OFFICIAL REPORT
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Health and Sport Committee

Tuesday 19 February 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 19 February 2019

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HEALTH AND SPORT COMMITTEE
5th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Councillor Stuart Currie (Convention of Scottish Local Authorities)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Alison Taylor (Scottish Government)
John Wood (Convention of Scottish Local Authorities)
Malcolm Wright (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 19 February 2019

[The Convener opened the meeting at 10:02]

Subordinate Legislation

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2019 [Draft]

The Convener (Lewis Macdonald): Good morning, and welcome to the fifth meeting in 2019 of the Health and Sport Committee. I ask everyone in the room to ensure that their phones are off or in silent mode, and not to use them for photography or for recording proceedings. We have received apologies from David Torrance.

The first item on the agenda is subordinate legislation. The committee will consider the draft Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2019, which are subject to affirmative procedure. As usual with affirmative instruments, we will hear first from the cabinet secretary and her officials. Once all members' questions have been answered, we will move to the formal debate on the motion.

I welcome to the committee the Cabinet Secretary for Health and Sport, Jeane Freeman; Mike Liddle from the adult social care policy branch of the Scottish Government; and Anne Mathie from the Scottish Government's legal directorate. I believe that the cabinet secretary will make a brief opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you very much, convener. Good morning.

I am grateful to the committee for the opportunity to speak briefly about the amendment regulations, which reflect our continued intention to increase free personal and nursing care payments in line with inflation. If they are approved, the regulations will continue to benefit self-funding adults who are resident in care homes. The rates are calculated using the gross domestic product deflator inflation tool, which this year has produced an increase of 1.57 per cent. That means that the weekly payment for personal care will rise from £174 to £177 and the nursing care component will rise from £79 to £80 per week.

The committee will be aware that, from 1 April, our policy of free personal care will extend to under-65s, and that the weekly payment rates will be the same for people who are over 65 as it is for those who are under 65. It is estimated that that will cost £1.9 million, which includes the estimated costs for self-funders under the age of 65 following the extension of free personal care.

As part of our 2019-20 draft budget, £160 million will be transferred in-year from the health portfolio to local authorities for investment in integration, including delivery of the living wage, uprating free personal care and extending it to under-65s, and school counselling services.

I am happy to take questions on the regulations.

The Convener: Thank you, cabinet secretary.

David Stewart (Highlands and Islands) (Lab): I have a technical question, to which I genuinely do not know the answer. Measures of inflation are very important, and I am obviously aware of the GDP deflator, which has produced an inflation figure of 1.57 per cent, as you have said.

What room for manoeuvre do you have in respect of using that measure? If we jump to the pieces of subordinate legislation that we will consider next on the agenda, we see that there are other measures of inflation. The consumer prices index produces a figure for inflation of 2.4 per cent and average earnings produce a figure of 2.7 per cent. The inflation figure depends on what we decide to measure. From having worked on the United Kingdom Parliament's Work and Pensions Committee, I know that there is a long-term issue in respect of the measure of inflation that is used. Could you have used a measure of inflation other than the GDP deflator?

Jeane Freeman: The GDP deflator is the standard measure that is used by the Scottish Government to measure inflation, and it is used for creating real-time comparisons. If the CPI were to be used to uprate free personal and nursing care, it would increase the £174 carers allowance payment to £178 and the £79 payment for nursing care to £81. There are variations, but the overall standard that is used by the Scottish Government is the GDP deflator. The final decision about what we use sits with the Cabinet Secretary for Finance, Economy and Fair Work.

David Stewart: We are obviously not on the next agenda item yet, but the instruments that we will consider then use different measures—the CPI and average earnings—which give different results.

Jeane Freeman: Yes.

The Convener: As there are no other questions from members, we will move to the formal debate on the instrument about which we have just heard from the cabinet secretary. I remind colleagues that members should not put questions to the cabinet secretary or to officials during the formal

debate. I invite the cabinet secretary to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2019 [draft] be approved.—[*Jeane Freeman*]

The Convener: Thank you. Colleagues have no contributions to make. Has the cabinet secretary anything to say before we move to a decision?

Jeane Freeman: The only thing to say is that the provisions are dependent on Parliament approving the 2019-20 budget later this week.

Motion agreed to,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2019 [draft] be approved.

National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2019 (SSI 2019/12)

National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2019 (SSI 2019/13)

The Convener: The next item is consideration of two instruments that are subject to negative procedure. The first is the National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2019 (SSI 2019/12). No motion to annul the regulations has been lodged, and the Delegated Powers and Law Reform Committee has made no comment on the instrument.

Members have no comments, so does the committee agree to make no recommendations?

Members *indicated agreement.*

The Convener: Thank you.

The second instrument is the National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2019 (SSI 2019/13). No motion to annul the regulations has been lodged and the Delegated Powers and Law Reform Committee has made no comment on the instrument.

As there are no comments from members, does the committee agree to make no recommendations?

Members *indicated agreement.*

The Convener: I suspend the meeting to allow a change of officials.

10:08

Meeting suspended.

10:10

On resuming—

"Ministerial Strategic Group for Health and Community Care, Review of Progress with Integration of Health and Social Care—Final Report"

The Convener: The next item is to take evidence on the report of the ministerial strategic group for health and community care, to inform the committee's on-going interest in, and focus on, delivery of integration. I welcome—again—Jeane Freeman, the Cabinet Secretary for Health and Sport. I also welcome Malcolm Wright, who is director general in the Scottish Government for health and social care, and the chief executive of NHS Scotland. I have worked with Malcolm in other roles: I congratulate him on his appointment and welcome him to his first meeting of the committee in his new role.

I also welcome Councillor Stuart Currie, who is the spokesperson for health and social care with the Convention of Scottish Local Authorities; John Wood, who is the chief officer for health and social care with COSLA; and Alison Taylor, who is the head of the integration division in the Scottish Government.

I invite the cabinet secretary to make brief introductory remarks on behalf of the ministerial strategic group.

Jeane Freeman: Thank you, convener. I am grateful to you for inviting Councillor Currie and me to give evidence, on behalf of the ministerial strategic group for health and community care, on the review of progress in integration. The fact that we are here together today is an excellent demonstration of the partnership working between the Scottish Government, local government and the national health service, which underpins integration.

The wider membership of the MSG, which we chaired jointly, demonstrates the importance of the sectors and professions across health and social care jointly committing to integration's success. The work belongs to all members of the MSG—the statutory partners, the third and independent sectors and the professional bodies and royal colleges.

One of integration's defining characteristics is that we all agree that it is vital. It is a necessary change to ensure that our health and social care services keep pace with the evolving needs of Scotland's people. I will not rehearse our reasons for integrating; I know that members are very familiar with them.

When I became Cabinet Secretary for Health and Sport last year, I set out my top priorities, of which integration is one. I said then that my focus would be on increasing the pace and effectiveness of change. We now have evidence from the Audit Scotland report, "Health and social care integration—Update on progress", which was published in November, that integration is beginning to work well in some local systems and is having a real impact on people's experience of care, and on the quality and sustainability of care.

The review of progress that was jointly led by the Scottish Government and COSLA provides us with an excellent vantage point from which to set out our priorities for the next year or so.

We know that there remain challenges in properly and fully implementing integration. The review group sought, in particular, to identify barriers and to address them in its proposals. The review does not set out high-level principles for integration; all that work was done when we legislated for and set up integration authorities. Therefore, the report is deliberately focused on practicalities, and it includes some challenging timescales. In order to ensure success in that regard, we will draw together and build on existing workstreams across health and social care, and we will, in some instances, undertake new work to reinforce progress.

Councillor Currie and I, through the MSG, will hold to account all contributors' progress. We are pleased to take this opportunity to restate our shared commitment to making integration work, and we will be happy to answer members' questions, on behalf of the group.

The Convener: Thank you very much, cabinet secretary. The report appears to recognise the need for increased pace and effectiveness, as you said. I ask you, first, what role the Scottish Government sees for itself in ensuring that the recommendations are implemented. I ask Stuart Currie then to say what role he envisages for COSLA.

Jeane Freeman: You will see from the review report that we have set out clearly what requires to happen and the timescales within which it must happen.

We also set out very clearly what the Scottish Government and COSLA, jointly, intend to do in order to provide visible joint leadership. We have commissioned the group that was charged with undertaking the review to continue as an oversight group to lead implementation. The review was published on 4 February. The group then met on 11 February and drafted an implementation plan that sets out very clearly the practical steps that need to be taken.

10:15

One of the things that Councillor Currie and I have discussed and have undertaken to do is to embed the partnership approach. That has three elements: to bring into the Scottish Government direct experience from a chief officer to assist our joint work; the Scottish Government providing additional resource to COSLA to support its work; and to make good use of the considerable expertise in the quality improvement methodology that is available in the health directorate of the Scottish Government and now, too, in the joint work that is being undertaken with COSLA.

Members will recall that the QIM is the significant methodological and practical approach that produced the Scottish patient safety programme. That programme has resulted in a Scotland-wide systemic improvement in patient safety that has been sustained over 10 years. The approach has also contributed to the collaborative work with local authorities on children and young people. We will use the resource to help our integration authorities to improve their practice systematically so that we share that good practice.

As I have said on more than one occasion, I am not interested in learning from good practice—I am interested in implementing good practice. However, we need to give our integration authorities tools and expertise that exist in COSLA and the Scottish Government so that that can be done practicably.

The Convener: I will invite Stuart Currie to comment in a moment. You mentioned an implementation plan that was drafted or agreed last week. Can that plan be shared with the committee?

Jeane Freeman: It can be shared with the committee once the ministerial strategic group has seen it. At this point, it is a draft. Some more work will need to be done by the oversight group to fill in the areas that have not been completed. That draft plan will come before the MSG: I will be happy to share it with the committee as soon as the MSG has approved it.

The Convener: Thank you, that will be appreciated.

Councillor Stuart Currie (Convention of Scottish Local Authorities): It is important that we show the leadership that is required at national level. That can only be done jointly, and it is about working with our partners in the third and voluntary sectors to ensure that we all understand why it is so important to work together to deliver. It is also about increasing the pace of integration.

In the past few years, there have been a lot of reports and discussion, but now there is expectation about delivery. When we consider the

timescales in the MSG leadership report, we see that they are challenging. The report does not pull any punches, but goes straight to the nub of many issues. The timescales are challenging, but it is important that we meet them because to do anything else would mean that we will not succeed, which is what we all want.

Best practice is important. There is evidence of best practice out there, where things are working really well. We need to identify the examples and consider how we can use them elsewhere. If something cannot work somewhere else, we should understand why. When something can work somewhere else, we should understand that, too. We should ensure that best practice reaches a wider area.

I emphasise that there has been a lot of discussion—there has been the Audit Scotland report and the MSG report—so there is, rightly, real expectation about delivery. That is why the timescales, challenging though they are, must be met in order to ensure that we make progress.

The Convener: That is good to hear from the Government and COSLA. Can both of you comment on how the success of the proposals that have been agreed in the report and how the integration authorities' delivery of outcomes in implementing the report will be measured?

Jeane Freeman: Just for the record, I should correct myself: the oversight group met on 12 February, not 11 February. The group has agreed to meet every six weeks, which is important and indicates to the committee the seriousness with which we are taking not only the work that needs to be done but, as Councillor Currie said, the challenge of the timescales. We are determined that we will meet those timescales.

The way in which we will measure whether we are progressing as required will be included in the draft implementation plan. My colleagues from the Scottish Government—or, indeed, Mr Wood from COSLA—might want to talk a little about the data that is already collected and how we might triangulate it a bit better in order to measure across the system how well integration is working. Members might have questions later about the impact of successful integration on, for example, delayed discharge. We cannot measure the success of integrated health and social care in a stand-alone way, without looking at comparable measurements that feed into that from, for example, performance in health as well as performance elsewhere in local authority services.

Councillor Currie and I have had productive discussions about what the milestones and measurements of success might be without requiring integration authorities to collect significant additional data. We need the authorities to get on and deliver the services, so they should not have an additional unnecessary element of data collection. The oversight group and the COSLA and Scottish Government officials working for it will consider how the data that we have currently can be triangulated most effectively to demonstrate whether there has been progress. Councillor Currie and I are keen to know timeously how progress is being delivered because, if it is not, we need to consider what further interventions we might want to take jointly to ensure that progress is made within the timescales.

Councillor Currie: I will ask Mr Wood to comment on some of the data issues, but it is important to point out that, where concerns or issues arise, or where things perhaps do not work as envisaged, we do not just wait for a report to come out at some point in future to tell us what we potentially already know. We can help in such situations. It is about providing knowledge, support and leadership in practice across the board. We are not saying that we know everything at the centre but, if we can assist with resource or by bringing people together to discuss matters, we can provide a helpful way forward.

I ask Mr Wood to comment on data and how we measure things.

John Wood (Convention of Scottish Local Authorities): On the question of how we measure success, I suppose that it works at national and local levels. The MSG receives national data—we have agreed six indicators on which the group receives regular reports—and, as Ms Freeman has said, that data will be triangulated against the success that we hope to achieve. There are also the 23 integration indicators that IJBs report against. All that information will give us a picture, although, of course, there is a time lag in that respect.

As for measuring success against the implementation plan that we are setting out as a result of the review of progress, integration joint boards will benchmark their progress and activity against some of the actions and the asks in that report. We expect that to be reported regularly to the leadership group but, most important, it will be picked up in the IJBs' annual reports.

The Convener: Thank you. Sandra White has a supplementary question.

Sandra White (Glasgow Kelvin) (SNP): I was interested in Councillor Currie's reference to the third and voluntary sectors, which are very important, and in that respect, I want to raise the issue of alcohol and drug initiatives in relation to the implementation plan. Mr Wood talked about getting information on outcomes. Like most of the committee, I have visited the alcohol and drug partnerships that, unfortunately, have to deal with

alcohol and drug abuse. Will the outcomes that the partnerships measure be fed through to the IJBs and then into the implementation plan?

The Convener: Who would like to respond to that question?

Alison Taylor (Scottish Government): We would certainly expect those measurements to form part of local improvement plans. Mr Wood has described how we will take a small number of key high-level indicators to the ministerial group, but the important thing is to make sure that we interleave the outcomes that are important in the local system into what we look at across the piece. Alcohol and drug interventions are of considerable importance, but it is for the chairs of the ministerial group to decide whether they wish to look at a specific subject at any meeting.

Emma Harper (South Scotland) (SNP): I am interested in collaborative leadership and relationship building. Stuart Currie talked about achieving best practice. I know that health and social care integration requires lots of people to work together to develop teams and share good practice across health boards and regions and that it can take a while to achieve certain processes. How can the Scottish Government and COSLA ensure that appropriate leadership is in place to deliver continuity and to support services, delivery and, ultimately, integration itself?

Jeane Freeman: You have raised an important point. When the ministerial group looked at and approved the final report from the review of progress, there was a lot of discussion about leadership. We noticed that each of the integration partners had its own leadership programme, and it was evident that we needed a single leadership programme that brought together all the parties, whether at chief officer level in health boards and local authorities, at finance officer level or whatever. As a result, it is proposed that all leadership development, whether it be inside the health service for clinicians or others, whether it be inside local authorities or whether it be joint leadership development with regard to the work on integration, be focused on shared and collaborative practice. That discussion was one of those moments when we all realised that parts of our own practice were not sufficiently integrated and that change was essential in underpinning the overall drive towards integration.

If I may, I will ask Mr Wright to pick up on some of those points.

Malcolm Wright (Scottish Government): The leadership aspect is pivotal. If we can get that work right, a lot of the other actions in the implementation plan will fall into place.

We need to tackle this issue at different levels. We need to bring together the range of national programmes that the health service and the Improvement Service have under way, and that means looking at how some of the NHS national bodies work with the Improvement Service and how we can pull that together. Critically, most local systems have leadership programmes of one form or another, and it will be important to see whether we can bring those together at local level. The most important issue is how we support the chairs and vice-chairs of the IJBs, the chief officers and chief financial officers, the senior teams and, pivotally, the practitioners who are working together on the ground to deliver care in communities and into people's homes.

10:30

The second aspect that I would highlight is the importance of working relationships at the most senior level. My experience of working in different health service boards is that a lot of improvements flow from good working relationships between the chief executives of the health board and the local authority and the chief officer of the IJB, and that the challenges arise when those relationships are not working well. The chair and non-executives of a health board need to work collaboratively with the conveners and leaders of the councils, and we need to do a big bit of work to make sure that we cover that at all the different levels.

With regard to the draft plan, I can talk a little bit about the meeting that was mentioned and some of the areas that we covered in it. However, there was a strong sense that, if we can get the quality of relationships and leadership right at the most senior level, we will be able to help with some of the more technical but important issues such as set-aside budgets and ensure that we get a shift not only in resource but in people being cared for much more in their homes and local communities.

I hope that I have explained the importance of leadership and what we intend to do in that respect.

Councillor Currie: A mutual understanding of where everybody is coming from is crucial. Obviously, the integration of the health service and local government represents a huge shift, and it is really important that people work together. A joint approach to leadership ensures that integration does not stop when a meeting finishes, but forms part of our day-to-day activities. It means that, if you are walking down a corridor and stop to speak to someone, you should not know whether they were formerly from the health service or from local government. You should not be able to spot—just from their lanyards, say—that one person has come from health and another has come from local government; instead, it should be clear that you are dealing with people who are involved with integrated health and social care. After all, that is

the point of integration. In that respect, leadership is important. When people meet outwith formal meetings, they talk and gossip about integration, and it is really important that integration is the sole focus of the work that goes on.

One of the major recommendations is about not just leadership but building relationships, which goes beyond the confines of a council or NHS building to include the third and voluntary sectors. The whole-system approach is crucial. No one part of the former system can deliver on its own; only through the different systems coming together—in other words, that whole-system approach—will health and social care integration be delivered. We all want that to work.

It is crucial that in discussing such matters, we understand that integration has to run through not just the formal meetings that we have but everything that we do. Challenges and issues will arise, and people will have concerns, but we will be in a far better place to meet those challenges and address those concerns.

Jeane Freeman: It is only fair to recognise that, as Councillor Currie and Malcolm Wright have said, we are bringing together cultures, styles and expectations that have been different for decades. There are a lot of similarities, but there are also significant differences, and the real challenge is for our NHS and local authorities to recognise that a different cultural approach is required. We have experience of helping people to fear that sort of thing less than they might otherwise have done and to see the gains. The real trick, if you like, in the review report will be to produce—jointly, at the same time and in a consistent way—tangible improvements in service delivery across the country to back up our requirement for those cultures to make these changes to those relationships.

Audit Scotland has set out very clearly that this is about relationships; we do not need to alter legislation and there are no issues with the clarity of governance. There might be some issues with understanding that clarity, and that stems from the fact that we have these different cultures. As a result, part of what we have to do is to ensure that our leadership makes all of this really clear, and Councillor Currie and I will have significant roles in that respect.

The Convener: When you talk about things being clear, do you mean that they are clear in the letter of the law and in guidance, but not necessarily so in people's minds?

Jeane Freeman: Exactly so.

Emma Harper: I will pick up on the point about different cultures and people. There are allied health professionals and multidisciplinary teams across health and social care. I am a former NHS employee and I witnessed that it can take an awfully long time for change to happen. An issue that has been raised with me is that because local authorities and healthcare use different language there is a need to speak a national common language for the purpose of health and social care integration. Leadership collaboration would focus on and support that. How can we expect integration authorities to ensure that multidisciplinary teams, social workers and allied health professionals are all part of the discussion and are using the same language?

Jeane Freeman: If I am honest, there are limitations to using the same language, but it is important that people understand one another. We do that through joint leadership and collaboration, to ensure that a person better understands the particular requirements and pressures of a colleague's job compared with their own, and vice versa. By doing so, people can work better together.

At the moment, it is noticeable that, for integration at delivery-team level, people are often just getting on with it. It makes perfect sense to them that they are delivering healthcare alongside allied health professionals, social workers and social care workers. Those people are closest to the individual who requires and is receiving care, and therefore it makes sense to them that the care should come from more than one place. We need to ensure that there is such a sensible understanding of what is needed at all other levels of integration—at health board level, local authority level and integration joint board level.

One of the specific recommendations of the MSG review is about how we will assist integration authorities to better engage with their local communities and with people who represent those communities. Part of the delivery plan is about how we might do that, which has, as we have discussed in the committee, a resonance for how well or otherwise our health boards engage with local communities and for ensuring that there is persistent and consistent engagement, not just when something big is about to happen.

Alex Cole-Hamilton (Edinburgh Western) (LD): I will expand on the issue around leadership. We have picked up on the slightly worrying churn at the higher end of the leadership of IJBs—57 per cent of senior managers have changed since the project started. There was a change of chief officer in Edinburgh early on in my term as an MSP. I work closely with the chief officers of IJBs, as I am sure all parliamentarians do, because we have cases that take us into that universe, and I have always been struck by the high calibre of the individuals whom we attract to those roles. If they are talented individuals and they have the right skills set, why are they leaving? Is it because the

project is ungovernable, or because the expectations are too high? What is the reason for the churn?

Jeane Freeman: I have not conducted a survey about it, but I will give you my view. Integration is relatively young and new and, for some individuals, it might not have been the experience that they expected. In those circumstances, it is entirely sensible for those individuals, and for the wider integration project, that they seek roles elsewhere. If the job is not right for someone, the best thing that they can do is, if it is at all possible, to move to a job and an environment that works for them. My view is that that is what has happened, at least in part. I do not see anything troublesome with that, nor is it something to be worried about.

Overall, we have a very good group of chief officers and a talented and able group of senior officers in local authorities and the health service. However, people need to move into the new world of integration and to do so in their heads, as well as in their practice. Mr Wright and other colleagues are referring to the importance of that leadership and of shared and collaborative leadership support and training to help people to make that shift. Too often, when change comes our way, we are understandably fearful, but with the right support, we might discover that our role is enhanced and is more rewarding in that different environment. We are seeing the inevitable flow that occurs as a new idea is created and embedded; that idea now needs to move on to deliver much more systematically and sustainably. Mr Wright or Councillor Currie might want to say something about that.

Councillor Currie: I am not certain that turnover now is massively different from turnover in the past. As a councillor, I remember that before integration, a number of senior people in health and local government moved on. When something is new—and integration is new—there is a point at which people decide whether it is right for them, and if it is not, they sometimes move on.

I am not aware of a shortage of candidates when roles are advertised, and that is good for competitive recruitment. People see it as an opportunity to do something new and exciting and to deliver better outcomes for the people whom they seek to serve. That is encouraging. Time will tell, but when two such huge organisations—in this case health and social care—are brought together, some people will decide that it is not for them. That is fine and happens all the time, but it is important that when we are recruiting chief officers and a range of other officer roles, we ensure that we get the best possible people to do the job. We want people who know the challenges and are excited about meeting them.

Malcolm Wright: It is also important to recognise that the jobs are changing and have changed. At the time when integration was first established and chief officers were appointed, a lot of their work involved getting the integration authorities established in law, setting up the statutory body and making rapid improvements as a new body in an already complex landscape.

The report that has been published signals a step change in the pace of integration. My sense from working with the chief officers is that, as the cabinet secretary said, we have a good group of them in Scotland and that they are up for that challenging change—and there are lots of challenges. The Scottish Government, local authorities and the IJBs need to look at how we support chief officers to deliver in that very demanding landscape. The leadership group that supports the ministerial group, which is co-chaired by me and Sally Loudon, offers an important signal that the Scottish Government, COSLA, and health and local authorities are going to work together to support the chief officers in their hugely challenging positions.

As I said previously, the report signals a step change in how we drive the pace and scale of integration. In addition to the chief officers, the report also mentions the section 95 officers and the chairs and vice-chairs of the IJBs. We need to get behind and support our folk. As the cabinet secretary said, it is inevitable that there will be turnover of chief officers as the job evolves, but I do not see a shortage of people who are keen to take on the challenges. We should get four-square behind our chief officers.

10:45

Alex Cole-Hamilton: I am grateful for that response. It is encouraging to hear that we still have healthy competition for those roles.

The cabinet secretary described integration as a “new world”. I share that vision; I think it speaks to a shared ambition to move away from a siloed culture, in which acute care and social care in the community were thought of as two separate entities and people were very protective of budgets and so on, and towards one with a lot more fluidity and flow, as the cabinet secretary has described. However, I am concerned that there is still a disconnect and that we are still failing in that regard.

I often raise the example of a constituent of mine who spent 150 nights in Liberton hospital after he was declared fit to go home, because a minor addition to his care package was needed but nobody could find provision for it. His stay at Liberton hospital cost £400 a night, whereas a

care package costing £80 a night would have seen him home. Why is that still happening?

Jeane Freeman: There are two things to say at the outset. First, I share your view that such things should not happen; our intention is that they will not continue to happen. Secondly, delays and bed days lost continue to decline, albeit not at the pace that any of us in this room would wish for. Across our integration authorities, the picture is mixed: some are successfully reducing significantly the volume of delayed discharge in their boards through care-at-home packages and so on, but others are significantly less successful, for various reasons.

Alex Cole-Hamilton and Miles Briggs have both raised issues in relation to the city of Edinburgh that are partly—I do not accept that they are totally so—a product of the local economy, competitiveness in employment, wage rates and so on. As you both know, the local authority and the health board have both contributed additional funds to address at least some of the issues, and we have seen some improvement in the situation. We are trying to achieve with the report—through tight timescales, the delivery plan and six-weekly meetings of the oversight group that reports to Councillor Currie and me—fewer situations such as the one that your constituent faced. I hope that we are continuing to assure you of our absolute shared personal commitment to delivering on the actions.

The intention for the coming year is to reduce significantly the disparity across the country in what integration authorities are successfully achieving. That is what we mean when we talk about implementing good practice; not every bit of good practice in the integration authorities that are doing well will be directly applicable to those that are more challenged, but there will undoubtedly be applicable elements. Through recognising that and using the quality improvement methodology and its practical tools, we can allow people to lift and apply relevant good practice without having to reinvent the wheel. There is more than one strand, but the aim is to combine them all to get exactly the kind of results to which you refer.

George Adam (Paisley) (SNP): The cabinet secretary said that it is a “new world”. It is a major step for the leadership and the culture in local government and in various other bodies, and they need to be involved in that vision. I am a former councillor, so I have seen the situation from both sides. I do not want to be negative, but people can sometimes be quite difficult: they will be thinking about their own traditional ways of working as opposed to grabbing hold of the new vision, looking at new ideas or trying to deliver for the people whom they serve. Do we not need to ensure that senior staff can work together in that way? That is quite difficult, because we are talking about chief executives who have been used to making their own decisions. How do we get all those personalities to work together in one joint board?

Jeane Freeman: That is a very good question. Most of us—I know that I fit into this category—sometimes mistake control over a number of things as equating to levels of authority and leadership skills. Actually, good leadership skills are often demonstrated when the person devolves decision making to others and does not hold it all to themselves. That is sometimes a big ask for folk—or, it can feel like a big ask—who have not traditionally done tha in their their positions or if that has not been the culture of the organisation in which they have risen. As we know, leadership from the top can dictate in large measure behaviours at stages further down an organisation. If a person wants eventually to have the role of a leader at the top and the approach of that leader is to hold everything to themselves, the person will understandably think that they will be promoted by doing that.

They are big changes, and we are making big asks of people. However, in our local authorities and health boards and in our chief officers we have individuals who are demonstrating a different approach to leadership that is producing results through improvements in care and in the service to those whom they seek to work with and through the creation of an environment that people want to work in.

A tipping point will be reached at which that position will become the norm. We are not at the tipping point yet, but the very practical propositions that have been made are about leading us to that place, where not working in that way and not leading that kind of culture becomes the outlier. At that point, personal decisions will be taken: a person will either want to be on the bus or think that it is not for them and that they need to go somewhere else. As I said, we are not at the tipping point yet. We need to move—through the leadership, the practical propositions in the review report and the quality improvement support that we have talked about—so that we get a body of leaders in all three partners as well as in the independent sector and the third sector, where we will find some of the leadership skills that we are seeking to emulate. We must ensure that they are at the table alongside everybody else.

Ms White mentioned the third sector. The independent sector has an important part to play as well. It is already looking to learn lessons and get ideas from the health service, for example. I am sure that, in other committee sessions, members have heard that some of our smaller independent care providers are looking at working

in clusters in order to share additional professional skills that they might need and that they would not be able to deliver for themselves individually. I am convinced that all of that shared learning and leadership will take us to where we need to be.

Councillor Currie: The most important thing to be aware of is that integration is here to stay. When there is a huge amount of change, people who are maybe not convinced about the need for change will often say that they will wait for a couple of years and we will all go back to where we were. However, that is fanciful. The reason why integration is absolutely here to stay is that it makes sense.

This morning, Mr Cole-Hamilton and other members have referred to people discussing things with social workers in the wards. That is because people have been doing integration in an informal way for several years. When it works, it works. It is really important that people realise that there is no door marked "Option B"—integration is the only option. The integration of health and social care is crucial in achieving the delivery and successful outcomes for the people we all seek to serve. Shifting that balance of care is crucial because it works. It has worked in the past and it can work in the future.

On leadership and the need to ensure that everyone understands what leadership is required, we should not think that any section of our stakeholders—be that the independent sector, the voluntary sector, health or local government—has a monopoly on wisdom. A good idea is a good idea. If that idea delivers a better outcome for individuals, it must be the way to go.

I stress that integration is the way forward—we are not going backwards; we are going forwards. That is why the report contains challenging timescales. It sends out the strong signal from COSLA and the Government not only that integration is here to stay but that we are in short order going to deliver the changes that are required.

John Wood: I have two points to make in response to the question on how we get senior staff to work together. The cabinet secretary and Councillor Currie are demonstrating a bit of it today. Political leadership is really important in getting senior staff to work together collaboratively as we want them to at national and local levels. The joint statement that was issued on 26 September last year, reiterating the commitment to integration, was really useful. Leadership is not just about instruction but is about constantly reminding the system of the direction in which we are travelling and the way in which we want to work. That constant leadership at national and local levels in taking on the identity of IJB members will really help the integration joint boards.

The other point is about the development of staff. Mr Cole-Hamilton was right to say that it is not about the calibre of staff. A side benefit to bringing staff up through the ranks together is that, when they reach the senior ranks, the clash of cultures is not felt so strongly. We need to remind ourselves that that relates not just to local government and the health service but to senior managers in the third sector, whom we hope to attract into senior public sector roles.

Brian Whittle (South Scotland) (Con): We would agree that the consistency of people's commitment to the delivery of integration is key to its ultimate success. Some of the evidence that we have heard has shown disparity in where IJBs are in the process and in their understanding of the commitment.

How is the Scottish Government taking a lead in ensuring consistency of commitment across Government departments in health and social care policy and legislation? There have been several policies and ministerial statements on health, and those are always quite light in their mentions of integration. Could the Scottish Government be encouraged to take a lead in that work?

Jeane Freeman: That is a very good point, Mr Whittle. I will add to what Mr Wood said about the political commitment to integration that is shared by COSLA and the Government. People are beginning to appreciate that, across the Parliament, regardless of political party, there is a shared commitment to the integration of health and social care. Undoubtedly, we will have disagreements from time to time about the speed and success of integration, but it is striking that all political parties agree that it is the right thing to do. The more that message is received in all the organisations that are charged with making a success of integration, the better. As Councillor Currie said, there is no point in people waiting for something else to come, because that is not going to happen.

11:00

Let me get back to Brian Whittle's point, which is a very good one. In my defence, I might say that, if the Presiding Officer were to give me longer to speak when I make a statement, I might get all those other points in. However, I think that he thinks that I speak for too long as it is. I do not have anything else to say; you have made a really good point. In the future, when I speak about issues in our national health service, I will reflect on how whatever we are doing will or will not contribute to this bigger piece of work—that is, the

integration of health and social care. It is an important point.

Every aspect of the health directorate now has a role in assisting in the delivery of our part of the review's recommendations. We are actively looking at how we work inside the Government, within the health directorate and with other portfolios, reaching out to cabinet secretaries where there are clear connections to the work that is undertaken elsewhere. Mr Wright might want to say something about that.

As I think about the specific measures that we are taking in relation to the NHS in Scotland, such as the waiting times improvement plan, I will reflect—absolutely—on the point that you make.

Malcolm Wright: One of my roles in the leadership of the health directorate is to put integration front and centre. The cabinet secretary has talked a lot about integration, about the importance of mental health and about the importance of the waiting times improvement plan. All those things are linked. It seems to me that, if we get integration right and bring together health and social care, getting more people cared for at home or in community settings, with teams of people working on the ground in people's communities and homes, we will create space in the hospital environment for the waiting times improvement plan to be driven through. Issues such as mental health are not just for the health service; they are for local authorities and third and independent sector providers. When we consider the public health reforms and the general practitioner contract, we see that all these things are interlinked and that integration is central to everything.

In my conversations in the health directorate and with board chief executives, I am saying that integration is central and that it is the responsibility of all of us to make it work. In the context of the delivery plan that we are preparing, I want to put integration front and centre in the conversations that I have with my board chief executive colleagues and my colleagues in the Scottish Government.

Jeane Freeman: Mr Wright rightly mentioned the new GP contract. All the work on primary care reform is central to effective integration because that is the context in which the health service can provide a more integrated primary care service.

Before we came into this meeting, Mr Wright and I were discussing what better or increased use we could make of the new paramedic provision, the aim of which is to deliver not acute care but a response at home. The approach is proven to reduce admittance to accident and emergency departments and, on from A and E, to a hospital bed. Of course, such a response is not always clinically appropriate; paramedics are trained to a level at which they can make decisions in that regard. They can prescribe and deliver care to an individual at home, and we are increasing their number: we will have 1,000 additional paramedics. The more effectively we can use their skills, the more effective what the health service provides will be in integrating health and social care, and in achieving the shift in the balance of care that Councillor Currie mentioned.

Brian Whittle: Thank you for that full answer, cabinet secretary.

On a more practical area, a key element that will underpin the successful delivery of integration will be an information technology system that speaks to everything. The committee has heard evidence that the IT systems in health boards do not speak to each other and that collaboration in some boards is problematic, and we are now layering local authorities on top of that. What work is being done to ensure that the operational plans will be properly integrated in an IT system that will speak at national level?

Jeane Freeman: Mr Wright will deal with that.

Malcolm Wright: I will start, and then I might ask Alison Taylor to come in.

The Scottish Government's digital strategy is another important building block, and we absolutely need to improve the digital infrastructure to allow local authorities and health boards to share data in a way that meets all the requirements of data protection legislation and patient confidentiality. At the national level, the health service is working to drive through the new digital platforms. Information sharing with local authorities is of pivotal importance, but so is doing that in a confidential way that meets the requirements of the law.

Alison Taylor: Obviously, the digital strategy is the main vehicle for addressing those issues, and it is therefore hugely important. When I am out and about, people who deal with patients and service users tell me all the time about the importance of ready access to the right information on the ground. The three issues that arise, which have already been broadly mentioned by Malcolm Wright, are: interoperability between systems; making sure that the equipment is up to date and appropriate; and information sharing, which is critical and on which we have made great strides in the past few years.

From an integration perspective, the other pleasing thing about the digital strategy work is that governance is shared between the NHS, central Government and local government. The approach to overseeing the work is integrated, and that probably gives a very good grounding for making progress.

Brian Whittle: So we have a strategy for integrating our IT systems that allows for integration within the IJBs. Has that been costed out? Do we have an end product and a cost element in that respect?

Jeane Freeman: My colleagues will correct me if I am wrong, but my understanding is that we have work under way on how well NHS Scotland's systems integrate with each other to exchange information, and that sits alongside partnership work on ensuring that the systems work for integration and that information is exchanged.

That does not necessarily mean that we will create a brand-new IT system that everybody will play into, but we need to make sure that the existing IT systems can talk to one another in the areas where that is needed. Is that right?

Alison Taylor: Yes.

Jeane Freeman: I am glad that I got that bit right.

There will be cost elements, and we can make sure that members have information on our bit of the Government's digital strategy and our work with COSLA in that respect. Perhaps Mr Wood or Councillor Currie will want to add to that.

John Wood: The only thing that I would add is to highlight the digital health and care strategic portfolio board. It is a group of senior officers who are overseeing the implementation of the digital health and care strategy, which has been co-signed by COSLA, and it is a focus for a lot of the activity in that respect.

On the local government side, our local government digital office, which is situated with the Improvement Service, is the interface with the NHS on building a single platform. Work on exploring that task is under way, but we need to keep encouraging the pace.

The Convener: David Stewart wants to ask about information sharing, after which I will come back to Sandra White.

David Stewart: I will focus on data sharing, on which I recently chaired a conference; other members have chaired conferences on the subject, too. As one wit in the audience said, data sharing is a bit like world peace: we all want it, but it does not always happen in practice. What specific steps have the Scottish Government and COSLA taken to look at national solutions, as Audit Scotland has recommended?

John Wood: That is part of the implementation plan, and it is an issue that the leadership group will consider and take reports on. It is not just in the integration space that information sharing is important; separate pieces of work are being done on data sharing in community justice and across public health, where the same conversation comes up. It is important that we look across all those bits of work to ensure that we do not consider data sharing in a siloed manner.

Alison Taylor: As Mr Wood has said, the delivery plan touches on Audit Scotland's recommendations on information sharing. There are several factors that come into play, the first of which is the sharing of data between health boards, local authorities and IJBs. That allows us to build up the resource of data to support effective forward planning for services. There are information-sharing protocols in place around the country to enable that to happen, with NHS National Services Scotland providing support for all that planning effort.

Another factor that has been touched on several times is the effectiveness of information sharing around the country. The chief officers have agreed to make sure that good practice is exchanged on the effectiveness of information sharing within a partnership area, so that there is a common understanding of why some areas are much more effective at sharing information than others. That leads on to the question of making sure that we are effective at sharing good practice in a broader sense and have a broader understanding of what good practice looks like on the ground. The issue touches on several points.

David Stewart: You made a good point earlier, when you highlighted the importance of consistency in integration authorities' data to ensure that you can make comparisons across Scotland. Have you been strong in pushing that message out from the centre?

Jeane Freeman: Yes. We have asked the oversight group that is looking at the implementation plan to identify what it believes to be the appropriate measures of success. We will look at those and they will be signed off by the ministerial strategic group.

As I have said, between us we collect a lot of data. It might be all that we need, but it might also be the case that we should be triangulating it better. Alternatively, there might be some data that we do not need to collect, and there might be areas where we should but do not collect data. We have asked the group charged with responsibility for the implementation plan to identify fair measures for assessing how each of our integration authorities are doing and how we are doing overall. Obviously, we will report to the committee and to others on those.

Malcolm Wright: At the meeting on 12 February, which was chaired by Sally Loudon—she and I are co-chairs of the group—we went through each of the items on the delivery plan and discussed what the outcome would be and what

would be different as a result of our approach. The next iteration of the delivery plan will illustrate that more clearly. The important bit is how we know that that is happening; in other words, what data can we report to the MSG to demonstrate that those changes are happening? We must pull together a data pack to demonstrate that we are making the necessary improvements. Much of that data is already there, but we need to pull it together.

As for how we use data locally to make improvements, I go back to the cabinet secretary's point about the improvement methodology being extremely important. When it comes to the sharing of data for individuals and communities, GPs, social workers and nurses must be able to work together and to share information confidentially and legally. There are a number of levels to the issue.

David Stewart: My next question is probably more for Councillor Currie and Mr Wood. Should integration authorities make their data publicly available?

11:15

John Wood: Performance data is publicly available, and rightly so, for the purposes of local accountability and so that communities and partners at local level can understand what progress their integration authorities are making. That element of local accountability and transparency on performance and improvements in performance, which can be reported through the annual report at local level, is a fundamental benefit and principle of health and social care integration, and it happens at the moment.

David Stewart: Do you have examples of integration authorities that have made their data publicly available? If you do not have that information now, you can perhaps write to the committee with it.

John Wood: I see Alison Taylor nodding. Absolutely—we have such examples. Some of that information is contained in the Audit Scotland report on integration, but we can, together with the Scottish Government, provide a bit more on that, if that will be helpful.

Councillor Currie: On the data being made publicly available, if you are driving improvements, the data needs to be at the right level to ensure that people understand that a difference is being made. If the data points to genuine improvement, the public in a local area should see that. We should not have data showing that things are going really well when the experience does not chime with that. If that were to be the case, it would be a concern.

In terms of accountability, engagement is, as we say in the report, really important. It must not be some kind of one-trick pony that happens only when something is going to close or when there is to be a major change; it needs to be an on-going discussion with the public on the services that they are receiving from integration joint boards. With that, we need the data, so that we can say what difference has been made. There needs to be a base point that we can measure against to show that things have got better. We cannot just say that we think that things have got better—we should be able to demonstrate it not just to the public but to members of Parliament and many others.

The Convener: When you say that if the data shows improvement it should be shared, I presume that you are not implying that if it shows no improvement it should not be shared.

Councillor Currie: Indeed, I am not. The process of accountability and holding to account is not just for when things are going well but for when things are going less well. In that case, the responsibility is on everyone to ensure that measures for improving things are put in place, and we can then measure whether that improvement has been delivered.

David Stewart: My final question is perhaps for the cabinet secretary, but I would welcome contributions from the rest of the panel members. As I am sure that you are aware, Audit Scotland, which is obviously independent, had in its recent report quite a killer line. It said:

"An inability or unwillingness to share information is slowing the pace of integration".

One example that the report gave was the inability of many GP practices to agree data-sharing arrangements with their integration authorities. Do you have any comments on that?

Jeane Freeman: As you will know, the overwhelming majority of GP practices are independent businesses, and part of the work on primary care reform in relation to GP clusters and the additional investment that we are putting into primary care alongside the GP contract involves helping our GPs see the gains to their practice as well as to their local partners that come from proper data sharing. That work is under way. Many GP practices do not have a concern about information sharing, but others do. The situation is not dissimilar to that in other areas of health and social care integration in which we have examples where it is working well and other examples where it is working less well. We need to use the good examples to help the others overcome some of the concerns that they might have, and the work on GP clusters is one practical way in which we can do that.

David Stewart: In summary, then, the new GP contract is an important data-sharing tool.

Jeane Freeman: It is an important tool for a large number of the improvements in primary care that we, the British Medical Association and GPs want, and which will be achieved partly through the investment that we are making. Last week, I announced a loan scheme to help to de-risk GP practices. It is designed to encourage more people, particularly younger people and women, to come into general practice without what they often see as the burden of having to sign up to a partnership, with all the financial concerns that that brings. There is a range of areas in which the GP contract contributes positively to primary care reform, which is in itself absolutely essential to effective health and social care integration.

Miles Briggs (Lothian) (Con): Good morning, panel. I welcome Malcolm Wright to his position.

I want to ask about reform of financial planning. If the experience of integration has shown us anything, it is that problems in delivering reforms often come down to who pays the piper. One of Audit Scotland's key messages was that

"Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support."

Will the panel outline what level of debt the IJBs have collectively, as things stand today?

Jeane Freeman: I do not currently have that detail for the IJBs, but I will be happy to provide it to the committee.

I can say what the reserves look like, though. As the committee will know, a number of IJBs have significant reserves, about £23 million of which is not earmarked for anything. In the draft budget, £160 million is being moved from health to local government to provide additional investment in integrated health and social care. Councillor Currie and I have discussed reserves—the overall percentage that we could fairly expect IJBs to have and, therefore, what our expectation should be in respect of reserves above that level, and how boards might use them to improve their services. We have also discussed our position on what is known as set-aside money.

Essentially, we are looking to achieve a fairer balance in financial decision making. The legislation is very clear, as was Audit Scotland's report: where an IJB has delegated authority to deliver a service, decisions on planning and commissioning of that service and, consequently, on financial planning for it, sit with the IJB. That bit of governance is crystal clear. Of course, accountability for delivery of the service that is commissioned sits with whoever is delivering it, whether that be the health board, the independent sector, the third sector or the local authority. The financial planning should be integrated into the overall planning and commissioning for which the IJB has responsibility.

Either John Wood or Malcolm Wright will be able to give detail on what the implementation plan says we should expect before the start of the next financial year by way of individual IJBs' planned use of their budgets. That will also allow Councillor Currie and me to be sure that where additional resources have been given, they are being passed over to the IJB and used for what we need them to be used for. Malcolm Wright might want to add to that.

Malcolm Wright: I will come in on that. The report takes us forward on a number of fundamental things that need to happen in every integration authority across Scotland, in terms of working with the health board and the local authority.

My experience of working with health boards is that levels of financial transparency vary. During my time at NHS Tayside, I worked with chief executives from the local authorities and health boards and the chief officers of the IJBs in order to get on the table the financial position of each of the IJBs and the contributions from each of the local authorities and health boards, so that we could have transparency about that. When I worked in NHS Grampian, the four council chief executives in the board's area were able to put in place such a system.

We all know that public service finances are under challenge right now, so partners' having joint understanding of each other's financial positions and there being transparency are really important. For better consistency, an important principle is that each integration authority's budget be agreed by a particular time—and certainly before the start of the new financial year. If the NHS and local authorities agree on the plan—as we do—it is important to do that. If we put in place the leadership arrangements that we have talked about, if we ensure that budgets are delegated on time and if we have joint understanding of everyone's financial position, the strategic planning commissioning arrangements will enable the set-aside arrangements to be implemented as per the legislation.

It is important not only that there be transparency on the range of reserves that we have, where they sit and—as the cabinet secretary said—what is and is not designated, but that each integration authority has a policy on use of reserves that is open, transparent and known by all.

If we can focus on the leadership and relational aspects, that will deliver what Audit Scotland recommends in its report. We need to implement

that really important bunch of recommendations. Work is on-going on all the recommendations to make sure that we put them into practice.

Stuart Currie: On longer-term financial planning, a crucial aspect is that past budgets have been set in different timescales. For example, it has been unhelpful for local authorities to set their budgets a few months before health boards set their budgets, because different offers come in from different partners at different points. The report is strong on that aspect: it says that there should be no reason why, with the medium-term financial framework, the budgets cannot converge. That has to happen. If an IJB is to plan ahead successfully not just for one year but on a multiyear basis, it must be clear what the offer is.

The report also mentions giving sufficient support to finance and section 95 officers who are involved directly in the integration joint boards. The role cannot just be something that a person does as part of another job; it has to be clear that they have a crucial role to play, as would a person in such a role in a local authority or any other part of the public sector. That is really important.

The report does not say what the reserves should be, nor does it set limits for them: it says that they should be "appropriate". As the committee will have seen from the Audit Scotland report, some IJBs have no reserves and others do. It is important to ensure that reserves are not being built up without a reason. Therefore, if a bar chart, flow chart or whatever shows that an IJB has reserves, the first question to be asked might be why there are issues around finance when it has £X in reserves. Work and discussions are on-going in relation to reserves.

Longer-term financial planning should be possible; it has to be possible. Some service changes do not happen in a fortnight, a month, six months or even a year. They can take years to roll out and for individuals to feel the benefits fully, so it is important that, whenever possible, people can plan ahead not just for six months or a year, but beyond that.

Miles Briggs: That is useful. It would be useful for the committee to have sight of data on that, which we have had not had in the past. We need to look closely at what it means on the ground. The cabinet secretary mentioned Edinburgh, where the council has been using its reserves and considering diving into set-aside budgets. This week, it will be looking to make £19.4 million of cuts. I know from members who sit on the Edinburgh IJB that the situation is undermining some of the integration work that they have done in the past.

11:30

We all agree that it is important, in order to make integration work, to move towards proper financial management and sustainability for our IJBs. I raised single budgeting, which Northern Ireland has moved towards, with the previous cabinet secretary. There is also the issue of regional planning for some aspects of integration, which does not seem to have happened and which Audit Scotland suggests needs to happen. How will that be taken forward in terms of the leadership teams and what we have heard today?

Jeane Freeman: Do you mean in relation to all that you have said, or a particular aspect of it?

Miles Briggs: Financing will be key, if IJBs are to be asked to make changes in the future. The Audit Scotland report suggests that the IJBs are currently looking to make £222 million of cuts. That has an impact on how they can deliver integration.

Jeane Freeman: Audit Scotland wrote its report before our draft budget committed a further £160 million to integration. We are clear that the £160 million is additional and is not a substitute for other expenditure. The decisions that a local authority chooses to make are for that local authority: they are not decisions that I can intervene in directly.

We have the advantage of being a relatively small country and there being a strong shared political commitment between COSLA and the Scottish Government to make integration work, so we can look at individual integration authorities and have discussions with them and the key partners that form the integration authority in order to try to understand why they feel that they must take particular steps. I am unconvinced that the City of Edinburgh Council needs to take such steps, either as a local authority or in terms of the consequent knock-on effect on the integration authority. We will pursue that point.

Councillor Currie is right that the medium-term financial framework—among the many other things that it has done successfully—has allowed longer-term financial planning. Like Miles Briggs, I am primarily interested in how all the changes affect delivery on the ground. The review and its proposals are clear about all the steps that are required on integrated finances and financial planning, as Mr Wright set out. That is picked up in the implementation plan.

We want the involvement of Audit Scotland—I believe that it is already providing some assistance—and of the Chartered Institute of Public Finance and Accountancy, on what would be a prudent reserves policy for a body to have, for example. All that work is under way. My point about the additional money in the draft budget stands.

A regional approach on health and social care integration would be useful for a number of areas of the service. My view is that we need to get all our health and social care partnerships operating in a more consistent and outcome-focused way on the core measures that we want them to deliver. We can then look at whether there is room for additional regional working.

The reason for that is simple: I do not want folks' eyes to be taken off the ball on what we and the review require, while they think about how they might work regionally. I need them to work and deliver well locally, according to the review's recommendations. There is, in health and social care—as there is in the health service—a need for consistent and effective regional planning for important services to develop over time.

The Convener: You mentioned the additional £160 million. My understanding from the budget at stage 1 is that it provides local authorities with the flexibility to offset their adult social care provision by up to 2.2 per cent of the 2018-19 figures, or by up to £50 million across all authorities. Does that mean that, in practice, the £160 million could look more like £110 million or somewhere between those two sums?

Jeane Freeman: That is entirely a decision for local authorities. As far as I am concerned, £160 million for additional provision in health and social care integration is going from my health budget to local authorities. As with the car parking levy, it is entirely for local authorities to decide whether they wish to use that flexibility.

The Convener: Can Stuart Currie cast any light on that?

Councillor Currie: There are two issues. First, the report is strong in saying that in order for integration to work fully and successfully, it is important that the arrangements on set-aside are implemented. That does not require new legislation; the legislation exists and is, helpfully, very clear, so the arrangements need to be implemented on that basis.

On longer-term financial planning, IJBs should be able to look ahead and think about use of the set-aside to transform funding. "Set-aside" is a strange term to use because it is a transformational fund, not a forever fund. It is about shifting the balance of care—that 50 per cent—from the acute sector into the communities. There must be planning for that to happen; it cannot happen overnight or even in one year.

The other aspect is that we cannot say to IJBs that they might need to use their day-to-day funding to transform services, because that will not happen. It would result in Peter being robbed to pay Paul, or in overspends. The set-aside is to help to resource the changes that are required. It might take one or two years for the benefits of such changes to unwind in a staggered way, but it is crucial that the set-aside works in that way to ensure that there are the resources to make the transformation happen.

The important thing about flexibility is that it allows decisions to be made that will result in the best outcomes. For example, in most—if not all—IJBs, control over children's services is not a delegated function that sits within IJBs, from a local government point of view. However, investment in children's services can make a huge difference to the social care and related activities that are part of the IJBs' purview. That is really important. Local government colleagues to whom I have spoken are looking for flexibility in such areas. Some people have said that they will leave the potential flexibility where it is, but others have said that they will invest in areas that are aligned very closely to the IJB services. That will be really important to ensure that the services are sustainable, further down the line.

The Convener: There is a mixed picture, as far as you can tell at this stage.

Councillor Currie: Yes.

Miles Briggs: I want to come back in on that point, because Audit Scotland wanted the Scottish Government to commit to continued additional pump-priming funds, as a key aspect of integration finance, in order to facilitate local priorities and new ways of working that will progress integration. The cabinet secretary does not have a figure on debt today, but has said that she will provide the committee with it.

Given that health boards have found themselves in difficultly, and that the Scottish Government has written off £150 million of health board debt, are we not in the concerning position in which some IJBs feel that they are sinking? I know that that is the case with my local IJB in Edinburgh, which is constantly trying to make cuts or is unable to manage its overspends.

Movement towards the vision that we all support is not happening in some areas. Some IJBs—the one in Moray has been highlighted to us—are managing. However, no one at the table wants IJBs in the future to be in the position that health boards have been in, with huge debts. What is the panel's view? We do not have figures today to tell us what the picture is, so what work is being done to prevent that from occurring in the future?

Jeane Freeman: In answer to the second part of your question, I say that all the work that my colleagues and I have described is work that is under way under the medium-term financial framework. We should not lose sight of such things.

Earlier, Brian Whittle asked an important question about how we present all the work within the frame of integration. It is incumbent on us all to join the dots on some of this stuff. The medium-term financial framework is an important part of what underpins our approach to integration of health and social care, along with all the other elements that we talked about and the work that is going on to get as clear a picture as possible of the financial position and the forward look. I think that that answers the second part of your question.

We are not complacent. Health and social care integration will face all the challenges that other public services in Scotland face, and we need to see what we can do that is best for that.

However, a question that always comes to my mind when I see one integration authority doing well and another authority not doing well on delayed discharge or in managing its finances, for example, is to ask what one is doing that the other is not doing. The share by which funding is allocated and the requirements that are made are comparable, and I do not accept that individuals the length and breadth of the country are so different in their health and social care needs that that would account for significant differences.

That is why I said that when integration authorities or, in some instances, health boards appear—let us not overstate matters—to be facing financial difficulties, we are fortunate and absolutely determined to be able to have a conversation with them about what exactly is producing the financial difficulty, how they are using their resources and whether support from the health board or local authority is what we expect. If the support is not what it should be, it is Councillor Currie's job and my job to see whether we can improve the position. That is the approach that we will take.

I want members to be really clear that, although it is the oversight leadership group that continues to work on the implementation plan every six weeks, the work sits with Councillor Currie and me. Where we see difficulties, for whatever reason, we have a shared and agreed responsibility to act together to resolve them.

Councillor Currie: From looking at the report and everything that we have talked about this morning, we can see that it is about making sure that services are not just deliverable but sustainable. Even if we look at nothing but the demographic challenges that we face around Scotland, we can see that it is absolutely crucial that we put the measures in place now. That is why the set-aside funds are so important to transforming our services and to ensuring that we can sustain the level of health and social care services that people have every right to expect.

The £160 million in the local government settlement is welcome additional funding. There are many challenges and areas on which COSLA and the Scottish Government take different views, but on health and social care, the additional funding is not only welcome but crucial for delivery. It is for things including school counsellors and for ensuring that we can deliver the living wage in the independent and third sectors. It will build capacity and provide a good wage for a day's work.

As Mr Briggs will know, extending free personal care to the under-65s is possible because of the additional funding for health and social care that is in the draft budget. That is welcome and we should say so. When there are things that we do not welcome, COSLA will not be shy in coming forward to say that, too. The additional funding will make a huge difference around Scotland to members' constituents and to the people whom we serve.

David Stewart: Cabinet secretary, on your point about the funding formula and how different parts of Scotland are not that different, I accept the generality of the point that the strength of management is a factor, but, as you would expect, I will raise a specific point about the Highlands and Islands.

As you well know, staff retention is one of the reasons why authorities such as NHS Highland and NHS Shetland have problems and require brokerage. We know from studies that retention rates are much stronger in the teaching hospitals in Glasgow and Edinburgh.

I spoke to NHS Shetland not so long ago. If I remember correctly, it requires brokerage for the first time ever purely as a result of the costs of locum staff. I gave the NHS Highland example of locum consultants costing £400,000 a year. Even the best manager in the world will have real management problems if they are paying £400,000 for a locum. Do you accept that staff retention and recruitment, particularly in relation to key occupations such as consultants and doctors, is an issue in rural areas?

11:45

The Convener: Can you include the requirements of integration authorities in your answer to that question, cabinet secretary?

Jeane Freeman: Yes.

My answer to Mr Stewart's question is that I accept his point. We consistently look at recruitment and retention. For example, alongside a number of other measures, we have a specific relocation package for GPs to encourage recruitment and retention in relation to rural GP

practices. I do not disagree with Mr Stewart's point, because we must consistently look at what more we can do to help in areas where retention problems, and therefore increased recruitment or locum costs, are significantly more of an issue than they are in the central belt.

There is a link to health and social care integration, but our biggest retention issue with social care workers is the prospect of the UK leaving the European Union. As Scottish Care has made clear, about 5.6 per cent of our social care workforce are EU nationals, but we have hotspots in health and, in particular, in social care where the figure rises to close to 30 per cent. Of course, the prospect of losing those individuals within the Brexit timescale—Brexit is not that far away—is of considerable concern, and we can mitigate it only to a limited degree.

Paying the real living wage can help. With COSLA, Scottish Care and others, we are also looking at other joint work on social care as a career option, with additional training and support and the possibility of moving to enhanced roles within social care. Some of the work that is under way on that will help, but the real workforce challenge in social care is Brexit and the prospect of losing those valuable EU workers.

The Convener: Indeed. That is understood. In that context, can you provide us with an update on when you anticipate the integrated health and social care workforce plan being published?

Jeane Freeman: That is still the subject of discussion between us and our partners. We have tried to take a bit more time in order to build in what we anticipate might be the difficulties resulting from Brexit. I am not making a political point; it is simply a sensible point to consider when we are planning the workforce and anticipating that we will lose some of that workforce, which is a realistic prospect. For example, we will see a reduction of about 80 per cent across the UK in the number of EU nationals registering to nurse. It is sensible to take account of that; it is just a statement of fact that, with Brexit, the position remains remarkably fluid. However, I hope to be able to publish that workforce plan in the coming weeks.

The Convener: Thank you.

I have a final question on governance for both Councillor Currie and the cabinet secretary. The ministerial strategic group recommends that IJBs provide clear directions to health boards and local authorities. What implications will the greater use of directions by IJBs have for the governance and accountability of local authorities and health boards?

Jeane Freeman: It is important to say that they are not directions in the sense of ministerial directions; they are about providing clarity on where decisions are taken. At the most recent meeting of the ministerial strategic group, we had a very useful discussion about the report, which was then in draft form, and agreed that, where functions are delegated to the IJB—for example, on planning and commissioning in relation to various service areas—that is the place where decisions should be taken.

In the health service, the accountability for the delivery of a primary care service to proper clinical and other standards sits with the health board. There is no confusion about where accountability lies. Another example is the provision of nursing care in a care setting. The care provider is accountable for the quality of the service that it provides under the contract that it has undertaken, but the individual nursing professional is accountable to her professional and regulatory body for the work that she undertakes. That accountability is in addition to the accountability of the care provider that employs her to do that job. Those dual accountabilities in the health sector have always been successfully managed and understood. We simply need to be clear about the IJB's role in making decisions and the follow through in respect of who provides the services and what their accountabilities are. The discussions that the ministerial strategic group had and what the report says are very helpful in that regard.

Councillor Currie: As with everything else, it is important that we are clear about governance—who has the responsibility for making decisions and is accountable for making sure that those decisions are delivered at various levels. Let me give an example. It came as a shock to me and to many other councillors that decisions on what used to be called section 10 grants are no longer made by the local authority. That decision making has been delegated to integration joint boards, which make decisions that are based on a whole range of factors, from not only a local authority point of view, but a joint health and social care point of view.

However, there are still issues. For example, if a lunch club's funding ends, whereas in the past local councillors would have just sorted that out, we now have to recognise that the decision is now one for the integration joint board. The governance and accountability that are involved in making that decision mean that the IJB must make sure that it can evidence why it has made its decision—whether it is to invest or no longer invest in the service—and how that will deliver a better outcome. That is the key issue around governance and accountability. A decision should not be made just because it can be made; it should be made because it will deliver better outcomes for individuals, their families, carers and the

community. If better outcomes do not happen, the decision was probably not the best one to make and the wrong conversation was had.

We have to be crystal clear. There is a learning process. People are sometimes upset if something that they think should be their decision is no longer their decision, but the world has changed. As I said, integration is here, it is here to stay and it is here for a purpose. That means that the decision-making responsibilities that some people had in the past have gone. Decision making is now a joint responsibility, and accountability for delivering better outcomes comes with that.

The Convener: The emphasis on outcomes is a positive note on which to conclude this evidence session. I thank the witnesses for their attendance and for their evidence.

I suspend the meeting for a few minutes.

11:53

Meeting suspended.

12:00

On resuming—

Petitions

Mental Health Services (PE1611)

The Convener: Item 5 on our agenda is consideration of two petitions. The first petition is PE1611, in the name of Angela Hamilton, on mental health services in Scotland. The petition was lodged on 27 July 2016.

Members will be aware of the previous work carried out by the committee on the petition, as detailed in paper 5 for today's meeting. The committee agreed to consider the petition as part of its previous work on mental health. We wrote to Sir Harry Burns in his role as the chair of the review of targets and indicators, to make him aware of the petition and its request for a reduction in mental health waiting times.

Members will also be aware of the recent commitment from the Scottish Government in its proposed budget. In a letter to the committee on 23 January, the cabinet secretary stated that

"overall funding for mental health services will amount to £1.1 billion in 2019-20."

Colleagues will also note that the committee will undertake an inquiry into primary care in 2019, which will include consideration of mental health.

In light of those points and the fact that the petition is now some two and a half years old, I invite members to consider whether it would be appropriate to close the petition at this stage in order to focus on other aspects of mental health services. Do members have any comments?

Sandra White: I appreciate the amount of work that has gone into the petition, having sat on the Public Petitions Committee many years ago.

I would be minded to close the petition in light of what you have said, convener, about the Scottish Government's commitment to extra resources, as well as the age difference in relation to child and adolescent mental health services, which is important. Most important, given that the petition is more than two years old, it does not reach the same level as our inquiry into primary care will. However, we should also include evidence from the petition as part of our inquiry, if that is acceptable to the committee.

Brian Whittle: I sit on the Public Petitions Committee, to which an increasing number of petitions are being submitted that have a mental health element and so are pertinent to our consideration of PE1611. That is quite concerning. The Public Petitions Committee is considering how to gather the separate petitions together into a

wider piece of work. If we close the petition and put it aside, there is a very good chance that many of those other petitions will come to the Health and Sport Committee and members will go over the ground again. Could we suspend the petition? There is a lot of work coming down the line on the topic and the petition is still pertinent.

The Convener: If there are no other comments, I will respond to that point. You are right that increasing attention will be paid to these issues in the future and we can expect further petitions. The question is whether our scrutiny of policy in the area should be based on the more current petitions as opposed to one that was submitted some time ago.

Miles Briggs: I am not aware of the petitions that Brian Whittle has referred to, but I suggest that, if it is possible for the Public Petitions Committee to group them so that we can consider them together, that would be useful.

Brian Whittle: That is exactly what we are doing just now. We are trying to pull together elements in common and bring the petitions together as a much bigger piece of work. Inevitably, that work will land on the Health and Sport Committee.

Alex Cole-Hamilton: I endorse what Miles Briggs has just said. It is important to recognise that mental health is a very dynamic landscape, although it is not necessarily one of improvement.

The fact that the petition has been before the committee for two and a half years concerns me slightly, because the debate has moved on and I think that we are backsliding in some areas around mental health. If we closed the petition, it would not be because we think that the issue is sorted—far from it—but because we recognise that there have been developments in the area on which we will receive representations from the Public Petitions Committee and to which we should devote our attention.

Emma Harper: I take on board members' comments, especially those of Brian Whittle, in which he noted that lots of petitions relating to mental health are coming forward. I would be interested in a collaborative approach that looked at the evidence. The Minister for Mental Health has made announcements committing to spending money, especially for young people and schoolchildren, so I would be interested in taking a broader approach to scrutinising what has been announced and what will be delivered. Mental health is really high on everyone's agenda right now.

The Convener: Thank you very much. I suggest that we agree to close the petition, but that we draw our decision to the attention of the Public Petitions Committee, which will consider how best to group the petitions in front of it and may wish to take that into account. Do members agree?

Members *indicated agreement.*

NHS Centre for Integrative Care (PE1568)

The Convener: The second petition before us is PE1568, in the name of Catherine Hughes, on funding for, access to and promotion of the NHS centre for integrative care. The petition was lodged on 12 May 2015.

Members will be aware that, as is detailed in today's public papers, the committee agreed at our meeting on 15 November 2016 to invite the Scottish Health Council to give oral evidence on its general input and approach to consultations of the type being run in this case, as well as on its involvement in the classification of major service changes. I wrote to the chief executive of NHS Greater Glasgow and Clyde on 28 November 2018 to request an update on the centre and on whether any further changes to the service were anticipated. The response from NHS Greater Glasgow and Clyde is included in today's papers, along with letters in support of the petition from Elaine Smith MSP, the British Homeopathic Association and other concerned parties, including the petitioner herself.

I invite comments from colleagues.

Miles Briggs: I thank the petitioners, the campaigners and those who have sent us correspondence. Catherine Hughes and her mother are here today; I know that they have not been well over the winter, so it is good to see them here.

There is a lot of important work that we still need to take forward. I am a co-chair of the cross-party group on chronic pain, and I know that Elaine Smith's correspondence raises on-going issues relating to the variation in treatment available across Scotland. As the Friends of the Centre for Integrative Care has outlined, keeping the petition open would allow time for correspondence to continue and investigations to take place, so I would be reluctant to close it. I look towards the work of the cross-party group, but also towards any work that our committee could undertake on the matter.

Brian Whittle: Further to Miles Briggs's comments, I chair the cross-party group on arthritis and musculoskeletal conditions, which does quite a lot of work with the cross-party group on chronic pain. As always seems to be the case, there is—without question—a much bigger piece of work to be done. A much bigger outcome is possible; the question is how to fit it in and whether it should be dealt with by cross-party groups or by our committee.

Alex Cole-Hamilton: Unlike PE1611, PE1568 will not be followed by a glut of similar petitions to the Public Petitions Committee; it relates to a stand-alone issue. I am anxious about closing it, because that would suggest that the issue had been resolved. I am not sure that we are at that stage yet, or anywhere near it, so I endorse Miles Briggs's recommendation that we keep the petition open.

Sandra White: As I said earlier, I have been involved in this area with others for around the past 10 years. It concerns me that the petition was lodged in 2015 but has just come to the Health and Sport Committee now, four years down the line. That alone is a concern for me.

Many issues have been raised. One person says that the out-patient service is still open whereas somebody else says that it is closed. We need evidence of exactly what is happening.

I refer to what Brian Whittle said. In the evidence session earlier, we talked about the integration of health and social care. The issue should be part of that. There is a much bigger issue.

I do not know how we can move on with the petition. Miles Briggs mentioned the cross-party group on chronic pain, which I know about. Dorothy-Grace Elder has also been involved in it. Perhaps the issue could be discussed there.

I am pretty loth to close the petition, but I do not know where we can go with it. It is not just about the centre at Gartnavel; it is about much bigger integration. A counselling and dietary service is mentioned. Surely that should be provided in every health authority.

The Convener: For clarity, the petition was lodged in 2015 and referred to this committee, and the committee took evidence in 2016. We pursued the issue last year, as well. Therefore, the petition has not arrived at the committee for the first time.

The committee has to decide whether there is anything further that it can add to the consideration of the specific matter.

Emma Harper: Over the past couple of years as an MSP, I have attended many events in my constituency and in the Parliament that have been related to different aspects of pain management, myalgic encephalomyelitis and fibromyalgia, which are related to the petition. My main focus is on evidence-based approaches to the delivery of best care, whether in the community or health service settings, and I am reluctant to simply close the petition without seeing a resolution. I am interested in a way to ensure that we have the wider ability to look at all the other issues that have come forward in the past couple of years.

David Stewart: Like other members, I, too, have served on the Public Petitions Committee for a number of years. I praise the work that Catherine Hughes has done in the petition and endorse the thorough letter that Elaine Smith has issued, albeit at the 11th hour. She has made a very strong point. She said that it is

"vital that this petition remains open so that we can put patients first".

She also stressed that the problem is Scotland wide and not just to do with a local area.

I agree with the comments that colleagues have made.

Brian Whittle: There must be some way in which to pull together the work that various groups have done on the topic into something a little more cohesive. There is not much point in repeating the work that has already been done. I would look for the committee not necessarily to do a great bit of investigation but perhaps to be a catalyst to pull together a lot of the work that has been done into something a bit more solid and cohesive.

Miles Briggs: The Scottish Government has outlined an advisory group that is meant to be undertaking work on postcode lottery issues, so there is an opportunity. That information has not been made available to the cross-party group. I welcome the fact that the cabinet secretary will come to our cross-party group to outline some of that work, but there is an opportunity to use what the petition looks at to ask the Scottish Government what it will do with what comes out of the advisory group. It is important for the outcome of the petition to find out where the future of the centre for integrative care sits. That would be useful for the petitioner to see whether there are questions in the petition that we could take forward with the Government.

The Convener: Emma Harper should be very brief.

Emma Harper: I will be.

I am reminded that, the week before last week, I attended an event about migraines. How we support people with migraines is a postcode lottery. That issue is along the same lines. We should consider a whole, integrated approach that supports people throughout Scotland.

The Convener: It is clear that the committee does not wish to close the petition. However, rather than coming back to the petition again in a year's time to ask what has happened in the previous 12 months, I suggest that we write to the cross-party groups that have an interest in the matter—at least two such groups have been mentioned—to say that the Health and Sport Committee is keen to understand what they can do to advance the issues that have been raised,

and to ask them to report back to us. On receipt of those replies, we can make a judgment on what we can usefully add. Is that agreed?

Members *indicated agreement.*

The Convener: We move into private session.

12:15

Meeting continued in private until 12:29.

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