal benefits?

Elaine Tait: There are high expectations of pharmaceutical-driven care. Where the evidence is there to support such therapies, people would expect to have access to them. There is significantly less evidence about other areas of care, and that is where we need to put our emphasis. We need to encourage and support research into some of those other interventions and be clear that if there is evidence in support of them, that should be the direction of travel for policy makers. However, in the absence of evidence, we would be experimenting, and that is not something we would endorse.

Clare Haughey (Rutherglen) (SNP): I want to explore the need for disinvestment. Members of the panel have talked about shifting care and resources to communities, but would they agree that there is a need to identify areas for disinvestment? If so, how can that best be approached?

Dr Mack: That is a difficult area—

Clare Haughey: I would not ask it if it was an easy question.

Dr Mack: I was just giving myself time to think. You are absolutely right, and some of the issues that we are starting to tackle about realistic medicine are starting to get to grips with that issue. Our chief medical officer is correct to challenge us about whether the treatments that we suggest are what people want and need. That involves some difficult conversations. We need the continuity of care that GPs provide, but we need to be well linked up with our hospital colleagues so that decisions can be made. There is nothing worse than someone who has difficult decisions to make about end-of-life care getting one message from us and then getting a different message from someone in an oncology clinic who has not necessarily had the benefit of the discussion that we have had. Somehow we need to deal with that, but I am well aware that those individual decisions do not lead to quick disinvestment decisions further down the track; that is more difficult.

We need to be extremely careful about how we tackle some of the preventative care agendas. For example, questions are now being asked about the cost of some types of screening and how much benefit we get from them. Increasingly, we are seeing issues around overdiagnosis and overtreatment, which are causing us a great deal of concern. It is clear that our profession has not quite got its head around what the answer might be to those questions.

Such decisions are difficult and, when it comes down to it, the public need to be involved in them as well. What you would do personally with regard to a decision about screening can sometimes conflict with what you might think would be best for the population.

Jill Vickerman: The question was about how to approach the challenge. There are a number of dimensions to the issue. Without question, we are all saying that in order to release the kind of additional resources and investment that we need to support transformation and the delivery of services into the future, we need to find ways of doing some things differently and making additional funds available, but we are also saying that we need to think about stopping doing some things. That is the territory that we are in at the moment. We have explored the issues and have come to the view that there are a number that we need to look at seriously.

We have all recognised that the culture of establishing targets to be achieved requires to be reviewed. We are still awaiting the outcome of a review on that, but I think that there is potential to understand the drivers that are created by the targets that we set and to explore whether they are the right ones or whether they are, in fact, directing activity in a way that is not in the best interests of patients and is not the best way in which to spend resources.

Miles Mack has touched on the expectation of the public and patients about what they will have access to and what might be best for them. I think that we are all clear that being able to have a more open and honest discussion with members of the public about what is evidence based and best for their individual circumstances is likely to produce better-quality care for them and, ultimately, result in savings and stopping the provision of particular interventions in certain cases.

11:30

Elaine Tait: I do not disagree with anything that our colleagues have said, but I draw the committee's attention to the timeline differences between investment in prevention versus investment in repair. We have called for increased investment in preventative activities, but we will not see the benefit of that until some years down the line. Therefore, the disinvestment, naturally, will be delayed.

In addition, if we look at the inequalities agenda, we see that patients from more economically deprived communities make much more use of unscheduled care services than others do. If we can address investment in that, as well—if we can combine addressing inequalities, deprivation and prevention—that will help us to reduce the burden on acute hospital and unscheduled care services and, indeed, on our colleagues in general practice, who take an even larger share of that unscheduled care work.

However, disinvestment might not sit nicely in a time zone with investment. I know that the committee does not want to hear that, but it is important to remember it.

Rachel Cackett: To build on what a lot of colleagues have said, we have been in many conversations over the past three or four years about what sustainability in health and in health and social care could look like. A couple of years ago, the RCN published a piece of work on rethinking targets, specifically as a result of conversations with colleagues about how we could define very clearly what we were looking for. In building on that, last year we put forward a proposal to develop very clear criteria for change, which needed to be really transparent, because we have a double whammy, which we have heard about, which is that there are significant holes in finance at the same time as people are being asked to be radically creative and to rethink. We have to remember my point that, like social care, the NHS is a people economy; there are people at the heart of what we are talking about who are trying to deal with both of those things. It is not just about moving figures around on a spreadsheet.

Last week, we had an event at which we talked about the current really big transformation agenda. Someone there reminded me of a graph that I had not seen for quite some time, which I dug out. It was in the 2011 spending review document, and I have it with me. I do not know whether anyone remembers this particular graph, which showed a great big red hole. That is where we are at the moment; we are down at the bottom of the red hole, and it feels like that in the service—it will also feel like it to some patients, and BBC headlines this morning highlighted that.

I agree that there has to be real engagement. It cannot just be about those of us in policy making making decisions, or about politicians, communities or, indeed, staff making decisions—we have not spoken about staff engagement in change being absolutely key. It has to be about all of us together, because there is no doubt that some very brave choices will have to be made about how we reframe things to ensure that we deliver the very best outcomes. That has kept coming up this morning, and we absolutely support doing that for the people of Scotland in relation to the resources that we choose to make available to our health and social care service.

We think that criteria would be really helpful in assessing whether change fits with the policy direction and where we say we want our society to go and whether it has the support of the people who receive and deliver our services. I go back to Ivan McKee's comments about evaluation. Criteria would help us to evaluate whether we are making the right choices. It is right that, traditionally, medicines have been easier to evaluate than many other things. On that basis, if we are making decisions about how to invest in long-term change, we need to know that we can come back at some point and evaluate whether that change was the right investment. All those things come together and it is clear that a step change needs to be made there.

The Convener: The previous panel spoke about transitional change. A nod of the head will do for this question, if you do not mind. Do you all agree that, unless money is put in for the period of transition from acute services to the community, it will be impossible to deliver that change on the scale that we need? I see Jill Vickerman, Elaine Tait and Dave Watson nodding.

Dr Mack: The issue is about not just transformation and new systems but better ways of working, particularly to improve the care interface. The Royal College of General Practitioners Scotland has taken that issue on, and I am grateful for the support of the Scottish Government and the Academy of Medical Royal Colleges and Faculties in Scotland.

We believe that the issue is not just change to the organisational structure; that may well lead to different ways of divvying up budgets, but we tend to see the same people doing similar jobs. From a patient's point of view, the key thing is how we all behave. It is crucial that I have expert specialist clinical support from hospitals, and it is just as important that I am able to deliver that to the rest of the primary care team and get the same from it. That system is not necessarily functioning.

Miles Briggs: Rachel Cackett raised the people economy. We are acutely aware of the recruitment problems that our health service faces. To what extent has the lack, until recently, of a workforce plan prevented the IJBs from making progress to a community setting? Will that plan solve the problems that we face?

Dave Watson: We are pleased about the new focus on workforce planning, and we have seen the first-stage work. The NHS stage is the easiest one—that is not meant to be disparaging. Workforce planning arrangements are established, and the proposals are largely about process. They set up systems for workforce planning, rather than come up with solutions.

The third stage is more in Miles Mack's area. The second stage—in the social care area—will be much more difficult, even for process, for the reasons that were given earlier. The workforce is hugely fragmented and there are well over 1,000 adult care providers—up to 7,000 in total for a country of 5 million people. We do not have the institutions or frameworks that we need to deal

with that situation, and we try to sort matters out with ad hoc arrangements.

The challenges are set out in our submission; all the points are there about workforce planning. You will not be surprised that pay is an issue—there are huge issues because of people not coming into the NHS and broader services. A real-terms pay cut of 16 to 17 per cent over six years does not make those services as attractive as they should be. We need to pay more attention to such issues as Brexit, particularly in the private and community sectors, which have a big use of EU nationals. To be frank, some staff are not registering and others are leaving—the other day, I spoke to a group of our members who affirmed that some had been at an event that a French firm held in Glasgow.

One of the much more difficult big issues is gender segregation, which has been ingrained in the care sector over many years. We must attract young men to the new jobs in Scotland—in the care field in particular—but that is not happening at the moment.

Concerns that I did not flag up in my previous answer are about safe staffing and litigation. There is also concern that regulation, which is growing in the social care sector, tends to create more caution about practices.

Our detailed research earlier this year about the ageing workforce might not surprise you. It showed that the local authority workforce, including those in social care, is older, because nine out of 10 of the jobs that have been lost since austerity are in local government. However, we also found an ageing workforce in the NHS, although its workforce is growing, and that opens up questions about why young people are not attracted to those jobs. That is certainly about pay, but it is also about the physical and psychological demands of the job, which put people off.

That is about four headings, but there are a lot more in our submission.

Jill Vickerman: I would describe two separate dimensions to workforce planning: one is about understanding the demand for the workforce and the other is about where the supply will come from. On understanding the demand, the publication of the workforce planning framework is a start in the right direction, although it is not a full workforce plan for the future and it could not possibly be at this stage. We need a clear understanding of what the future health and social care delivery landscape will look like, and we do not have that yet. That needs to be developed following the implementation of the health and social care delivery plan and the development of the rather complicated landscape of planning documents that are being produced for regional planning, national planning, NHS board planning, integration joint board planning and local authority planning. That has to come together and it needs to be made sense of.

We then have to understand what that means for the future workforce that we need; my colleagues have described the possible complexities of that workforce. Only then can we develop a map of how we get from where we are to where we need to be. I think that most of us would agree that we do not even know with 100 per cent certainty where we are. We do not have a complete understanding of the workforce in primary care—for example, we do not have figures on specialty doctors.

A lot of work needs to be done to know where we are and where we are going, and then we can start to map how we get from A to B. That is what workforce planning is about; we are a long way away from that. Once we have done that, we can start to think about how we attract people into the roles.

A huge amount of thinking needs to be done about how we make the roles more attractive. We need to recruit and retain people. We need to look at the start of the journey for the workforce and we need to keep people in the middle of their careers, because we are losing people at that point in primary and secondary care. We are also struggling to keep doctors at the end of their careers—they are leaving early—and we need to find ways to address that end-of-career issue. The same picture is playing out in the other healthcare professions.

Rachel Cackett: I back up most of what my colleagues have said. Pay is clearly a big issue in recruiting and retaining people in the workforce.

I will go back to the issue of complexity, which I talked about in answer to Maree Todd's question. To go back to Jill Vickerman's last point, one of the issues that we face is that, as people decide to leave the workforce early—we have a huge retiral issue in nursing and particularly community nursing—we end up losing some of our most experienced nurses when the complexity of healthcare that is required is at its greatest. That gives us and IJBs a problem.

We also have to think about workforce morale, about retention and about how attractive it is to come into the workforce. Members will know from our submission that we have released early findings from a large survey that we completed across the United Kingdom on staffing. When describing what had impacted on their ability to deliver high-quality care, a third of respondents in Scotland reported there not being enough registered nurses and a quarter reported there not being enough healthcare support workers. The

vacancies that I talked about earlier have a huge impact when we expect the rest of the workforce to pick up that work.

As I said, it is a people economy and people go into it because they want to make a difference and do some good for people. They want to work alongside people who have health needs. If someone comes away every day feeling that they cannot quite do what they want because the vacancy levels are too high, they are too stretched or they do not have the resources that they need, that has a direct impact on their ability to feel good about turning up to work every day.

We are in this great funnel of not having enough money and, in situations when money becomes the big driver, it becomes harder to hold on to quality. I listened with interest to our colleagues in the previous panel talking about service redesign and cuts. To go back to the point about criteria, we must have a really clear idea of which is which. That is because some service redesigns are cuts and some are based on really good evidence where the patient outcomes are equal to or better than the previous ones. Sometimes, we are not always clear on that and we end up with replacement models and downgrading models, which is not a good outcome and does not deliver good outcomes.

When finances are all, which they are at the moment, what I described becomes difficult to hold on to for people who start the year knowing that they have an £8 million or £9 million hole in their budget. I go back to our call for criteria; we need criteria so that we can be transparent with the public when a service change is genuinely an improvement.

11:45

The Convener: I wish that you would speak to chief executives of health boards and ministers. We have been pursuing this for so long, and there is the voice of sanity.

Elaine Tait: We often talk about valuing a world-class workforce. If Scotland is to meet the challenge that it has set itself of making a significant transformation in how services are delivered, we will need that world-class workforce across all the healthcare disciplines.

I will speak specifically about hospital doctors who are members of our college. What drives them is direct patient care. That involves contributing to service development, to quality improvement initiatives and to patient safety initiatives. It is about contributing to the research agenda where there are gaps in the evidence about what is needed if we are to achieve safely the care that is needed or make the changes that we have already identified. Last, but by no means least, it is about contributing to the education and training of the next generation of doctors who will take over from them.

One issue in workforce planning is generating enough space in doctors' work plans to enable them to fulfil their patient responsibilities as well as to make their longer-term contribution to the development of health services. If we do not generate that, we devalue the job for them, which makes us less attractive as a health economy in recruiting doctors to our service and retaining them.

Hospital doctors are working under pressure in exactly the same way as other professionals in the community and in the hospital sector. Trainees—young doctors who are coming into the profession—are watching them. They see their senior colleagues retiring early because of pressure or working in a different way, and they are starting to ask whether they really want to live their lives like that. If we do not stop that cycle of pressure and difficulty, we will struggle to recruit in the future, and then we will struggle to make the changes that we all need to make.

The Convener: Miles, are you finished?

Miles Briggs: Yes.

The Convener: Colin Smyth is next.

Miles Briggs: The other Miles wants to come in.

The Convener: I am sorry—there are too many Mileses.

Dr Mack: There are too many Mileses although there are not usually many of us around.

In 1996, there were 2,600 hospital consultants and 3,400 general practitioners. In 2014, there were 4,500 hospital consultants and the number of whole-time-equivalent GPs had fallen to 3,200. We have had a failure in workforce planning for general practice. Such planning is difficult because we are an independent contractor service but, when we are tightly bound by the amount of resources that come in to employ new GPs, it is perhaps not surprising that we are in the situation that we are in.

It is so interesting to hear comments from the social care side. The ideas about GP career flow and how we have to think about how we recruit people into the profession, train them and retain them throughout their career seem to be relevant to other parts of the profession. We pinched the ideas from the rural side and they now seem to be main stream for general practice. We really need to be careful about that and I am really pleased to see the progress that the Scottish graduate entry medicine programme is making, in that the graduate entry medical school will be training

doctors in the right way for the future needs of the NHS.

Colin Smyth: I am looking forward to seeing how the *Official Report* reflects the fact that members of the panel nodded when the convener asked a question earlier.

When the Government is challenged about resources in the health budget, one of the criticisms is that it often makes a defensive response. The Government points out that we have more doctors and nurses than we have ever had before, and I know that that frustrates a lot of organisations, because the real debate is not about how many we have but about whether the numbers and resources are keeping up with demand.

In the budget-setting process, how do we move the debate on to how resources meet demand? Can we do something as part of the budget process to achieve that? For example, can we put in the budget document a figure that reflects how much it will cost next year for services just to stand still and compare that with actual growth in the budget?

Jill Vickerman: I refer you, at least in part, to my answer to the question on workforce planning. We need to understand better the future demand for healthcare, but it is not that hard to model, given that we know what the age and morbidity profile of the population will look like in five or 10 years' time. In fact, the population forecasts that we have allow us to predict fairly accurately where those with different morbidities and healthcare requirements will live. On that basis, we could make reasonably good estimates of what the costs of delivering healthcare to that population would be if we did not change anything.

That is a really important piece of work that needs to be done, and I know that the Scottish Government is talking about it in the context of workforce planning and transformation. That work is about getting a better understanding of how to model future demand and scenario plan on the basis of what the costs of alternative healthcare models might look like. That must inform the budget setting, because we must be absolutely clear and honest about the cost of delivering healthcare with and without transformational change to the population that we know we will have in the relatively short to medium term.

Dave Watson: Every year I produce my analysis of the numbers, and it always turns out to be different from that of the Scottish Government, COSLA and everyone else. We all carry out such an exercise, because people bandy numbers about. The statistics are published through the Office for National Statistics, but the difficulty with an awful lot of this is that the services in question are interactive and there are lots of transfers between them. As a result, the numbers do not always add up, because people do not take account of transfers of staff. In Highland, for example, there was a big shift of staff from local government into NHS Highland, and that sort of thing is rarely taken into account when people claim increased staffing levels in the NHS.

One of the big things with the Christie commission, which I have mentioned before, was its attempt to move us away from inputs and focus more on outcomes. There are some difficulties with that but, if we are always focusing on having 1,000 nurses, doctors or whatever, we will not be focusing on where they are going.

I agree that a lot of this is about better planning. However, that will not produce some nice little formula, such as x over y to the power of 2 equals the answer; we will have to make judgments. Part of that will come down to the political process of making big decisions about the future of care in Scotland. All of that has to be focused on before we can carry out really credible workforce planning.

What really irritates staff at the sharp end is that, when we talk about theoretical arrangements, particularly in the social care field, people say, "Oh yes—we're going to produce 500 care packages to do X," when the staff are simply not there to do that. Companies will say that they get offered 100 care packages but that they do not have the staff to deliver that level of work. We have to get all the elements in place, but we must also recognise that none of this will have the sort of precision that will be able to be monitored and that we will have to make broad judgments about the way forward.

Rachel Cackett: One practical approach that the committee could take relates to the parallel process that we expect the proposed safe staffing bill to go through. It will have a direct implication for all this. I appreciate that it will not apply to next year's budget, because seeing it in will require a longer-term process, but it relates to the point that was made about not just talking about the raw numbers but looking at what people are expected to do.

The proposed bill could cover the ability to determine workforce numbers and the skill mix on the basis of people's dependency and acuity and could come up with a far more sophisticated answer on the number of staff we need to provide good-quality care and the levels of experience, knowledge and competence that they should be at. Through the parallel process of considering that bill, the committee will have a say in making sure that we can, in the future, budget according to need with regard to the NHS's biggest resource, which is its people.

Colin Smyth: I want to touch briefly on another pressure on the budget, which is the current discussion around the general medical services general practitioner contract. My question is for Miles Mack and Jill Vickerman. What do you want to get from that contract? What does it need to deliver and what impact will it have on the budget?

Jill Vickerman: Fundamentally, the contract has to support a model of general practice that is sustainable and attracts medical students into careers in general practice. We need to develop through the contract a model for the role of the GP that addresses the challenges in the work environment that we have heard a lot about this morning.

The contract needs to be clear about the role of the GP and the other staff who work in primary care; we need clarity about what individuals do in different roles and how many are required. That is part of the on-going discussion and negotiation. We also need to understand the factors that make general practice unattractive for some people who are making choices about their medical careers.

Additional support and investment in primary care are unquestionably part of what is required. We need to attract more people into the profession and create a sustainable model to deal with the types of increasing demands for care in the community that we have talked about.

Dr Mack: Those things are very much in keeping with the views of the RCGP Scotland. First, we must ensure that there are resources for a sustainable future for general practice. We need a reversal of the drop in funding to ensure that general practice remains sustainable.

Secondly, we will undoubtedly need to grow the GP workforce, so Jill Vickerman is right that we will need to attract people into the profession—we need to ensure that we have enough GPs to do the work. The transformation will mean that we will be working with others and we will need to provide support for them as well as doing the other parts of our work.

Thirdly, we need to consider what sort of GP there will be in the future. We have been clear about what we see as the core values of general practice. I am sure that the committee would not disagree with those values, which are about being the first point of contact, continuity of care, and being able to co-ordinate care and provide comprehensive care for patients. That is what our patients expect. We should hold the contract up to those measures to see whether it is achieving what we need for the future of the NHS.

Alex Cole-Hamilton: Rachel Cackett alluded to this morning's headlines, from which we learn that, according to an investigation by *The Times*, 14,000 fewer operations were undertaken in the first quarter of 2017 than were undertaken in the same quarter in 2016. That is a critical indicator of an interruption in patient flow through the health service. There are a number of areas where we might be able to point the finger of blame.

I would be very interested to know what the panel thinks is to blame. Is it a fundamental shortage in social care destinations for patients leaving hospital, problems in hospital because we are not ring fencing elective surgical beds, or a lack of safe staffing provision in nursing? Does it go back to the start of the journey and the GP sector? Is in-patient care being necessitated because conditions are getting more acute as a result of people having to wait longer for appointments?

I know that that is a big question. You may have different answers depending on your sphere of interest, but I am keen to hear them all.

The Convener: We are really pressed for time, so I must ask people to be very succinct.

Elaine Tait: I will be brief. Hospital physicians have the majority of the unscheduled care workload; the balance of their workload is unscheduled. Its pattern is predictable, but it cannot be scheduled or delayed in the way that surgical procedures may have been. Also, because of a lack of provision and other difficulties in community care, medical patients have taken up resource in hospitals and that has prevented surgical procedures from going ahead. That will come as a surprise to no one.

Our hospital management colleagues have had to manage that pressure. We cannot turn away a sick medical patient from accident and emergency or from a GP's surgery. Until such time as we can achieve that transformational change, that pressure will cause our surgical colleagues difficulties from time to time.

12:00

Dr Mack: There are two aspects to consider. We are concerned about the rise in waiting times, which has a direct effect on us because patients come back to us again and again to get symptomatic treatment while they are awaiting surgery. Jill Vickerman was right to mention the downstream effects, and unscheduled care is a big issue. There is clear evidence from Helene Irvine's work that failure to invest in primary care services, particularly GPs and district nurses, puts proportionate pressure on A and E departments, particularly with regard to the elderly population, many of whom get admitted.

There are issues that we need to look at as a whole system, and my real concern is that, if there are things that can be measured—waiting times is

one of the measurable ones—we may find that we are investing in the wrong place and are not actually getting to the root cause. It may well be the aspiration of the committee, and of the witnesses, to build capacity in the community.

Dave Watson: A lot of people say that they will design solutions, and in the NHS staff and management are doing a lot of work in partnership on improving flows in hospitals, improving design and doing innovative things. There are plenty of good examples of that, but clearly there are a lot fewer operations being done, and that is down to vacancies. We have talked about doctor, nurse and other staff vacancies in the NHS, which sometimes lead to straightforward cancelling of operations. There is also the issue of people who are in hospital and who should not need to be there. Progress has been made in a number of those areas, but that is largely down to social care.

The first question that Maree Todd asked was why the reference goes to a hospital. The answer is that hospitals do not turn people away—it is as simple as that. If you are not sure whether another service is there, you refer to a hospital, and the hospitals have to manage the situation.

Jill Vickerman: I will try to be brief, so I will not reiterate many of the points that have been made, which I absolutely agree with. It sounds like a relatively simple question, but it has a very complex answer. There is a range of factors. The one that I would stress is the fact that we have a high level of consultant vacancies in hospitals. The latest figures show that there are 460 vacancies, which is one in every 14 consultant posts, and of those at least half have been vacant for six months or more. That has to have a significant impact on the number of operations that can be performed.

Brian Whittle: There is an inevitable logic about shifting some resource towards the preventative healthcare agenda, but there is a reluctance to make that move. There is an issue around defining what the preventative healthcare agenda actually is, because there are a lot of different ideas around it, and it almost requires a leap of faith to adopt the agenda. Where are we on quantifying the financial and social benefits of long-term investment in preventative healthcare?

Dave Watson: The point was made earlier that the issue was flagged up in the Christie commission report. I was an adviser to that commission, and we looked at lots of practical examples that could be costed. We are not always good at costing up the benefits and shouting about them to demonstrate to people such as MSPs that such investment makes a difference, because doing that kind of reporting is very complicated and takes a lot of staff time. Nevertheless, there is solid evidence right across the world that shows that broader preventative activity is effective.

There is a certain amount of frustration when people constantly talk about the NHS having problems in this area or that area, when we all know that health inequalities require action in education, sport, leisure facilities, housing and so much else as well. I would like to make a point about something that arose after I wrote our submission.

I urge the committee to look very carefully at the recommendation in the Barclay review of business rates that leisure trusts and sports facilities should no longer be excluded from paying business rates. That proposal would take a big chunk of money out of sport and leisure. I do not disagree with the technical recommendation in relation to business rates, but, if the same amount of money is not put back into local authority budgets, there will be a big cut in sport and leisure facilities of the sort that Peter Johnston and others referred to. I urge the committee to give some input from a health perspective to whatever recommendations the minister takes from that report.

Dr Mack: At the meeting of the Academy of Medical Royal Colleges and Faculties in Scotland yesterday, Obesity Action Scotland made the point clearly that not only do we need preventative actions but we need actions that work across society. There is no point in having something that just makes the people who are the most wealthy and the least likely to suffer from ill health even fitter. We need to bring everyone up together.

The key point is continuity of care and being able to embed the preventative activity into routine treatment. The GP must be able to see patients long term, understand them and their community and perhaps understand their family better. They could potentially intervene for future generations. GP visits are an ideal opportunity to get those messages across, particularly in a way that is appropriate to the person who is coming to the GP.

For many of our patients who are most needy, the idea of living to 80 or 90 seems like a middle-class abstraction. It is not something that is on the cards, when all that they are worrying about is how to pay their bills that week or make sure that their rent is paid. GPs have to work with people where they are. We have a great deal to learn from the deep-end group of practices about how we can do that and how the key role of general practice and primary care is to deliver in the context of continuity.

Rachel Cackett: I return to the convener's earlier question, in response to which we almost managed only to nod our heads—although we did

speak a little. It was about the issue of extra funding.

The question came out of the idea of moving funding from the acute into the community sector. I question whether that is possible in the current climate. The NHS remains, quite rightly, free at the point of need and does not turn people away, and there are still people who require acute services to be delivered. It is almost impossible to remove money and put it elsewhere when it is known that there is not enough.

I return to the point that there is a need for a double funding arrangement to make the sort of step change that is looked for. I agree with the comments made throughout the meeting about evaluating what that step change looks like and making sure that the new investment goes to the right place.

One thing that we have not touched on is long-term financial planning, which has been brought up by the RCN and many others. At the moment, the constant annual cycle requiring budgets to break even does not allow a step change to come to fruition over a number of years. The Auditor General for Scotland among others has talked about the potential for three-year planning cycles, which the RCN believes would support at least the beginning of a longer-term approach.

Finally, NHS Health Scotland published work with Information Services Division Scotland over the summer. Although I do not like the publication's title, "The Scottish Burden of Disease Study, 2015", I understand why it has it. It is some very interesting work that looks at where in Scotland particular conditions are having the greatest impact on the population.

NHS Health Scotland and ISD Scotland are intending to do more work on how to forecast on that basis. I suggest, in response to the question about prevention and where new investment should be directed, that "The Scottish Burden of Disease Study, 2015" provides some interesting data to interrogate about whether investment is getting to the right places to meet the greatest needs in our communities.

Jill Vickerman: This morning, a number of people have made the point very clearly that the investment that is required in order to tackle the upstream health improvement and prevention agenda largely needs to be made outside health and social care budgets. The majority of the interventions and action that need to be invested in to tackle mental health, obesity, alcohol, drugs and smoking need to be funded and resourced from beyond the health and social care budget. There has been some very good discussion about the implications of that. It does not mean that good things cannot be done within the health and social care budget. Miles Mack talked at length about the role of GPs and the potential for them to make positive interventions at various levels of family life.

Our plea would be that although we must look at what we can do to contribute to the prevention agenda in the health and social care budget, the responsibility for funding the majority of that work definitely lies outside health and social care.

The Convener: I have a final question about pay. It has been announced that the 1 per cent pay cap is to go. Last year, we had the introduction of the living wage. There is still a hangover from that in relation to sleepovers and how sleepover money will be paid—there are all sorts of machinations on that. Does anyone know where the money to break the 1 per cent pay cap will come from?

Dave Watson: The short answer is no. A couple of factors are relevant to addressing that, one of which is the UK Government's autumn budget. We can all guess by how much the Chancellor of the Exchequer will jiggle his targets to create what we hope will be revenue spending. In the past, some capital moneys have always been fed in in the budget, but all the things that we are talking about—pay, in particular—need revenue funding. We hope that the chancellor will free up some resources so that the Scottish Government gets a revenue increase, which it can then use partly for pay.

A second relevant factor is what the Scottish Government decides to do about the part of the budget that it controls and what it does on tax. The First Minister told us that a discussion paper on tax is to be issued.

We very much welcome the statement of principle that the 1 per cent cap is not sustainable, which is very good news. Obviously, a pay increase of 1.1 per cent will not be acceptable. We want there to be a significant increase in pay this year. If we are to tackle some of the long-standing issues in attracting people into the sector, we need to do more. Pay is the basic starting point when it comes to sorting out all the recruitment and retention issues. It is necessary to take action on the number of staff who are being trained and on many other areas, but pay is crucial.

We hope that the Scottish Government will have some flexibility to enable it to put serious money into health rather than just make a token increase above the 1 per cent level, so that we can start to catch up and make the health and care professions attractive ones for people to come into.

The Convener: Some of the money for paying the living wage to workers in the social care sector

had to be found internally. Is that likely to happen again?

Dave Watson: A question was asked earlier about double counting. In my submission, I made a point about double counting of living-wage moneys. One of our finance members said to me, "I can't spend the same £1 twice, Dave." That is a real issue.

The living wage is largely being paid for waking day duty and waking night duty. We are still in discussions with the Government, COSLA and others about how we will deal with waking night duty and sleeping in, in particular. We need to recognise that the historical use of sleeping in is no longer an appropriate model in care. The idea that if someone is on sleeping-in duty, they will spend the night kipping and will not be woken up no longer applies—that just does not happen. We will have to bite the bullet and recognise that the difference between sleeping in and waking night duty is now pretty blurred, if it exists at all. In fairness to the minister, she has said that she wants to pay the Scottish living wage for such hours. We think that that is right, and discussions are taking place about how we might get round to doing that.

The Convener: Thank you very much.

12:14

Meeting continued in private until 12:34.

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