OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 22 May 2018

Session 5

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HEALTH AND SPORT COMMITTEE
17th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Kate Forbes (Skye, Lochaber and Badenoch) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Eddie Fraser (East Ayrshire Health and Social Care Partnership)
Pam Gowans (Moray Health and Social Care Partnership)
Janice Hewitt (North Lanarkshire Health and Social Care Partnership)
Robert McCulloch-Graham (Scottish Borders Health and Social Care Partnership)
Judith Proctor (Edinburgh Health and Social Care Partnership)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 22 May 2018

[The Convener opened the meeting at 10:01]

Pre-budget Scrutiny (2019-20 Budget)

The Convener (Lewis Macdonald): Good morning and welcome to the 17th meeting in 2018 of the Health and Sport Committee. I ask everyone in the room to please ensure that their mobile phones are off or on silent. Please do not record or film the proceedings.

The first item on our agenda is a pre-budget scrutiny evidence session on the Scottish Government budget for the financial year 2019-20. The Health and Sport Committee has set a bit of a pace in terms of pre-budget scrutiny; we are keen to ensure that we continue to set that positive pace, so we are taking an early look at the budget for the forthcoming financial year.

We have received apologies from Miles Briggs.

I welcome the representatives of five health and social care partnerships from across Scotland—Judith Proctor, chief officer, Edinburgh health and social care partnership; Eddie Fraser, director of health and social care, East Ayrshire HSCP; Pam Gowans, chief officer, Moray HSCP; Janice Hewitt, chief accountable officer, North Lanarkshire HSCP; and Robert McCulloch-Graham, chief officer, Scottish Borders HSCP. I look forward to hearing from you all.

The committee has been keen to ensure that we—and others—have sight of full financial information regarding integration authorities as well as health boards. We were therefore pleased when the Scottish Government made that information available earlier this month in the form of a consolidated report on integration authority finances. How helpful is the publication of that information for you in your work? Will you use it to benchmark and compare your authorities with other integration authorities?

Eddie Fraser (East Ayrshire Health and Social Care Partnership): It is really helpful to be able to see that information. It is also important that we understand what the fair comparisons are. Different partnerships have different services within them, so you will see differences. Some partnerships include children's services and some partnerships include justice, so it cannot just be a straight read-across—you need to look at a family of partnerships that are like for like.

That being said, we can see trends in the information and it is really good to be able to see what is happening across the country in similar board areas such as Tayside or Grampian, where there are several partnerships within the one board area, rather than just looking at what is happening in Ayrshire. Seeing that information—and seeing it regularly—is a helpful tool in our financial planning.

Pam Gowans (Moray Health and Social Care Partnership): We need to understand the detail of what lies beneath the information. The process, which stimulates debate and allows us to ask more questions, will be very useful.

Robert McCulloch-Graham (Scottish Borders Health and Social Care Partnership): A great deal of learning is to be had across the 32 partnerships, so any information that is shared will be useful. It is essential that we benchmark against one another coming into each of the budget rounds.

The Convener: Excellent. That seems to be a shared view across the board, which is helpful to understand.

It has become clear from the consolidated financial information that a number of partnerships face an overspend in the current financial year. What are your plans for addressing that overspend in this financial year?

Eddie Fraser: We are one of the partnerships that indicated that they were heading for an overspend. Again, that overspend is in specific areas and there are specific reasons for it. Our overspend in the health part of the budget is almost totally on primary care prescribing, and our overspend in the local authority part of the budget is on outwith placements for our children's services. Our big mainstream services operate within budget; it is those services that are specific to us in which we are overspent.

We work closely in each area to determine how the change programmes will address the issues. I work closely with the director of pharmacy, and we are looking at the new input of resources through primary care, including the new pharmacies that are going into general practitioner practices and how that could change some of our prescribing patterns and reduce the spend. Some of this year's increases have been about not the volume of prescribing, but the increases in the unit cost of prescribing. That is outwith our control, but at the same time we need to take control, so the situation is difficult.

On children's services, the issue is about the wider wellbeing of children. On service delivery in that area, we have recently had our joint children's services inspection, which received a very positive evaluation. Children who come to us in the

partnership need the services. Our work must be about ensuring that we deliver wellbeing further upstream—we must give different support to families and communities, so that not as many children need our services.

We have clear planning programmes. Indeed, yesterday, we took a strategic plan associated with a financial plan, a workforce plan and a property and asset management strategy, which had already been to the council and the integration joint board, to the national health service board. We know where we are going; we know the specific areas in which there is overspend and we seek to address them.

Pam Gowans: I am from one of those areas with an overspend, too. We have a significant gap to fill, as you will have seen from our written submission. Some of the bigger pressures are the same as those that Eddie Fraser has just described, but there are also broader historical themes. For example, the budgets that are needed to run community hospitals at the current level do not match the budgets that have been provided historically, so we are trying to deal with legacy issues.

Out-of-area placements, high-care packages and prescribing account for the biggest areas of overspend. We have identified more than £1 million of savings that we are confident we can make. It looks as though our year-end sign-off will be better than we thought it would be, to the tune of £750,000, but that would still leave us with £3.5 million to find.

Given the size of Moray, the budget for the area is small. It does not take much of a shift for us to be in difficulty, so we are mindful that the decisions that we take now could have a legacy and therefore must be considered.

We have decommissioned respite facilities, which was very difficult for the three individuals who were using them. However, on best-value grounds and our ability to deliver through the modernisation of self-directed support, people are choosing not to use those traditional ways of seeking respite, but we have had to manage sensitively the small number of people left. In some ways, those were difficult decisions for those who were involved from a quality and family perspective, but they were easy from a financial perspective, because that provision did not make good, viable, best-value business sense.

A huge number of activities are going on with our senior management team to drill down into all the services in order to understand the implications of the existing gap and the gap that we might have next year, particularly given Moray Council's difficulties with its budget. We are asking what it would mean for the people of Moray if we had to reduce even further and reprioritise what we do. We are looking to make decisions about such matters with the public and with both the partner agencies that fund us, so that we do not have a legacy of unintended consequences. We want to have a reasonable handle on that by June, but the work will go on throughout the year, because the change programme is for three to five years.

Dr Gray's hospital is our key district general in Moray and it accounts for most of our unscheduled care. On a positive note, we are looking with NHS Grampian at how we can bolster the system with capacity for planning, because we want to make sensible decisions. We have recruitment issues, and there are rural aspects to the GP contract and to how we run the hospital. There is an opportunity to look at that more broadly, in a systemic sense. We hope that we will get something reasonable and palatable that does not compromise quality.

Judith Proctor (Edinburgh Health and Social Care Partnership): This is my fourth week in my post, so I have not been very involved in budget setting in Edinburgh to date. However, I echo what has been said about challenges. The challenges that are apparent in Edinburgh are similar to those that are being experienced in Aberdeen and those that my colleagues on the panel have described.

Challenging aspects of the budget—those that are harder to control—include prescribing. Our savings plans for this year focus a lot on prescribing—on the opportunities in the primary care improvement plans and in the new primary care contracts. However, it becomes increasingly difficult to make savings in prescribing through practice and custom when some challenges relate to external factors.

From my previous role, I am familiar with issues that could drive challenges in Edinburgh, such as the characteristics of the job market; the make-up of the care home market, which involves a high level of private care homes; and the capacity of care homes that charge us the national care home rate. To address the well-known challenges of delayed discharge and access to good services, we need increasingly to look to the private and more costly market. That is an on-going challenge that we definitely need to look at in balancing our offering across Edinburgh.

Robert McCulloch-Graham: Particular challenges in the Borders relate to the area's rurality. It is difficult to appoint staff there, so we have challenges with the number of residential care beds, and we have the same problems as others in having to use private providers, which are significantly more expensive. Our bed model in the residential sector is at saturation, so we need to create more beds in the area, particularly to

deal with delayed discharge and ensure patient flow, which are difficulties at present.

Since the inception of the Borders integration joint board, £6.5 million has been saved on a permanent basis in the partnership. However, the savings targets for the past couple of years have been met on a non-recurring basis, which means that they have been carried over into the next year. In this financial year, the Borders face a difficult savings target of just short of £10 million, from a budget of £168 million.

The IJB's intention is to use our community asset better—that is the only way in which we will make headway. To manage the demand on our services, we need access to more of the community asset, so we have been working with communities in a much better and more efficient way than in the past. That will enable us to make the shift from acute care to community care. All our strategies and actions are on that basis, which is how we will move into the future. However, the Borders face a significantly challenging year.

10:15

Janice Hewitt (North Lanarkshire Health and Social Care Partnership): We are the very fortunate partnership with an underspend. Like other colleagues, I would say that prescribing is one of the things that is overspent, but we have created a rigorous process for the scrutiny of budgets. We have some workforce challenges: we have vacancies, particularly in certain areas. As you know, we sit in the corridor between Glasgow and Edinburgh, which sometimes works for us and sometimes against us. That is particularly the case for certain aspects of mental health and some of our mental health workforce; it would be great if we could recruit more people into it.

In light of the underspends, we have been fairly creative around some of the models. This year, we have taken through a new home support model. As colleagues have said, it is about managing demand in a different way and trying to get more with the same amount of money.

We have been creative around the use of technology and taking demand out of the system. Indeed, there is a huge opportunity for technology. That area is completely untapped, and we would welcome any support in that regard. Colleagues have mentioned custom, practice, behaviours and the expectation of service. We need to try and manage that over time.

Our home support service is now in a place where we are able to access resource where people need it. We used to have quite rigid workforce patterns, and we work with our trade union staff-side colleagues. We have been trying to change the views on when workers should work. We have some quite traditional ways of working—Monday to Friday, and 9 to 5—but we realise that health and social care is now 24/7, and we need to provide appropriate services.

We have taken quite a bit of time out to seriously try to change our resource. That has not been particularly easy, given that the things that might seem sensible are not always politically palatable. We have had to work hard on evidence and the opportunities for change. From our perspective, those have been fairly managed underspends. To date, we have been trying to create some transformation money, so that we can change the balance of care into the community.

On the redevelopment of Monklands hospital, as we design a new acute facility, we are spending quite a bit of time on what is required in the community. Health and social care has been very well respected and, if we are to have an effective acute service, the whole system needs to come together. I certainly think that some of the transformational money needs to be invested in health and social care.

As other colleagues have suggested, I would say that our independent and third sectors are key to all this. We have a very good relationship with the third sector interface, and capacity needs to come from there, too.

Alison Johnstone (Lothian) (Green): I will focus, first, on some of the evidence in the Edinburgh submission. Last year the committee heard about difficulties with the budget-setting process, which were in part the result of different timescales for the NHS and local authority budget processes and the fact that local authorities need to present balanced budgets, whereas other bodies do not. Edinburgh said in its submission:

"The key challenge in agreeing budgets is the prevailing financial environment facing the public sector and the consequent requirement for a high level of savings in services which face significant growth in demographic-led demand."

Your submission suggests that communication is good and that, although the process itself has not been too difficult, the major challenge is perhaps a lack of cash.

Judith Proctor: The budget setting certainly has not been difficult for me this year, as I have not really been involved in it. That aside, it is important to know that relationships work well. All the guidance and the legislation that we have in place that drives us to work in a certain way is necessary, but more important than that are the relationships and the willingness for integration to work and for the budget-setting process to continue in a positive, proactive way.

I understand that that is what has happened over previous months in Edinburgh, and that is

continuing. However, one of the things that is very challenging is the wider interface with the NHS and the savings that it is required to make, and with the local authority and the savings that it is required to make. That involves us, as chief officers in our IJBs, in a detailed round of conversations on priority setting.

It is about what we are required to do for our IJB to ensure the best settlement possible, but it is also about ensuring that we have good working partnerships with our colleagues and partners in the NHS and the local authority to help to achieve the savings that are required and the outcomes that they are trying to achieve. Against a generally shrinking financial envelope across Scotland, it involves us all in quite challenging discussions.

Alison Johnstone: I would be grateful if other panel members could share their experiences. Is lack of finance as big an issue as different timescales? I would also like to hear your views on another point. Do you think that the IJB voice is loud enough? Are you perhaps being too polite and too restrained? Do you think that you are waiting for others to set budgets when you could be making a more strident call for what you actually need?

Pam Gowans: There is potentially something in that. IJBs are still maturing—we have really just been in operation for two or three years, so we are still finding our feet, and we are working alongside organisations that have been around for a long, long time: the NHS and local authorities.

I know my colleagues well, and many of us are striving to maintain relationships to try to resolve this together, because there is a fine balance between being diverted into a fight and getting the right outcomes for people. However, we need to ask whether we are asserting the authority and the power that we have at the level that we could be. As we move forward, we need to do so confidently. As I said, we need to understand what it is that we are trying to assert, so that there are no unintended consequences that are a legacy for the system.

I think that we are becoming more assertive; it is a journey. We have had to take time to get our feet into a firm position. However, I still think that relationships are key to success and therefore we will always have to work on that balance.

Eddie Fraser: It is fair to say that in East Ayrshire, the IJB is heard quite loud and clear. We have a seat at the community planning table, and our three-way relationship with the NHS board and the council is open and honest. We have real discussions about the fact that we can suck money into social work and health services, but if we do not have money in housing, education or some other health improvement services, all we will do is continue to professionalise our services.

Our partnership work with the third sector and the independent sector is really strong. We are in a different situation from Robert McCulloch-Graham, in that we are reducing the number of people who are in care home beds. A big part of that is to do with our partnership work with acute services. We bring people out of hospital very early. More people are going home, and possession is nine tenths of the law—people tend to stay at home if we can get them home, so our numbers in social care are coming down as well, in terms of care home places.

We work with the independent sector only on care homes. Our partnership work with those care homes and the Care Inspectorate, through the my home life initiative leadership programmes and the care about physical activity improvement programmes, is really strong.

When you are loud and you have an influence over what is happening, that does not mean to say that you want to attract all the money to yourself. It is about how you see that money working right across your community planning partnership, not just the council and the health board. We are starting to see that make a real difference in some of the work that we do.

Janice Hewitt: Lanarkshire is genuinely committed to a whole-system approach. Where differences can be found, they are regarding targets; expectations around meeting some of those targets drive certain behaviours, which is understandable.

All four partners—the council, the health board, the IJB and the third and independent sector—want the same thing. We genuinely want great outcomes for people. I mentioned earlier some of the behaviours of individuals. There is still a cultural expectation that the state will provide a variety of services to a certain level of quality.

We need to tackle some of the inequality issues. Some of the fairer Scotland duties seem to clash a bit with best value. In North Lanarkshire, where we have areas of deprivation, one thing that we ask is that partnerships are trusted to invest where they think that the greatest need is. I realise what the needs of my population are, but often money comes with a tag on it that says where we have to invest it. We have to trust partnerships to invest for outcomes for people. To our detriment, over the years, we have not invested enough in prevention, early intervention or some of the independent community support.

Alison Johnstone's question was whether there is enough cash in the system. The answer is no. I want more cash in the system and I want it to be given without tags so that partnerships are trusted.

I am all for scrutiny of performance but, when money comes with tags, it restricts us greatly. I say "Yes, please" to more cash, but we must be trusted to identify the needs locally and invest in addressing them.

Robert McCulloch-Graham: The way that the legislation is set up relies heavily on relationships and, if the relationships at the senior level between the three main organisations are not working, the system will just not work. There is not enough money in the system. There are three independent bodies that are all accountable for their own budgets and, at some points, they conflict. Working in partnership is a necessity to see us through that, but the legislation is overcomplicated and relies heavily on the relationships between the individuals. Perhaps it relies too much on those.

Partnership is the only answer that we have. The only way that we can start to manage the demand on our services is to get more into the prevention work. The partnerships are set up to do that, but there is a balance to be struck. We can take more resources out of the system if we manage the demand, but we have already taken a significant amount out. Looking at the pressures that all of the partnerships are under, I do not think that there is enough money in the system to cover them all.

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): That leads nicely on to my questions about efficiency savings. Are there particular services that will be hit harder than others when we look for efficiency savings? In its written submission, North Lanarkshire IJB says:

"It is challenging to continue to protect the budgets supporting preventative and early intervention work."

What are your fears about what could be hardest hit? How do intend to mitigate that?

Pam Gowans: The risk—it is a risk that I am certainly aware of—is that, when budgets are under pressure, we can default to soft targets, as I describe them. That is perhaps not the best term, but it is the one that I will use. The trade-off is prevention versus high-cost packages of care for individuals who absolutely require that care. However, there is a real danger that we lose sight of the long-term goal. We also often default to cutting support services such as administration, then we get a false economy of what our clinical and practitioners staff do and how we support them appropriately.

That goes back to being able to consider fully what we are trying to achieve. Our strategic plans commit to prevention for good reason. We know that that is a long-term game and we need to keep going with it. However, as others said, that is not always about the direct budget. Community resilience, the community groups that we have been able to tap into and the third sector that is already thriving are big players in how we ensure that prevention prevails. Community planning partners play a big part in that.

10:30

Going back to what Eddie Fraser said, when I think about the budget it is in the context of a range of partnerships that bring a lot to the table. We need to maximise that to get prevention firmly in the middle, because it is critical. We do that through things such as the Moray growth deal and housing.

If the growth deal is to be successful, we need to make sure that we are a key player and contributor, and that we understand what it can bring to communities. Housing has been a massive transformational partner in what we have achieved in Moray, and in my submission I mentioned a couple of areas where that has had an impact. All of that is prevention, because it is keeping people living independently in their homes and mentally well, rather than languishing somewhere that they do not want to be.

Eddie Fraser: I absolutely agree with Pam Gowans about the contribution that housing can make. Our strategic housing investment programme has already delivered a number of projects that directly support wellbeing in the communities.

Some projects have been generally for older people in our communities, encouraging those in big tenancies to buy and move to new houses, which frees up the big tenancies for families. Other projects have been for people with high levels of need, who may choose to go to really high-quality housing with tech attached. That is not about forcing people to move—they are choosing to. There are a number of other projects coming along the line in the strategic housing investment programme to deliver that.

We see a change from having perhaps 10 people spread across the area, all of whom have 24-hour one-to-one support, to people living in different models of care where there is still 24-hour cover, on site and on hand to them, in such a way that they do not all need individual one-to-one support. That makes significant savings and also delivers more independence for people.

Rather than talking about cuts, focusing on independence and inclusion is the way that we need to manage demand. We call it our community front door when people first talk to us about social care services. We talk about what their priorities are, what self-directed support should be about and what control and choice they want. It is the same agenda as in nursing and

realistic medicine—we ask what matters to them. We are having different conversations with people.

This year, the output has been a 1 per cent reduction in our social care services, as opposed to the predicted 3 per cent growth, and it has not been about cuts but about different conversations with people. That is the way to go. We talk to people about what is important to them and make sure that we deliver on that, rather than taking the more traditional approach of saying that someone has a certain level of need that requires three visits a day, seven days a week. That is not the type of support that we are providing or the conversations that we are having, and we are seeing rewarding returns. It is about how we work with the people who are coming to us for services, and with the communities and other providers—housing, in particular.

Judith Proctor: I agree with my colleagues. There is a project under way in Edinburgh that is showing some real benefits of the approach that colleagues have been talking about, in an area where there had been long waits for an assessment. People with a need for health or social care have had to wait a long time to access that, because of some of our challenges with regard to workforce availability and so on.

By taking that very different approach and working with people to find alternatives from the third and independent sector offerings in the community, people have had better outcomes—mostly from the third or voluntary sector. They have been able to get the support and companionship that they need, and get links into their community that in many ways are far more beneficial to them than a statutory intervention.

Obviously, there are people who require a statutory intervention, and we have been able to move those through, but we have managed to reduce waiting lists and the subsequent need for statutory intervention. That is really important. We often funnel people into service land, as opposed to supporting them to find the links in their communities that can often be more rewarding for them. We always strive to balance the need for efficiency with outcomes for people.

It can be a challenge for us to articulate transformational potential and use transformation funding. One difficulty is that the transformation programme is cultural—it is about new models and the use of technology, all of which can take time to embed and to deliver the expected outcomes, including benefits to people and the efficiencies that we want. Because such money often seems to be sitting spare, we can be under pressure to justify its use. We need to have well-articulated transformation programmes that set out a vision of where we are going, and we need courage and bravery to hold that line, because such transformation will deliver sustainable change in our system.

Janice Hewitt: Kate Forbes asked what is hardest hit, and that is often things that do not have targets. Attaching a target with an expectation of delivery drives a set of behaviours. Only 46 per cent of my budget can be challenged for savings; the rest is fixed. An incredible amount of money is set, from which I cannot take anything.

Kate Forbes: Will you go into more detail about how such money cannot be touched?

Janice Hewitt: Fixed costs include those of care packages and of using care homes, because care cannot be taken away from folks. It is interesting to analyse how much can be taken from the edges. I see my budget as an integrated budget, but that is not always how the two partner bodies see it. I would like to lose the labels from the two parts of the budget. Sometimes I invest social care money in a model and sometimes I invest health money in it. Somebody has to do a ledger that accounts for health spending, the use of council funding and the use of any additional funding. However, I consistently see the budget as integrated. I would like to be able to invest where we need to.

We have talked about investment in prevention. As colleagues have mentioned, the first point of contact is key, whether someone has been known to us or is brand new. At that point, we can take a view on folk's financial situations, their needs and their support, and we can direct them into prevention, self-management, information and advice. However, we do not do that well enough. We really need to explore and invest in self-management.

I will give an example of managing demand through self-management. We have just completed a project that won a local NHS award this week because it involved a truly integrated workforce of occupational therapists, physiotherapists and home support staff. They worked together as one co-located team that used one system—one group had to use the other's system, and the approach was difficult and challenging.

A significant aspect of the project was that we managed waiting times demand. We did not take a cut, but we managed more people through the system, which is growth in itself, and people got a good service. In the future, such self-management and the use of technology in physiotherapy could mean that, after someone has their procedure, they are given electronic ways of managing their condition, which would save visits to our statutory services. That is an example of how we have managed demand.

Kate Forbes: You talked about fixed costs and you suggested that it is harder to find efficiencies when costs are linked to targets. You said that 46 per cent of your budget is not fixed. Does that mean that those aspects do not have targets attached?

Janice Hewitt: Some of them do for some of the things that we have to provide. There are more targets in one world that we live in than in the other. Sometimes, we talk about volumes rather than specific targets. Some of those fixed costs also have targets or expectation of reduced demand or reduced growth.

The Convener: It sounds as though you are saying that existing care packages with fixed costs cannot be remodelled, whereas I think that we heard something different from Eddie Fraser. What is your response to that?

Janice Hewitt: They can be remodelled. It is often challenging to sit with the family and do that. We have done exceptionally well on learning disability where we have remodelled the care, but it takes a long time working with families to do that.

On overnight support and overnight care, families genuinely fear that we are taking something away as opposed to giving them something better. Indeed, that applies even to our own staff. I had a member of staff who sat outside a client's house when we moved to overnight care with technology because they were anxious about the first time. It is about the trust that we build up in the whole system being able to respond.

We can remodel packages, but it is at the margins, and often families have to come on quite a long journey with us.

Judith Proctor: Another example of fixed costs on which we are unable to influence changes is money that comes into our budgets that goes straight out again. A good example of that is the money that is tied up to GP services. They are largely fixed and, although there is transformational potential in how we shift primary care, we are not actively able to make a saving on that money, which is a significant amount of the budget.

Pam Gowans: I support some of the statements that Janice Hewitt made, particularly on complex packages for people with learning disabilities and mental health issues. Indeed, like I said on respite, it takes time and a lot of confidence building to work with individuals to help them to understand that there are other ways in which they can experience the system. It is not a quick fix.

It would be useful to share with the committee one thing that I mentioned in our submission that feels really exciting as learning for us all. It relates to a project on which we are having an academic piece of work done. In Forres, which is a small town in the west of Moray, we had a residential care unit for people with extreme autism and challenging behaviour. That was at the high end of challenge. It was a really difficult environment for people to live in. They were living with people with whom they would not choose to live and their families did not have privacy and the ability to interact in the way that they would wish. Our recruitment and retention was pretty bad, although there was a core group of staff who stuck with the unit all the way through. They were home care-level staff and were really dedicated.

Before integration, Moray Council had started to address two objectives for that unit: one was recruitment and retention and the other was optimising the individuals' right to a better quality of life. When the people were in the residential service, we averaged about 70 incidents of assault on staff a month. That is a lot of distress for the individuals involved and for the staff, so it was not a good situation.

Last August, we opened brand-new bungalows that were all built to suit the needs of the four individuals who moved across in the first instance. The individuals have technology-enabled care. Their right to a family life is fulfilled because they have privacy in their own homes and their families can come and work with them. They are also in a community in lovely, spacious and bright environments. We have also recruited teams specific to their needs to work with them.

In the first six months, our incidence of assault went down to one, which was pretty minor. That will be a honeymoon period and there will be peaks and troughs. I do not have the exact figures here—I can get them for you if you want—but I think that there was a 73 per cent reduction in our use of as-required medications, which means money. There was a 100 per cent reduction in the use of one restraint technique and a 93 per cent reduction in the use of another. It goes on in that positive manner. Recruitment has been really successful. One person has left because they went on maternity leave. It will be coming up for a year in August, obviously, so we will be able to have a really good data set on that.

The next point is really important from a budget perspective, because we are all spending lots of money on out-of-area placements. Since we opened those bungalows, we have repatriated individuals who could be costing us around £600,000 to £1 million a year in out-of-area placements down south. In a budget the size of mine, that is a scary number. In out-of-area placements, we do not have the same connection or have control over everything that happens

there. Plus, for the family, it can mean significant travel to try to see the individual.

10:45

We have successfully brought people back and into the bungalows who were in those circumstances. Interestingly, we are having positive results in terms of their quality of life and having no further incidents, which are all things that felt very high risk from practitioner perspective. From a professional perspective, in traditional models, we were looking at scary prospects.

There was a bit of boldness there and we are really interested to understand all the factors, which we hope will be helpful for colleagues. I know that others have had similar results, but it shows a way that we can achieve quality, still have that right to family life and make savings. The average cost for those people is now about £250,000, and they have their own tenancies—the bungalows are their own houses. It is about making money go further and providing better quality, and there are examples of that that we are starting to understand.

Kate Forbes: I have one brief supplementary concerning Edinburgh. You may have touched on this already, but are budget savings for 2017-18 that were not achieved going to have serious implications for planned savings this year?

Judith Proctor: We will be reporting a balanced budget for the close of the last financial year, but that is as a result of increased investment from both NHS Lothian and the City of Edinburgh Council, in recognition of some of the pressures and also in support of the wider transformation that we are trying to achieve. The budget forecast efficiency that we are looking for this year is a target of £20.2 million, and we have identified £14.9 million of that, so we still have a gap in the identified savings.

As colleagues have also said, we have in place a savings programme and a scrutiny process for the deliverability of in-year savings. You pointed out that non-delivered savings this year will lead to additional pressure next year, because we will have to make savings then, as well. Any unidentified or non-delivered savings are of concern, which is why, from an operational perspective, we apply a lot of scrutiny to that.

Kate Forbes: Was the additional investment last year a one-off?

Judith Proctor: I do not have all the detail on that. We have not concluded it. There are both recurring and non-recurring elements within it.

Sandra White (Glasgow Kelvin) (SNP): I am interested in what Pam Gowans said about the savings and looking at new issues. How difficult is it to change the culture? You obviously have high-cost packages for families. Are their needs reassessed every year, every two years or whatever? How do you work that out? I am sure that all of us are approached by families in our constituencies who say, “This is not good for my child.” It is really high-end provision, so how do you make budget savings and how often do you reassess? What is better for the person involved?

Eddie Fraser: We assess at least every year, and likely more regularly than that. Often, with such transformational changes, folk want to hear not from professionals but from but the families of other folk who have transitioned into different provision. I am a carer for my 19-year-old son, who has autism, and if anyone told me that it would be okay for Callum to spend the night by himself, I would just laugh at them. There is a need to see and trust what is happening, and that is how we must work with families.

People need to see how something has worked for other people, so we have had some trailblazers who have changed, done things differently and created a different type of life. They are not sitting in a house with a paid carer who is giving one-to-one support 24 hours a day. A woman with a learning disability explained that to me as like being with the boss—she saw the carer as being the boss over her all the time. She felt that she had more freedom when she lived in an NHS facility, where she could go to the day room with other patients and watch the telly, feeling that nobody had any power over her. She saw that as a better environment for her than sitting with a paid carer all the time.

We are trying to find something that is in the middle. In some housing models that we are using, people have their own tenancy and their own space but are close to all the support that they require. That is the goal that we work towards.

Sandra White is absolutely right to talk about working with people and developing trust. Everyone is aware of the current environment of financial challenges, so they think that the purpose of someone coming in the door is to make cuts. There is no point in kidding people that we do not want to reduce costs, but we have a big job of persuading them that we want to reduce costs in a way that gives them at least as much independence as they have had and that delivers things absolutely safely.

Robert McCulloch-Graham: People want control of their lives, and a lot of the services that we are now inputting have an element of reablement. If someone has a hospital stay, we want to get them back on their feet as soon as

possible and back to their normal life as much as possible.

In the Borders, we have introduced a discharge-to-assess policy. We do the assessment in a place that is familiar to the patient—it is usually their home or, at least, a homely environment—to find out how they can start cooking, get out of the front door and start their lives again. That gives the power and the onus to get better back to the individual instead of having the state take care of everything, which is a cultural shift.

We, in the Borders, are fortunate to have coterminosity of the NHS board, the council and the IJB, so we can work in close partnership, and all the chief executives and officers have ownership of the challenges that are faced across the partnership. The solutions for some challenges in the NHS lie in the council, and vice versa.

We are trying to shift the balance of care, and the Borders have had success in introducing housing with extra care. As Eddie Fraser said, we have a range of facilities that individuals can get into, and we are providing choice.

Self-directed support gives people much more flexibility in how they get the care and support that they require, so we need people to be much more imaginative about what will be good for them. I will give you a quick example. When I was in a previous role elsewhere, a social worker was dealing with a middle-aged woman who had mental health issues and who, for a number of years, had constantly visited her GP to get antidepressants. The solution was to give her a puppy. She started to walk the dog, she got out of the door, she met people and she joined clubs—she was out of isolation. That was an ingenious move by an individual who had the freedom of a budget that she could use in a different way.

We are all trying to achieve such things with the community. The state does not need to provide everything; we can provide opportunities for individuals to look after themselves. That is a shift of culture and policy that involves councils, the NHS and IJBs.

Judith Proctor: The cultural change is significant and long term. We all work with and are supported by tremendous staff across health and social care and in the third and independent sectors, but sometimes the cultural change needs to sit with our staff, who have been trained in a particular methodology. We need to support them in having such courageous and different conversations.

It is as important for our IJBs, our governing bodies, our local authorities and our health boards to have the appropriate risk enablement approaches that allow staff to work in that different way. Janice Hewitt talked about a member of staff nervously sitting outside somebody's house. Our staff want to do the right thing, and we need to ensure, through our governance and our culture, that they can do that in the new way of working.

Ash Denham (Edinburgh Eastern) (SNP): It has been interesting to hear from all the witnesses. I will move the conversation on to longer-term budget setting. Will the five-year health and social care financial framework assist you with longer-term planning? If so, what level of detail will the framework need to support you with meaningful longer-term financial planning?

Eddie Fraser: I spoke about having a strategic plan, a financial plan, a workforce plan and a property and asset management strategy. If we do not know our financial plan for forthcoming years, it is difficult to have a workforce plan and to say what investment will be made in not just buildings but technology.

In our strategic plan, we include a three-year budget forward look, but it is an estimation, because we get an annual budget. A longer-term view allows us to say how we will do things differently and to plan for the different workers that we will have in three years' time. Indeed, how do the universities and colleges know how many people to train for each profession unless we collectively have that workforce planning information?

Longer-term planning also allows us to give the third sector more surety. Again, because of annual financial planning, there are often short-term contracts with the third sector. With our longer-term financial surety, we can give longer-term surety to the effective preventative things that we do. The issue is how we join the different aspects of planning together.

I do not want to say that we cannot do strategic planning at the moment, because, in reality, our budgets will move by only a few per cent every year—we know 95 per cent-plus of what we will get every year. However, the budgets are big, so the remaining 5 per cent is a lot of money. We can do financial and strategic planning, but we cannot do that to the level of surety that we would want to give all the partners unless we have a longer-term financial plan.

Janice Hewitt: If I were to ask for anything, I would implore for guaranteed approximate budgets. Eddie Fraser has hit upon the issue. Overall, we know roughly what we will get; the issue is the amount that we need to save and the pain that we have to go through, politically and with families, trade unions and staff, because of that. If the budget were guaranteed, any transitions could be managed. We hit, we hit and we hit the requirements. A managed transition would make it far easier to have negotiations with

trade unions and staff and to have far greater conversation with families and local politicians, who also have to manage expectations.

A five-year approximate budget would be great for us. We talk about the skills mix in the workforce; we also talk about the time that it takes to train doctors and allied health professionals and to train skills into the workforce. That takes three to five years. Every year, I try to work out how many nurses and social workers I can afford. With a longer-term budget, I could manage and strategically plan for those skills, which would make a huge difference to health and social care.

Judith Proctor: My comment is related but might not be completely to the point of the question. Both of my colleagues have mentioned that workforce planning is key, including to the wider service transformation, but another thing can be incredibly helpful. Although the focus on individual IJBs and localism is really important, when there are things that we could to at regional or, indeed, national level to support workforce development, it is important that we do those things.

One area in which we could be working at a higher level is the delivery of the new roles that we need as a result of the national workforce plans. We could do that as a group of health and social care partnerships across Scotland, although how we would attract those roles to our individual areas would be up to local areas. If we know that we need to train additional pharmacists to manage the shift in the balance of care, we would have far greater influence over achieving that end result if the negotiations took place at a national level, or certainly at a level that is higher than the individual IJBs, because that is where we would see real traction. That would apply across all specialisms and professions.

Robert McCulloch-Graham: The biggest gain from having longer-term financial planning, whether that is for three or five years, is that you can plan your savings over that length of time, you know the pressures that you will hit over the period and you can stagger when you will take the biggest hit on the budget or pass it on to the next year. That is simply about being able to forward plan.

Pam Gowans: I echo what others have said. Longer-term planning gives confidence in decision making. When we are having critical conversations with communities, highlighting the trajectory that we are on and the system that we need to redesign, longer-term planning allows us to be confident in setting clear parameters. On a couple of occasions, I have found myself holding my nerve on whether to move ahead with a difficult decision and asking whether we need to make the decision at that point or whether we have more time in which to have the right conversations. The certainty that longer-term planning brings gives us the confidence to do that.

11:00

Brian Whittle (South Scotland) (Con): I want to ask about the linkages between budgets and outcomes. Integration authorities are expected to contribute towards nine national health and wellbeing outcomes, and it is a legislative requirement that you report against those outcomes. In previous reports, the committee has expressed concerns about awareness of those reporting requirements and the lack of progress towards that awareness. I was struck by that apparent tension in the submission from North Lanarkshire, which says:

> "linking expenditure directly to one specific outcome does not capture the fact that the budgets support a range of outcomes. Attempts to allocate specific funding to each outcome may be notional and therefore less meaningful."

We want meaningful reporting, and it is a legislative requirement, so what progress is being made on linking budgets to outcomes and complying with that legislative requirement?

Eddie Fraser: In a partnership such as ours, which deals with children and justice, we have three outcomes for each of those as well as the nine outcomes for health and wellbeing. Those outcomes are right up front on our strategic plan, saying what we are trying to do, and we translate them across by asking what our priorities are and by mapping them against the national outcomes.

In East Ayrshire, our priorities are giving children the best start in life, promoting healthy living and health improvement, giving good access to services and addressing inequalities—particularly health inequalities. We take the national outcomes and talk to local communities about how to map them across, and we then work on that.

Janice Hewitt said that, if something has a very high focus, such as delayed discharge or whatever, that can sometimes become a distraction from delivering other outcomes. The challenge—although I am in a good position on this—is to reach a place where we are in control of hospital discharge and people come out early. We can then start to focus on other things.

The focus on other things in the wellbeing agenda, which is the core of the outcomes, is where we really get into partnership work with the communities. It is how we work together with people. The committee will be aware of some of the vibrant community teams that we have in East Ayrshire and some of the work that we do there in our day opportunity services. It is there that we see the real outcomes.

Brian Whittle is right to ask whether we then write down what has happened for the—for us, 15—national outcomes and map against that. We likely do not do that clearly enough. We do that in our planning and can see the linkage, but there is something in what you say about our not mapping directly across to report what we do.

Janice Hewitt: I have one brief comment. We seem to trust numbers but not narrative. There are some great stories out there about the interventions that health and social care has made. Given that some of the targets are process targets and are absolutely not about the outcomes, why do we trust numbers and not narrative?

The Convener: That is a good question.

Judith Proctor: It is important to demonstrate outcomes not only through the numbers and the targets but, crucially, as Janice Hewitt just touched on, through the lived experience of people and improved lives for communities and individuals. It is possible to track those things, which speaks to the challenge around balancing the transformation potential—what we are trying to do in the longer term—and the efficiencies that we must make now.

If we are able to demonstrate that new ways of working and the changes that we are putting in place will significantly improve our ability to achieve those outcomes with people, we have a good, solid argument for investing in that work and preserving it.

In my previous role, our transformation programme was tracked against delivery against those outcomes. The business case process had to include a clear demonstration of alignment with the IJB's strategic plan, the achievement of those nine outcomes—or, at least, most of them—and the measures of success that sit underneath that. It is more persuasive for the board in drawing in new funding and preserving transformation programmes if you are able to demonstrate the ability to shift the balance in that way.

It is very important to take a narrative perspective, and I agree that we must draw more and more on the stories of how people are experiencing services differently. That will give people confidence that, for example, new technology can be an improvement to rather than a substitute for a service. Both approaches are important.

Pam Gowans: It is timely that we are talking about learning how to do that well. We publish annual performance reports, and that approach is part of the dialogue that we are having in Moray. We will publish for the public what we published last year, and we will try to include a lot of stories. Most other authorities did the same—we saw what Eddie Fraser had done in Ayrshire and we tried to learn from that. We are now looking at how we can improve on that and show something that brings to life in a meaningful way what we are trying to do for people.

At the same time, we acknowledge that we are not getting everything right and that we still have to learn from those cases in which people have not had such a good experience and we need to optimise. Our annual performance reports—and the way in which we articulate them—are the vehicle for that, and we are still trying to work out the best way in which to make those reports meaningful. People seem to have appreciated the stories.

Robert McCulloch-Graham: If I have understood the question correctly—I may not have—I would say that it is difficult to allocate a specific budget to a specific action that has a specific outcome, because, in the majority of cases, all our actions hit all the outcomes.

I will give a quick example of that from the Borders. We have introduced community hubs that operate in the major towns in the Borders. The hubs give access to a range of services in health, wellbeing and social services as well as to wider services such as housing and those that are offered by the voluntary sector. That hits a huge number of outcomes, and I am not sure what the value would be of my allocating funding to the hubs and then dividing it into funding for the specific outcomes.

It is important that we are scrutinised against the outcomes and demonstrate how we are meeting and working towards them. However, allocating specific funding to a specific outcome would not be that helpful.

Brian Whittle: In the committee, the cabinet secretary fairly recognised the challenges in doing that. Given the statutory imperative to report on that, what support are you getting from the Scottish Government in developing a reporting structure that will make the process more transparent? Is that support sufficient?

Eddie Fraser: We deal with the Scottish Government across different health areas, so our relationships with the integration support team are strong. Different chief officers take a lead on different things across Scotland. I do some of the lead work on primary care, so I am linked into the primary care teams, but we also have mental health teams and performance teams that are engaged with us around delayed discharge and the four-hour accident and emergency target.

The specific Scottish Government team that gives us the support that you are asking about is the integration team, and they have been a huge support to us throughout the whole process. If

there are any difficulties in local areas, they are willing to come out and talk with us as groups of IJBs or as brokers with health boards. That relationship is positive and strong.

Ivan McKee (Glasgow Provan) (SNP): The discussion has been interesting. I want to focus on the shift in the balance of care, on which we have touched to some extent. I want to take it up a level. From where you sit, can you see a shift in the spend or is it difficult to see that shift flowing through in the numbers?

We have been given data in which integration authority budgets are chunked into four groups; I do not know whether you recognise how the budgets are broken down. The groups are social care, family health services and prescribing, community healthcare, and hospital. Those are for IA budgets, so I assume that the spending in the hospital group would not include what health boards spend on hospitals. I suppose that the hospital group is about the acute side, and we can see that that budget has gone up, whereas the budget for social care has come down, the budget for family health services and prescribing has come down, while the budget for community healthcare has also gone up. It therefore seems that the trends are going in the opposite direction to what we expected. That is about the macro level, but I am interested to know about the local level. What are the witnesses seeing in terms of how budgets are shifting?

Judith Proctor: There are some areas in Edinburgh where there has been quite a demonstrable shift in the balance of care. There has been significant success in relation to the balance around mental health and learning disabilities, which will have built on our direction of travel over a number of years in trying to support people out of institutional settings and into the type of tenancies that Pam Gowans and others have described. That has enabled us to close acute sector beds.

However, it has been challenging to take the change in investment to reinvest in the community. That is probably the case across Scotland. We might see the models shift, but the challenge that we are often presented with by our colleagues in the acute hospital sector on the NHS side is that the costs of acute provision are largely seen to be rising. That is part of the challenge with what is known as the large set-aside budget: when a shift is made in the balance of care and support in the models, we are not always able to release the notional cash and reinvest it in the community. A national integration finance development group is supporting that discussion and conversation across Scotland.

Ivan McKee: Is that because inflation in the acute sector is higher than it is in the community sector?

Judith Proctor: It is not only because of that. There is a host of factors, including managing rotas to ensure that they are fully compliant with the working time directive, the cost of overheads in the acute sector, the cost of drugs, and so on. The issue is therefore wrapped up in a range of complexities, but some very productive conversations are happening. The group to which I referred is chaired by Christine McLaughlin and is looking at unpacking some of that complexity so that we can understand it and begin to think about how we could be supported to achieve the shift in the balance of care to be able to deliver new models that are safe and effective in the community. The question is how we manage that.

Eddie Fraser: I will reflect what Judith Proctor has said. We have just completed our third year of being a fully operational IJB. When we map our numbers against the steering group indicators, we can show reductions in unscheduled-care bed use in acute hospitals, in mental health facilities and in geriatric long-stay facilities. There have been significant reductions in the latter two. However, no money is released from the acute side to us for that because our hospitals are still very busy—I think that everybody knows that additional beds are opening in Ayrshire and Arran to meet demand. We are seeing reductions, but in a board area in which there are a number of partnerships rather than just one, they all feed into the acute hospital so it is still busy. In fact, ours is too busy, so we are doing work around that.

We are starting to see a shift, but it is not yet at a scale that releases resource. It is fair to say that we are more likely to see more of a shift regarding geriatric long-stay and mental health facilities, which are within our control, than we are to see a shift in the set-aside budgets. We have been able to make a shift in the areas that I mentioned, but not in the acute side.

Ivan McKee: Are you saying that you are doing your bit but the other IAs are not, or are you saying that demand flowing through the whole area is such that any beds that you free up will be filled? Are you therefore saying that we are chasing our tail and that shifting the balance of care is an unachievable goal?

Eddie Fraser: We need to be realistic, but we can shift the balance of care and we are already doing it. I have worked in East Ayrshire for 20 years: when I started we had three community hospitals, which were, predominantly, full of older people. We also had 150 more older people in care homes than we have just now. At that time, delayed discharge in East Ayrshire was measured according to how many people were delayed for

over six weeks; we had more than 100 people delayed for over six weeks. For the past eight years, delayed discharges have not gone over two weeks. We now have only one community hospital and we have 150 fewer people in care homes. We have shifted the balance of care.

11:15

Ivan McKee: Are the financials showing that?

Eddie Fraser: The financials show it in terms of overall investment in the community over the period. There is pressure on our hospitals because many of the older people who would previously have been in care homes are now living at home and get on well there, but sometimes need to be in hospital.

Our challenge—and our purpose as integration joint boards—is to make sure that we establish the right types of community services, so that our general practitioners, local families and the acute sector trust that people can be supported in different ways. Just now, the number of people and the pressure on acute services are such that there is no resource to be released from that.

The committee knows that for NHS Ayrshire and Arran, our first challenge is to bring things into financial balance, before we can start looking at how to shift money around. We are seeing activity changing across Scotland. If you look at the numbers, there will be a similar pattern across Scotland, but getting that shift of money out of acute hospitals—

Ivan McKee: I am sorry to interrupt, but this is important. Are you saying that if we were not doing all the things that we are doing towards integration, things would be going backwards, and that just by virtue of the fact that you are standing still, you are actually making progress?

Eddie Fraser: Yes.

Judith Proctor: Yes.

Pam Gowans: Yes.

Eddie Fraser: We work hard to mitigate demands on us; it is about where we bend the curve. The demand on acute services would be much greater if we were not doing what we are doing. We do not want to set up a false conflict between community and acute services: both sides are really busy and are, on the whole, doing appropriate things. However, we can make changes.

Some of the change has to be in relation to medium-term to longer-term big public health priorities, so that the health of our population is stronger. IJBs get drawn into talking about specific parts of the service or parts of the budget all the time. However, some of the biggest gains that we will get from IJBs are from our work on what I call the health improvement and public health element, through supporting communities and being involved in communities. We have been able to do various things with communities through participatory budgeting—allotments, clubs and so on. That is where we are starting to see a change in the health of the population that will reduce future demand.

Pam Gowans: I will make a few points that reflect what Eddie Fraser said. Over the past 10 years in Moray, we have had a 20 per cent reduction in the bed base in acute services and a 10 per cent increase in the number of over-65s in the population.

We have generally maintained really good performance in terms of admissions and delayed discharges. We have been struggling a bit in the past year—we have had peaks and troughs—and we are trying to work out what has been causing that.

Moving cash from acute services to the community is quite challenging. We have tried—I think that others have done the same—to work through things and see whether there is a different way to approach them.

We can have the right conversations that perhaps change how we all work together. Most of us will have examples of that. A lot of it is about where services can go out into the community—for example, services for frail elderly people including geriatric medicine and old-age psychiatry resource, both in and out of hospital. Again, it is about confident and more prompt decision-making. If we do not have the appropriate level of expertise, the change will not happen and we will keep people in hospital. If we make the change, although we might not move the cash, we move resource and are making a more streamlined community hospital service.

The change is absolutely doable in relation to a host of things. If we look back over the past 10 to 15 years in primary care at the local enhanced services, we see that the number of activities that were traditionally delivered in acute hospital settings that now happen in general practice is immense. We have loads of stats on that. However, that was done through a particular investment route that did not immediately take money out of acute services, although it shifted activity. However, activity in acute services has also continued to rise, so the situation is challenging, although there are possibilities. I hope that we have given you a flavour of some of them.

Janice Hewitt: The hospitals, too, have more demands on them, given the increase in elective procedures, the reduction in bed days and faster turnaround. We are working with a system in

which there are demands on the acute side as well as the primary care side, with the expectation being that we will shift the balance of care.

Eddie Fraser used two words: "trust" and "scale". Those, for me, represent the biggest challenges. The opportunity that integration brings is about enabling hospitals to understand what is available, so that they trust the primary and community care sector and can let patients go in the knowledge that they will be treated with respect and given appropriate care in the community. There are still anxieties about letting individuals go when a full package of care is not in place: will Mrs Smith be as safe and well looked after as she would be in hospital?

Some of the cultural change that is needed is among very experienced consultants and nurses, but I think that it will come, as we make workforce changes. We are investing in advanced practice nurses, who are making a significant difference, and we are investing in local treatment rooms and services, which are becoming known to the community.

Our biggest challenge is unscheduled care, which my colleagues on the panel have mentioned. Where we can invest in hospital at home or community resources, with social work staff, physiotherapists, allied health professionals and nurses working collectively in teams, we absolutely will manage unscheduled care. However, that is the next challenge, because a lot of that front-door activity determines what happens in the hospital.

Scale and trust are the two issues. We have talked about scale, and people need to be able to trust the system so that they can let go and let people be looked after in the community, where they want to be.

Robert McCulloch-Graham: We have seen a shift: the number of people who are being cared for in the community has increased across the whole country. However, we have also seen an increase in demand on hospitals.

Let me give members an insight into the level of the increase. By 2032, we expect the number of people over 65 in the Borders to have gone up by 62 per cent and we expect the number of people over 75 to have gone up by 120 per cent. If we extrapolate from those figures we see that there will be increased pressure on the whole system, year on year.

Ivan McKee asked whether we are chasing our tails. We will never catch the tail, because the pressure is on both sides of the system. Without the work of the partnerships, I think that the hospitals would have fallen over by now. The work that we are doing to shift people into the community, where they want to be cared for, is the right thing to do—as we have demonstrated in bucket loads over the past three years.

The shared endeavour between councils and health boards is demonstrable. If you go round the country, you will see many examples of councillors and non-executive directors sharing an agenda and making a significant difference. For example, my council's chief executive has taken a lead role in combating type 2 diabetes across the whole eastern part of the region. Most of the services that are to do with healthy lifestyles are held within the council—for example, leisure services, education and access to good housing are all council responsibilities.

The IJB has provided a platform and an agenda that can be shared, and sharing leads to efficiencies, better quality and better outcomes for residents.

Ivan McKee: So, in summary, we talk about "shifting" the balance of care, but it might be better to describe what is going on as "maintaining" the balance of care.

The Convener: Indeed.

Sandra White: Ivan McKee's line of questioning has brought us neatly on to integration, which is really important. I was amazed by the comments about the need for hospital consultants, in particular, to trust community services.

There is still a perception out there—among professionals as well as the public—that there is a budget for health and a budget for social care, with the two not meeting. As Janice Hewitt said, the North Lanarkshire health and social care partnership submission states that

"The current system encourages the funding to work through both the local authority ledger and the health board ledger. The funding does not therefore lose its identity as was intended by the legislation."

I know that you mentioned changing it, but do you agree that that is what is happening? When you talk about acute care, it seems that the IJBs are doing a great job, which I do not envy them. However, you have said that when people go out into community care you are not getting the funding from the health board budget to help your budget.

Janice Hewitt: I said earlier—I will reinforce it—that health and social care integration will be successful only when we cannot see the lines: when the budget that came with a health ticket has lost its identity and the budget that came with a council ticket has lost its identity. At the end of the day, someone will do the accounting and the ledgers, but let us make those resources an integrated budget.

We will be successful also only when we cannot see the lines between workforces, either. Let us

ditch the lanyards that say that people work for the NHS or for the council, because we are skills mixing beyond anything that anybody previously understood. Some of the challenges are around our use of technology, and there are still some around organisational differences. We must also acknowledge that there is still some resentment from staff and trade union sides. Success will come only when you cannot see the lines between budgets, between workforces and between organisations, and there is strategic planning across the whole system.

Eddie Fraser: We see the resources working best when they have come to us jointly, and can see some of the money being used in the third sector, as well. We have the integrated care fund, and we have always had resource transfer. In my area, I have always got £10 million from the health board to spend on social care services for hospital beds that have closed. The new moneys for social care, whether they have come through the health service or the local authority, have come to the integration joint board as new moneys.

A particular success for us has been the alcohol and drug partnership money, which sits under community planning, so although I lead on that, it is a wider initiative. There is about £1.6 million for that, and we discuss with all our partners how to allocate it. I see good steps being taken with the new moneys that are coming to us for primary care, in terms of how we work with local GPs and the wider system.

It has been quite hard to move some of the established budgets across because, in the council and in the health board, there are people who think that they still have ownership of those budgets. A sense of ownership is not a bad thing, but some people are just not able to let go.

When new moneys have come to us is when we have been able to be innovative and to think about how to do things differently—even how our integration schemes are written. Ours is written to say that both partner bodies will take account of demographic challenges. People have their own thoughts about what the demographic challenges are, and they do not think about it all getting thrown into a pot. If the council recognises a real demand for social care and gives £2 million to the IJB, and then it sees that I am putting more district nurses out there, it will not be happy about that decision. With new moneys, we are able to be more innovative; it is harder to make changes with some of the established budgets.

Judith Proctor: I agree with everything that has been said. It comes back to the vision thing. What is it that we are all signing up to do? What are we all trying to achieve? Largely, we are all trying to achieve the same thing for populations—for people and for communities. If we can demonstrate that the investment of whatever bits of money there are will achieve that outcome, that creates a persuasive argument that where the money comes from does not matter. The accountancy bit, about there being two ledgers, can happen behind that.

If we can see that the best approach is to take NHS money to fund different housing models that are provided by the third sector, because that delivers an outcome that we are all signed up to and which will relieve pressure on the whole system, that is self-evidently the right thing to do, and the source of the money should not matter. Part of the challenge for us in our roles—which are great jobs—is to create that narrative and that vision and to exert that influence.

11:30

Janice Hewitt: May I make another point about that? It is slightly controversial, given what Eddie Fraser said. New money should not be given a label. Someone wants certain things to be done, but I know my communities and where I need to invest. In terms of the alcohol and drug partnership money, for example, I know that I have particular issues against needs. It is sometimes helpful to have a label, but I would argue—I am possibly standing out here—that you should not label new money.

Pam Gowans: I echo everything that everybody else has said. We are on a journey—a trajectory of improvement. As Eddie Fraser said about new moneys, we probably all have good examples of bringing the integration team together and saying, "Go away and think about how we might deliver this differently, collectively and in a better way with the third sector," and that includes primary care money going to the third sector in order to assist GPs.

There are real possibilities with the existing budgets. We have some workforce challenges and there is a conversation that is a helpful lever for shifting existing ways of working, as people try to push forward with what they have traditionally done and what they keep on doing brings the same results, in that they cannot recruit to the existing model, for example. That is a platform for discussing whether, if we always do what we have always done, we will just get what we have got. That is an opportunity to bring people together and say, "Come on—there are a range of different ways in which we can think about this. Let's be bold and go out there."

There are ways to facilitate those discussions with the staff side and the unions in order to think differently, but we almost have to coach people along and help them to feel safe and secure. People go into a profession because that is the

profession that they want to do, and it is scary for them when they think that they will be asked to do something different.

Sandra White: You are all excited about the new moneys that you have mentioned. I will throw something into the mix. Should the boards get their own direct funding? Would that help? If not, what would help, apart from the new moneys?

Judith Proctor: I am always hesitant on that, albeit that I have jumped in to answer the question. We are very active as a group of chief officers in health and social care Scotland, and we talk about this a lot. There is undoubtedly something challenging about how the budget comes to us, but we perhaps need to analyse more the creative tension that exists in the conversations that we get into, because all partners absolutely have to be signed up to this. Eddie Fraser touched on that.

The conversations that we can have with a local authority about the significant contribution of housing and housing models in the community planning arena are hugely important. I genuinely do not know whether we would get the same traction and discussions about those different ways of working if we were not all involved in those challenging conversations, but when the tension is right, it can be creative, rather than detracting from the ultimate goal.

Robert McCulloch-Graham: Where we have new moneys, we are able to pump-prime. In such cases, we are not stopping one thing in order to start something else, so it is always easier with new money. We get an increased level of debate from all the parties because there is a greater degree of freedom as to what we can use the funding for.

I think that all the parties are conflicted in deciding on the budget. There are allocations from councils and allocations from the NHS, and then there is a smattering of free money, if you like, in between. There are concerns in the NHS and council bodies about the value that they get on the back of the money that has gone in. There is bound to be a good thing in that regard, but a difficult negotiation has to take place at the IJB on how we are actually going to make the spend.

There are a number of masters over the funding, and trying to keep everybody on the same page is a difficult, challenging and enjoyable job for us all. There is more that we could do to simplify the money with regard to how the budgets are delegated to the IJBs.

Emma Harper (South Scotland) (SNP): It is interesting to hear the point about labelling new money. I love what Janice Hewitt said about ditching the lanyards that say that people are NHS or council.

I am interested in focusing on set aside money, because I find it all very complicated. The set aside budget is supposed to be the IJB's share of the budgets for delegated acute services provided by large hospitals on behalf of the IJB, but it seems that there are different approaches to set aside budgets. Some health boards delegate the hospital budgets as payments to the IJB, which has no separately identified set aside budget. It would be good to hear a simplified account of set aside budgets. Are there problems with that approach and could it work better?

The North Lanarkshire submission says:

"Within NLIJB, the transfer of the Community Assessment and Rehabilitation Service from the acute sector to localities is an example of a shift in resources".

That means that you are using some of the set aside money for social care. It would be great to hear a simple approach to set aside budgets.

Eddie Fraser: I can try to give you a simple approach to set aside budgets. When IJBs were established, there were 10 different specialties in unscheduled care, where a different type of work in the community could change the volume of people going through the hospital. The boards went on to look at what it cost to put people through the hospital. In East Ayrshire, that cost is approximately £20 million. If we are operating effectively in the community, we can reduce the amount of activity in the hospital in relation to those specialties, such as diabetes; we can shift the support to the community. If we do not achieve that shift, the cost will go up. As we said earlier, we are doing good work, but we are still floating around the same position.

In many areas, the set aside figure is just a statistic. At the end of the financial year, people look at the 10 specialties and how many beds—converted into money—were used by East Ayrshire and then give me a figure. In the first few years of operation, it has been a reporting position, rather than a leverage position.

We are three years in and we are moving into a second strategic plan. We have set roll-out targets and trajectories against the ministerial strategic group indicators to bring down spend in those areas. When we bring down spend in those areas we should see a release from the set aside budget.

We are all chief officers of IJBs, rather than acute directors. Acute directors would say, "If I see whole wards closing, that's okay, we'll move that money across," because shutting one bed does not save anything—you need to be at the scale of shutting a whole ward. At that scale, the acute directors will get into a conversation about it. However, we must meet demand and then go past

meeting demand to actually reduce that acute cost.

Set aside budget is a good indicator of the use of unscheduled care, but we are not at the stage at which—as I said in answer to the previous question—we see unscheduled care fall below the level at which that money would be released to us.

Judith Proctor: The issue of the set aside budget always feels like an exam question. It is highly complex. I find it helpful to think about the intent behind the legislation. Why does responsibility for planning those services sit with the integration joint boards? It is largely about how we create a community-focused service to support people better in communities as far as we can, and to support the management of our service, which is under pressure, to more actively address issues around unscheduled care and so on.

Part of the challenge is that, quite naturally, we tend to focus on the funding in the set aside budget and some IJBs, with our NHS acute partners, have been slow to get started on strategic planning. Thinking about my experience, that is largely because, early doors in developing our IJBs and our strategic plan, the intense focus was on a transformation within the creation of health and social care partnerships.

Increasingly, working as groups of IJBs and health and social care partnerships—where there is more than one working with a health board—the opportunity is to think about planning at population level. We ask what would make a difference at a population level in Lothian in terms of how we plan A and E services that support more people to go home rather than be admitted to hospital. We look at how to deliver respiratory services in a way that is far more focused on preventing acute exacerbations of respiratory illness, what we can do from a community perspective to help people who have respiratory illness to be as well as possible for as long as possible, and how to deliver as little of that care in a hospital as is required—it is the highly specialist stuff that we still have to do. Thinking about that intent and seeing it as our planning responsibility is really important, but part of the challenge is the capacity that we had at the time to do that strategic planning, because it is very different from what we have done before.

Pam Gowans: Judith Proctor has described the kind of process that we should be taking forward from a strategic perspective and that we are starting to get into, but at the moment that set aside budget is generally referred to as a notional budget. It is a budget with potential, but it is not any size of actual budget that we are able to invest in making change. If we can achieve reductions in unscheduled care to a particular level, we would technically have that money to invest in and to support our developments in the community, but to date it has been described as a notional budget. It is on our ledger, but it comes in and does not go anywhere.

Janice Hewitt: I refer the committee to paragraphs 3.2 and 3.3 on page 4 of North Lanarkshire's submission. The last sentence of paragraph 3.3 says that

"At a national level, there is ... a delay in accessing current activity levels at current prices",

which might give you some understanding. In paragraph 3.2 we set out that if there is a

"change in hospital capacity, the resource consequences will be determined"

through a bottom-up process.

If we look at the data on the activity shift, we can see what budget, notionally, could be moved, but it goes back to Eddie Fraser's point about scale.

Emma Harper: I know about the prevention of acute admission for respiratory illness—chronic obstructive pulmonary disease—because I am the convener of the cross-party group on lung health. If we keep folk out of hospital by investing in pulmonary rehab, that would perhaps be a way to use some of the money that is notional or set aside for emergencies or unscheduled admissions. If we put that money into pulmonary rehab, it will ultimately prevent acute admissions.

Eddie Fraser: Yes. Pam Gowans, I think, said earlier that some of the shift that we are seeing is to the specialist resources. Specialist respiratory and cardiac nurses have come across and worked with us in the community—that is the type of support. Reducing acute admissions is really important.

None of us has mentioned palliative and end-of-life care, but a high proportion of that cost is for people going in and out of hospital in their last six months of life. If we can provide better palliative and end-of-life care services, we will see a significant improvement in people's quality of life and reduced demand in the hospital.

We talk about the budget being notional and so on, but this work is really close to all our hearts. If we get it right, we will see the shift. We will all be able to evidence with a number whether the overall demand is going up in communities, but some of the ministerial strategic group indicators at the very end of the list, about where people spend the last six months of their lives, are really important, not just in terms of quality of life but also the associated cost.

David Stewart (Highlands and Islands) (Lab): The panel will know that there is lots of interest in mental health across the parliamentary divide, and I will ask about spending on that. A simplistic view

is that mental health has been a bit of a poor relation in comparison with physical health. How have you spent additional funding on mental health services in your areas?

Pam Gowans: I am happy to share an example of existing funding merged with some new funding in order to support wellbeing. In Moray we produced a strategy two years ago, "Good Mental Health for ALL in Moray 2016-2026", with a very strong wellbeing focus. As a result of that—and this was a tricky path to follow—we decommissioned a service that had been in existence for 30 years and that was being used by a small number of clients. The individuals had been receiving a really good service, but in the context of our plans to make some shifts and modernise there was an opportunity to work with the individuals and find the right, longer-term solutions, releasing money that could be used to commission something that would be fit for the future.

11:45

Like other partnerships, we had modernising primary care funds. We have tested the use of link workers and the creation of environments in which people can be diverted away from medical interventions. We are not telling people, "You can't have a medical intervention;" it is about offering community-based interventions and connections that are about good mental health.

We commissioned a third sector provider to offer interventions around good self-management, anxiety management, depression and the broader issues that people experience, in group settings and with individuals. The link workers were involved in that, as part of a hub-and-spoke outreach model in primary care across Moray. We are coming to the point at which we will receive the evaluation of that approach. The link workers have seen lots of people and have some good success stories, and the approach has generally been well received across the area.

Alongside that, and perhaps even more impressive, is that community activists have been working hard to create a wellbeing hub and develop peer support champions. Paid-for services and volunteers have been working closely and have been extremely successful in changing people's lives; we have done quite well.

Judith Proctor: In our submission, we refer to the reprovision of beds from the Royal Edinburgh hospital into community settings, which is to be welcomed, in that people who have experienced in-patient care can now be supported intensely in accommodation in the community, albeit that more of it is private.

The integration joint board has agreed a number of outline strategic commissioning plans, two of which focus on mental health provision in the longer term and another of which focuses on learning disability, with consideration being given to a blend of provision in communities for individuals in need.

Increasingly, too, we need to think about the promotion of good mental health and wellbeing and how we support our GPs and primary care practices, in particular, to offer first-line support around the promotion of good mental wellbeing. The work that we are beginning to outline for the link worker programme will support such an approach, so that primary care can appropriately support people when they attend for the first time.

We need to consider the entire spectrum across mental health services, from primary prevention and promotion of mental wellbeing to support for people, whether they have low-level mental health issues or long-term and enduring problems.

On learning disability, partnerships such as ours that do not contain children's services need to consider how we invest in good transitions and support young people to lead the lives that they want to lead. We are increasingly using self-directed support as a means to do that.

Eddie Fraser: Mental health is such an important area. We have used some of the resources that we have been given to work closely with GP practices in localities. Practices told us that counselling for young people is important, so we have been able to invest in that. In other areas, the community connector model is being used.

In Ayrshire and Arran we have the benefit of the new hospital, Woodland View, with services moving over from the Ailsa hospital campus. The service is fantastic. I did a leadership walk round the rehabilitation wards and I could see the opportunities for people to be rehabilitated in a more homely environment. I know that I am stuck on this issue, but it is about good housing options, because it is important that people can make the transition back into the community.

We are looking forward to the investment in primary care. We have HM Prison Kilmarnock on our patch, and we support the prison, as well as our emergency departments and GP practices.

Recently, one of our practices told me that 1,000 of its patients are on antidepressants. The staff are looking forward to when they have a mental health worker and pharmacist attached to the practice. The issue is how we review the situation in which patients just get repeat prescriptions and how we make sure that we change people's lives. It is such investment in primary care that can start to make a difference.

The proposed investment is important, and we have to ensure that it is spent on services that work alongside our existing teams. Our existing mental health teams tend to deal with the more acute end rather than the preventative end. Therefore, some of the investment must be used to support us at the lower-level preventative end—what we would usually call primary mental health rather than acute mental health. That is where we will see the benefits of the extra investment.

Janice Hewitt: We have decided to have truly integrated teams in three areas: children and families; mental health, learning disability, justice and addictions; and long-term conditions and frailty. We are forgetting the labels on all the practitioners, including where they work and who they work for, and the teams will come together. We have talked about the connections with justice services, and the staff decided that those groupings would be most effective. You could use a Venn diagram to show how the areas interface with one another. For example, some children and families have addiction and mental health problems, and older people with dementia will connect with mental health services. The three teams will not work in isolation; they will work together, sharing all the knowledge, the experience and the data relating to some of these families, because it is important to do so.

On mental health, we have a programme of placing those on out-of-area placements back into the locality. We are making the in-patient programme better. The out-of-area and community placements and the community supports around those have been a huge focus.

If I were to leave one integration legacy as I left the building, it would be the integration between our children's wellbeing and mental health services. Please invest in our children's wellbeing. The referrals to our child and adolescent mental health services have risen in tier 3 and severe by 23 per cent. There is something not right; there is something that we are not doing right with families or children. I am not sure that we are using the evidence to know what works with children, but the workforce situation is part of the challenge. I have talked about the need to invest properly in the right range of practitioners. On mental health—from children's wellbeing through to forensic services—let us get it right.

Robert McCulloch-Graham: I do not want to take anything away from Janice Hewitt's points, because nothing is more important than what she has just said. The demand on our children's services is increasing at a terrifying rate. We have to face up to the problems in the transition from children's services to adult services; we have to grapple with the issue and find a solution. Something is happening that is not right; we need to fix the situation.

On primary care, we need to make sure that we take a different approach to mental health and make it everybody's business. A number of practitioners who should be involved in mental health are perhaps not involved as much as they should be. I had one practice in which 50 per cent of a GP's consultations were about mental health, and all that he was able to do was refer patients on. That is the most expensive triage that I have ever seen. When we are developing primary care clusters and community work, we need to make sure that we have link workers who can deal with some of the lower-end issues in mental health, which often lead into other issues. I encourage this committee and others to focus on children's mental health services.

David Stewart: The answers have been helpful. Janice Hewitt has covered a bit of what I was going to ask about. How do you measure the effectiveness of additional resources? Is it genuinely additional resources that are being put in, or is some substitution going on? In other words, is there any element of stealing from Peter to pay Paul?

Eddie Fraser: It depends on the approach from the partner bodies and how they are funded. IJBs on the whole do not have the back-office functions and do not manage the property, HR or finance departments. If somebody asked me for 2 per cent cash release efficiency savings, that could come only out of front-line services. I do not have other services. What we always try to do, as we have said, is to be innovative and to manage demand. We have not taken the new money and hid it away somewhere. We have done things up front with local communities to try to reduce demand and cost in the other services. We use the new money as a driver to save in other areas where we have traditionally had to make savings. We try to be transparent about everything that we do, and we do not try to cross-substitute in that way.

Alex Cole-Hamilton (Edinburgh Western) (LD): Before I ask my question, I want to associate myself with the remarks made by Janice Hewitt and Robert McCulloch-Graham about child and adolescent mental health. That aligns with what we are hearing from stakeholders and in our constituency surgeries, and it is fast becoming the imperative under which this whole Parliament must move, on pain of the anguish suffered by some of Scotland's most vulnerable children.

I want to ask a similar question to the one that I asked at another evidence session this time last year. I asked specifically about funding for drug and alcohol services. We learned this morning that treatment times are outstripping by a country mile what we thought they were, particularly as people

are being seen for consultations but are not receiving the prescription support that they need for several months after that. We know that, over the past two to three years, we have had a dip in funding for ADPs of some 23 per cent, which can be measured in the highest number of drug-related deaths in the whole of Europe last summer.

Although there has been an increase of £20 million, it strikes me that that does not close the gap that we have encountered. It does not restart services that were lost to us or bring back that lost organisational memory. How much more do we need to spend in that area before we are back to where we were, and what does success look like in terms of a fully funded drug and alcohol service model?

Janice Hewitt: There has been a reduction in ADP services. Having just said that we should take the labels off things, I am reluctant to say that we should give money just to ADPs. We have had that conflict locally about accounting. ADP funding is mainstreamed for me, so the label is off it, which was a huge help, believe it or not. Conversely, your question is about the performance that you associate with that cut and a performance target that has gone up somewhere else. For me, there is an association between children and families services and learning disability, mental health, addictions and justice, because some of the individuals who use those services are the same, and some of them are the fathers, grandfathers and kinship carers of our children.

I do not mind that the label is gone. I just want to use the money in a different way. Where we see trends or differences in performance, we need to react to that, but from my perspective I am putting in a different set of services and using the money in a slightly different way. If the consequence of that for North Lanarkshire is that drug-related deaths increase, I need to review what has happened there. I know that you still want me to report on that, although we have taken the label off, which is interesting, so I have a wee bit of a conflict around that.

Eddie Fraser: In East Ayrshire, we have not had a reduction in our funding for the ADP. For us, it is funding for the ADP rather than funding for overall addiction services, which are two different things. Our ADP has an independent chair and the £1.6 million goes to the ADP, which will then have a discussion, on a community planning basis, about the right place to invest it.

We have done some innovative investment, such as with Barnado's, which was able to bring the same amount of money to the table—we doubled the money in effect. We invest with the Scottish Drugs Forum, which has done some work on getting people into work. We have worked with Addaction, which helps people in recovery.

12:00

The funding is slightly different from Janice Hewitt's as we give it to our ADP. Last year, even though there was a reduction in funding, NHS Ayrshire and Arran covered the reduction and maintained our level of funding. We have continued to work with those partners to do things differently.

This is about treatment. The number of people we get through treatment into recovery is still too small and the number of people who are on long-term substitute prescribing is still too high. Just last week, I was with East Ayrshire churches homelessness group, and local churches work with a whole range of people with complex issues from alcohol and drug addiction right through to homelessness. We can do the treatment stuff and invest in that, but if we are going to see a difference, we need to look at why some individuals have been harmed and are self-medicating to take themselves away from society. There is a whole range of reasons for different people.

For us, it is about investing and the ADP has a positive role in thinking more widely than just treatment services; it also thinks about prevention. It invests in, for example, alcohol co-ordinators for schools. It has invested in very positive things.

Pam Gowans: I echo everything that Eddie Fraser said. It is a partnership and whole-community approach, which is no different from what has been needed for years. In Moray, our approach is very similar to what he described. Accessing services is really good and we have a good integrated service operating with the third sector.

From my perspective, with a background in mental health nursing, it is interesting. I was an addictions nurse and, years ago, I managed addiction services in a context in which drug-related deaths were a big issue. In the area where I worked, it was important to understand what was contributing to that before we jumped in with solutions. We need to understand that from a care and treatment perspective. However, going back to Janice Hewitt's statement, I think that the greatest investment that we can make is by starting with children and preventing them from getting into that position in the first place.

In my experience of working with people with addiction issues, it is a very challenging task. People do not choose to be in the position that they are in, they are not happy to be in that position, and their confidence and ability to change is usually pretty depleted. Methadone and

substitute prescribing are tools, and the more dominant they are, the less effective we are at getting people into a recovery model. They have to be seen as a tool, but it is a big task to help those people to remove themselves from their day to day environment using the recovery model and by supporting individuals. Lack of confidence is probably the biggest inhibitor.

We need to understand what we are responding to before we are sure that it is a money issue. I had lots of money when I was managing addiction services—there was not the same stringent approach to money that there is now—but money was not the solution. It was about culture, understanding, resilience to working in challenging conditions and hope that the individuals could achieve success.

Alex Cole-Hamilton: I get that, but take, for example, our nation's capital, Edinburgh—I would like to hear from Judith Proctor on this—where the 23 per cent cut to ADP funding across the board last year was manifest as a £1.3 million reduction in budget. That has to have some impact. If workers are not being paid, they disappear to other jobs, so the provision footprint is reduced, which must have a tangible effect. However, I accept what Pam Gowans said about culture.

Judith Proctor: I am afraid that I will not be able to give you a very full answer on that, given my relative newness in post. However, I am more than happy to have a conversation as we begin to understand it. I have been made aware of the elevation of the work of the ADP in the IJB, and it can only be a good thing that it is being seen in the context of that partnership. I am afraid that I cannot give you any detail that would be useful today.

The Convener: I know that there are other questions that colleagues might wish to ask, but we have already had a very full session. I thank the witnesses for their evidence this morning.

12:05

Meeting continued in private until 12:33.

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