# HEALTH AND SPORT COMMITTEE

Wednesday 12 December 2007

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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## HEALTH AND SPORT COMMITTEE
**12th Meeting 2007, Session 3**

**CONVENER**

*Christine Grahame (South of Scotland) (SNP)

**DEPUTY CONVENER**

*Ross Finnie (West of Scotland) (LD)

**COMMITTEE MEMBERS**

*Helen Eadie (Dunfermline East) (Lab)
Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)

**COMMITTEE SUBSTITUTES**

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
*Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

**THE FOLLOWING GAVE EVIDENCE:**

Michael Johnson (Shetland Community Health Partnership)
Susan Manion (Dunfermline and West Fife Community Health Partnership)
David Potter (Annandale and Eskdale Local Health Partnership)
Gerry Power (Midlothian Community Health Partnership)

**CLERK TO THE COMMITTEE**

Tracey White

**SENIOR ASSISTANT CLERK**

Douglas Thornton

**ASSISTANT CLERK**

David Simpson

**LOCATION**

Committee Room 2

# Scottish Parliament

## Health and Sport Committee

*Wednesday 12 December 2007*

[THE CONVENER *opened the meeting at 10:03*]

**The Convener (Christine Grahame):** I welcome everyone to the 12th meeting of the Health and Sport Committee in this session. I remind everyone present to switch off their mobile phones. We have received apologies from Rhoda Grant and Dr Richard Simpson, and we welcome Irene Oldfather as a substitute. As this is your first time at the committee, Irene, I must ask you whether you have any interests to declare.

**Irene Oldfather (Cunninghame South) (Lab):** I have no interests to declare.

**The Convener:** Thank you.

## Decision on Taking Business in Private

**The Convener:** Item 1 on the agenda is to decide whether the committee is content to take in private item 4, which is selection of an adviser and witnesses for scrutiny of the Public Health etc (Scotland) Bill, and item 5, which is on the draft budget report. It is standard practice to do that. Are members agreed?

**Members** *indicated agreement*.

## Subordinate Legislation

### Official Feed and Food Controls (Scotland) Regulations 2007 (SSI 2007/522)

10:04

**The Convener:** Agenda item 2 is subordinate legislation. We have one negative instrument for consideration. It implements a European regulation on feed and food animal health and welfare controls, particularly on feed and food of non-animal origin from outwith the European Community. It also provides for the recovery of certain expenses by competent authorities.

No comments have been received from members, and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendation in relation to the instrument?

**Members** *indicated agreement*.

# Balance of Health Care Inquiry

10:04

**The Convener:** We move to agenda item 3, which is on our inquiry into the balance of health care. I refer members to paper 3 of this week's papers.

The session is intended to be exploratory. Someone has written "teasing" in my brief, but I prefer to say that it will bring out ideas to help inform an inquiry remit. The witnesses represent the Lothian, Shetland, Dumfries and Galloway, and Fife areas, and they are very welcome. They are: Gerry Power, general manager, Midlothian community health partnership; Susan Manion, general manager, Dunfermline and west Fife community health partnership; David Potter, general manager, Annandale and Eskdale local health partnership; and Michael Johnson, director of clinical services, Shetland community health partnership. Thank you for travelling that distance, Mr Johnson; we are pleased to have someone from Shetland before us.

The witnesses have provided written statements, which have been circulated, so we can move straight to questions.

That caught members on the hop—we are moving along too briskly. While members sort out their papers, we can perhaps have a short introduction from each of the panellists, if they wish.

**Gerry Power (Midlothian Community Health Partnership):** I am happy to make a statement.

Shifting the balance of care is not new to us in Lothian or, indeed, the national health service in Scotland. As far as operational implementation is concerned, all the major strategies in NHS Lothian have an underpinning ethos of shifting the balance of care from the acute sector into the community whenever that is appropriate. As members will see from my submission, there are some concrete examples of how that is being done.

I would not want to suggest that such work is happening just in Midlothian; it is also happening in the other community health partnerships in Lothian. However, particularly in acute mental health services, Midlothian is the first area in Lothian to show that we can operate a service in the community with a reduction of acute beds. We have reduced the number of acute beds that we make available to Midlothian. We have closed acute in-patient facilities in Midlothian and transferred those services into the community.

The CHP is demonstrating concrete examples of how we can shift the balance of care, rather than simply having it as a general ethos.

**The Convener:** I thank you for the detailed part of your paper on mental health services.

**Susan Manion (Dunfermline and West Fife Community Health Partnership):** Gerry Power is right to say that shifting the balance of care has been happening for a long time. As is outlined in our submission, we are trying in the CHP and local health system to build on the work that was done by the local health care co-operatives in developing important local partnerships and initiatives.

What is different from what has come out of the Kerr report, the subsequent strategic documents and the driver from the Government on shifting the balance is the expectation that the change should become much more systematic. Although the local health partnerships and the LHCCs were successful in driving innovation at a local level, I do not think that the changes were systematic or necessarily owned across the whole board and system.

We are now looking for a wholesale change in how we operate as a health system to ensure that there is clarity of expectations and priorities for the board. We must ensure that we build on good practice and that it becomes available to everybody—not just those in the local areas that were particularly good at developing local systems. The change needs to be driven locally, but we need a strategic framework to do it.

The submission from NHS Fife is almost a synopsis of what our board agreed at its October meeting. Professor James McGoldrick, our board chair, was clear at that meeting that shifting the balance of care is fundamental to the work of NHS Fife. That is important for engagement throughout the organisation. Although there are many good local initiatives, which we are working on, strategic high-level support is crucial for implementing such a significant change.

**The Convener:** Members are all thinking of questions now—but I will give each of you an opportunity to have your say first.

**Michael Johnson (Shetland Community Health Partnership):** I agree with what Susan Manion and Gerry Power have said. Shifting the balance is not new to us. In our context, it is slightly different, however. We would look at shifting the balance in terms of having two key themes. One is in a local context: shifting the balance from hospital-based care out into the community. That is work in progress. In our island setting, it is also a matter of shifting the balance of care away from mainland service providers. Some of our specialist services are provided mainly through NHS Grampian. For the past 10 to 15 years, we have been looking to shift the balance from Grampian to a local Shetland service. The

development of the shifting the balance agenda will be continuing work for us.

On the local health structure in the CHP context, we have in place an integrated structure between primary care and secondary care. For example in my role, I have responsibility for both primary and secondary care. We try to take an integrated approach to managing and delivering services. As I say, that is work in progress.

**David Potter (Annandale and Eskdale Local Health Partnership):** I concur with what my colleagues said about shifting the balance having been on the agenda for some time. In Dumfries and Galloway, we are looking to local health partnerships—LHPs—which have been built on the local health care co-operatives. We are currently undertaking service reviews within LHPs. Core to that is shifting the balance, not necessarily taking the accepted view of shifting acute care to community care, but shifting attitudes, which is really important.

We are working from the point of view of patient attitude. We are examining long-term condition management, enablement and rehabilitation. It is a matter of working up services, with a shift in attitude in local communities, both in how they look after themselves and in what their expectations are, and building up those services in primary care teams. We hope to bring about some change in attitudes and in the structure of our local services. That would enable the shift from secondary care to primary care to be more easily implemented where it is feasible.

**The Convener:** Ross Finnie will be next, followed by Ian McKee, Michael Matheson, Mary Scanlon and Helen Eadie. That is the list so far. You have to be quick here, Irene.

**Irene Oldfather:** I can see that.

**The Convener:** Members have all been nodding at me to indicate that they have questions. We will go in that order, anyway. I should explain to Irene Oldfather—it is her first time at the committee—that I do come back to members for supplementary questions. There is no need to say everything at once. Our team is beginning to learn this—members do not need to ask six questions at their first stab. If a member has asked a question and then thinks of something later, on the same topic, I will certainly let them in.

**Ross Finnie (West of Scotland) (LD):** The witnesses have given us a helpful introduction, and much more information is set out in the papers that they kindly provided in advance.

We are not just seeking to establish where the balance is. Following Professor Kerr's general statement that it is perfectly possible to establish in the community 90 per cent plus of what is being delivered, I am interested to know what the major impediments are to a serious, substantial change, rather than just the annual minor incremental progression that has been on your agenda? What is the major impediment to shifting the balance and achieving the necessary change?

**Susan Manion:** There are a number of factors. One is the fear of change. In the NHS, we have been used to organisational change for some time, but what is required is on a slightly different scale. This is a necessary move to change activity and to increase the infrastructure of primary and community services. We need to break down some of the professional boundaries. There is a perceived barrier—not necessarily a real one—in how we allocate resources and use capacity across the system.

10:15

The issue is partly one of perception and partly a good old-fashioned fear of change. Some professional groups and clinicians fear moving some of their services into the community and working in a different way. Although we have done that well for a number of years and there have been significant changes as a result of good clinical leadership, we are now seeking a step change in how services are provided that is greater than could be expected through incremental change. We must make it now, because of the demand on and expectations of acute services, which are not sustainable in their current form.

**Ross Finnie:** I do not disagree with you—we are using the same language. I am concerned to know what the big barrier to step change is. You started by talking about professional inhibitions, but you ended by coming back to the point that I was making. You and I agree that a step change is needed. The committee is interested in your professional view. You talked about changes in professional attitudes, but is there another big impediment that you would care to bring to our attention?

**The Convener:** Would you like to respond to that question?

**Michael Johnson:** I was going to make a different point, but I will reiterate some of what has been said about professional boundaries. We are nibbling at the edges of those boundaries in order to break them down. Earlier this week, I was looking at what NHS Education for Scotland is doing to develop health care practitioners with special interests, so that we are not reliant on specialist professionals and are able to move services down a level. This also involves challenging patient expectations. Sometimes patients expect to see a consultant; persuading

them that they can be seen by a physiotherapist or a GP with a special skill is a difficult barrier to break down. We must work with local communities on such barriers.

I want to talk about some of the challenges that we face, especially as a small health care system. There are good examples of how we can shift models of care. One simple example is community diagnostics. We can try to move diagnostic services from hospitals out into the community, but in our context that is not possible because of economies of scale. We have one imaging and X-ray department and one recently acquired computed tomography scanner. We cannot move those services out into the community—it has to be hospital based. However, we can shift the balance by using technology to save patients travelling down to the mainland for a scan or X-ray. The image is sent down the line, so that a specialist can report back on it quickly, reducing the time it takes for a patient to get care and treatment. That is a fundamental shift from how we operated a couple of years ago.

There are funding constraints. In small health care systems such as ours, there is not the flexibility to shift resources from the acute sector to the primary care sector.

**Gerry Power:** My colleague touched on funding. We discovered, when we changed the mental health strategy from an in-patient service to a community-based service, that moving from an existing model to a new model is a barrier. We have to keep the plates spinning with the existing model, to ensure that no one falls through the safety net, but at the same time we have to build up community services. That bridging issue cannot be addressed only through resources; there is also a time factor. We cannot go from the existing model, on day 1, to a new model in the community, on day 2; we need to ensure that the two systems are kept running at the same time. [*Interruption.*]

10:20

*Meeting suspended.*

11:03

*On resuming—*

**The Convener:** I call everyone to order. I hope that you are warming yourselves up with cups of tea and coffee after being outside. That will have blown away the cobwebs. We are now ready for lots of interesting questions.

Mr Power was speaking before the fire alarm rudely interrupted us.

**Gerry Power:** Thank you, convener. We were asked about barriers, and I mentioned that moving from an existing model to a new model requires a transition period, which has resource implications. On a positive note, that has been recognised in Lothian NHS Board and resources have been made available to allow that to happen, but the difficulty is that the pace of change depends on the resources that are made available. It is difficult to free up transitional resources when people are trying to run an existing health service. That is a barrier that we have overcome by allocating additional resources within NHS Lothian, although additional resources cannot be allocated for every element of care when people are trying to shift the balance.

**David Potter:** An important issue is the suitability of premises and services to allow the shift in the balance of care to take place. There has been some success with the development of Galloway community hospital, which is a completely new facility in the far west of our region.

**The Convener:** Where is that hospital located?

**David Potter:** Galloway community hospital is in Stranraer. It is a newly built hospital with state-of-the-art facilities. The fact that staff with more specialist skills have taken up positions in the hospital has encouraged our district general hospital to transfer out some secondary care services. There is confidence in our ability to establish fit-for-purpose facilities. However, there are constraints on doing that in more than one location in a rural area with a dispersed population. On the other side of the region, in the Annandale and Eskdale area, we have a number of cottage hospitals. There are quite a few constraints on changing them into state-of-the-art facilities, such as local affection, the dispersed nature of the rural area, and our ability to enter into positive dialogue with communities to say that if we can change things, we can improve them. Unless we can change things, secondary care will be less willing to transfer services out and to use community facilities.

**Irene Oldfather:** Does the panel have any experience of community casualty units, particularly in relation to diagnostics? That issue is vital to shifting the balance of care. Do community casualty units have a role to play in that?

**David Potter:** We have a casualty unit in the Galloway community hospital, and diagnostics are available—it is essential that they are available. Minor injury units are a different issue, however, and there is a question about how useful they can be because of the support services round them in traditional cottage hospitals.

**Susan Manion:** The ability to access local diagnostic and treatment services is crucial. In Fife, we are considering that in the context of the

redevelopment of the Queen Margaret hospital. The process is linked with our acute facilities. However, it is recognised that in shifting the balance and providing alternative referrals and access points, the development of larger diagnostic centres in which a range of facilities can be accessed is a crucial part of the overall infrastructure for community-based services.

**Ian McKee (Lothians) (SNP):** My question is similar to Ross Finnie's, but I shall put it differently. My background is as a general practitioner. It will be easier if I make some observations and ask the panel to comment on them. First, I am interested in what happens in Midlothian in respect of mental health: what is done there seems to be very good. Mental health is a good place to start the transfer because it has always been regarded as a primary rather than a secondary care service, although I find that to be a rather artificial distinction. One of the problems that I have observed is that services that move into the community tend to be just secondary care services taking place in the community—they do not go that one stage further and become integrated properly with general practitioners, nurses and health workers in the communities, but instead run in parallel. Individuals' personalities can mean that that works to a greater or lesser extent. Is it fair to say that as well as moving services from secondary care to the community, we must integrate all the care that takes place in the community? Hospital services that are closer to people's homes are a good thing, but that solution is not perfect.

My other observation is that, years ago, we had local commissioning, which involved health workers and other people in an area commissioning services. It was a bit like GP fundholding, except that general practices did not hold the funds—the community in an area decided what services it needed, which included secondary and primary care. That system fell by the wayside and we now have community health partnerships and secondary care. In practice, it is difficult to get people to give up the budgets in their areas of influence and I am not convinced that community health partnerships have enough leverage to do that. Do you see that as a problem? From my experience, many services that are provided in hospital could be provided in primary care with a bit of investment and organisation, but barriers in secondary care prevent that. There do not seem to be adequate levers to encourage that transfer to take place, when push comes to shove. Do you agree?

**Gerry Power:** On services in primary and community care, the issue is what should be provided, rather than what could be provided. For example, we have taken a tiered approach to mental health services in Midlothian, so most people with mental health problems first attend their GP practice and many mental health problems are dealt with in primary care. In taking an integrated approach, the issue is what services should be provided in general practice to deal with mental health problems at that level, such as counsellors and community psychiatric nurses.

When the issues move up a level, individuals may previously have moved into secondary care, but we do not think that that is appropriate. We need robust services in the community that can manage crisis and on-going problems—only a small minority of individuals should attend in-patient services or hospital-based services. I understand Ian McKee's point that transferring services from a large hospital to a smaller one is simply providing hospital services differently. However, we should consider what is appropriate at each level—only the small minority of individuals who require hospital care should get it. We have achieved that with mental health services.

On the influence that CHPs have in shifting resources, I understand Ian McKee's point about resources being decided at local level through local commissioning. However, CHPs can use a number of tools to influence decisions, including use of public involvement and public partnership forums. CHPs certainly involve the public more in decision making, which in turn can influence NHS boards' decision making. Crucially, unlike the local health care co-operatives, CHPs have a vote on the health board. In many areas, there are more CHPs than acute divisions—that balance is extremely useful in influencing decisions. In the decision-making forum at health board level, CHPs have leverage to try to make decisions work and to influence decisions so that resources are shifted. It is up to CHPs, having been given that opportunity, to ensure that they influence health boards.

**The Convener:** How many CHPs are there in Lothian NHS Board area?

**Gerry Power:** There are four—Edinburgh, East Lothian, Midlothian and West Lothian.

**The Convener:** So there are four people from CHPs on the board.

**Gerry Power:** Absolutely.

**The Convener:** How many people are on the board in total?

**Gerry Power:** I cannot tell you that.

**The Convener:** I just wondered what the balance is on the board.

**Gerry Power:** On the representation on the board from CHPs versus that from the acute division, the director of acute services sits there against the four CHP chairmen, who are highly

influential in ensuring that the priorities for their areas are voiced and listened to. That includes shifting the balance of care.

**The Convener:** That is interesting and applies to a large area. Do the witnesses from other areas have any comments?

11:15

**Michael Johnson:** I will pick up on Gerry Power's point about the structure of boards. Our context is slightly different. We take an integrated approach, so our medical director and our nurse director cover primary and secondary care and can take a holistic approach that does not split CHP services and acute services. That brings us advantages in developing services.

We still have some way to go on local commissioning and I do not know whether that is the right approach to take. We have recently considered and discussed with the Scottish Government changing our CHP structure. The issue comes down to governance and accountability. Lots of matters that the CHP deals with depend on how it works with its local authority partner. We have two separate governance structures and two separate lines of accountability: the question is how we integrate them.

We have considered locality planning—working from the bottom up. We are trying to pull together GPs, social workers, community learning and development workers and nursing staff to work together for their communities' needs, so that they understand what the people in their community need, and work together more cohesively to deliver services.

Complications arise when we go up the tree and become involved in governance, committees and line-management arrangements. As other areas have done, we are trying to move towards a single integrated management structure for some joint services between the health service and the local authority, so that we can break down barriers to providing a holistic service. We are told—I think the message from elsewhere in the country will be similar—that people in their homes do not care whether a professional is employed by a local authority or a health board; they just want to receive the right service at the right time for their needs.

We are trying to break down barriers and not to get too hung up on the finance issues. We are trying to work together to identify and meet areas' needs. We are examining the devolved strategic framework from the health board and the local authority so that we have an agreed joint framework and a devolved budget that the CHP committee can drive and take forward. That is where we want to be, but we are still walking along the path.

**The Convener:** I do not want to truncate proceedings and I thank Ian McKee for his informed question, but I would like shorter questions and answers, only because this is a preliminary session—we may very well call all the witnesses back. The aim is just to get an idea of where we are going with the inquiry. Members know that we have a heavy agenda that we must get through today, so I ask them to adopt that mood. If the witnesses want to comment on anything that has been raised, I ask them to do so when answering Michael Matheson's question.

**Michael Matheson (Falkirk West) (SNP):** Several witnesses have said that the transition from secondary care to primary care and community care has been taking place for some time. In my view, that has been happening for decades and not just since the Kerr report was issued. I remember, way back when the National Health Service and Community Care Act 1990 was introduced, that all the talk was about the transition to primary care and community care provision. It has been going on for decades, so I am a bit cynical about how effective community health partnerships will be in delivering the transition on the ground and in dealing with how it affects people. Why will community health partnerships deliver the transition that everything before them has failed to achieve?

**Susan Manion:** That is a good question that we all ask ourselves frequently. CHPs alone cannot achieve the shift. The phrase sounds slightly trite, but we need a whole-system sign-up, which is why boards need to be absolutely clear about where our priorities lie and how we will facilitate the shift. The structures are not hugely important, but we must have in place structures that facilitate the change. We can do it by ensuring that we get the infrastructure in primary and community services correct.

The previous question was about the fact that bringing acute services into the community does not always work. We tried quite a simplistic approach by saying that everything would fall into place if we brought a consultant into the community, but that does not happen because people work differently, and it is not necessarily efficient to do that; it must be efficient.

As an example, rather than employ more consultants in dermatology services, we can employ specialist nurses who will take referrals from practices in the community, who can soak up much of the activity and prevent people from having to go to hospital. We have demonstrated that a specialist dermatology nurse can have a caseload of more than 1,000, 2 per cent of whom will go on to acute services. The rest will be cared

for either by the nurse or through self-care. We have demonstrated that we can do it, although it takes time.

We have to avoid the quick fixes in relation to waiting lists and so on. If there is a long waiting list for dermatology services, we can solve the problem quickly and in the short term by employing another consultant. It takes longer, and a bit more bottle, to set up specialist nurses working out in the community with different referral patterns and access to diagnostic services in the community. I am convinced that CHPs are the best way to do that.

**Michael Matheson:** You used the term "whole-system sign-up" and went on to explain transition and health. One of the six key objectives of community health partnerships is

"to establish a substantive partnership with local authority services".

I have only heard one reference to social work services, which is why I am sceptical about how effective the change is going to be. It is very much about how many community hospitals and local services can be provided. It sounds as if the framework is medically and health driven. Why should it be more successful than what existed previously? Who should sign up who has not signed up? Why are we not hearing more about the partnership with local authorities, which is essential for particular services?

**The Convener:** Before we go on, Mr Potter, you have not had a chance to talk for a while. Would you like to come in on this point?

**David Potter:** The key is probably the word "partnership". If we go back to the idea of shifting the balance of care from secondary to primary care, the idea that secondary care is simply about taking a consultant out to run a clinic is not shifting the balance. We are talking about secondary and primary care, and council and local community services working together in a partnership to share the care.

There is a very good example of that. Michael Matheson alluded to joint working between health services and councils. We have established a very good community team, jointly funded by health and council—we call it STARS, or short-term augmented response service. The key to that team is that it moves between secondary and community primary care for people who need supported early discharge or to prevent their being admitted. It also works with specialist health services, such as chronic obstructive pulmonary disease services, to provide very quick, short-term intervention. That project is jointly funded by health and social care services, so it is able to carry out the care needs assessment as well as the health assessment.

You will probably find similar models dotted around the country. In our services review, we see that as the model for greater teams and building capacity. Basically, it means that the patient is supported in the community by multidisciplinary multi-agency teams that have links with specialist services and the traditional primary care team GP services. There are a lot of issues to deal with, but partnership, co-operation, working together across boundaries and trust are key, rather than the more combative commissioning approach. There has to be a lot of trust through sharing the skills and responsibilities of secondary care with primary care.

**Gerry Power:** I am sorry to be parochial, but in Lothian two of the community health partnerships are community health and care partnerships. There is a joint director of health and social care for Edinburgh and West Lothian, and the decision-making process is a completely joint process.

As far as the practical issues are concerned, I refer members to my written statement. When we shifted the balance of care in mental health services—I cite this because it is a concrete example—NHS money went into social care and the voluntary sector as well. It is not about being protective of health money and holding it within the NHS; it is about deciding who is the best person or agency to provide the service that we need in the community and directing the money at that service. We have money in the health service that is paying for a number of agencies to do such work.

As far as the decision-making process is concerned, if you look at any of the CHPs you will see that there are council officers, members, voluntary sector representatives and users on the groups. Unlike the LHCCs, CHPs have a broad membership and all their members have a vote in the decision-making process. There are some good, concrete examples of our working not just with local authorities, but with other agencies to deliver services for the local population.

**Mary Scanlon (Highlands and Islands) (Con):** The chairman of NHS Shetland took a very positive step towards working with local authorities when she became a councillor and a member of the social work committee in May. That is a good example to set.

I have just two questions today—

**The Convener:** Oh heavens! My goodness!

**Mary Scanlon:** I thought that you might be impressed by that, convener. I will pose them to just one person, too. My questions are for Michael Johnson and relate to the written submission from NHS Shetland. Can you explain how the hierarchy of care in Shetland is quite different? We talk about acute and primary care, but you have

community care, primary care, the Gilbert Bain hospital and NHS Grampian, so the hierarchy is quite different. I would also like you to explain further, for the committee's benefit, the point that you make under the heading "Funding". You state:

"Small systems don't have the flexibility of larger Boards for instance in shifting the balance of care from hospital to primary care, we don't have enough posts to lose any without compromising core services".

That is a crucial issue in the islands.

My second question concerns an issue that has not been raised today. As you say, social work has not been mentioned, but neither has the ambulance service although there have recently been concerns about that in the Highlands. Your submission states that

"further challenges remain particularly in emergency service responses".

We will have a debate tonight on the Orkney air ambulance. Can you talk a little bit not so much about that, but about how you feel the ambulance service might be more integrated to provide a better service in the island communities of Orkney, Shetland and the Western Isles?

**Michael Johnson:** I have mentioned the finance issue. A concrete example of that is the limitation in the core services that we can provide because of the constraints of our resources and the fact that we do not have a large acute hospital. In larger areas, there is the flexibility to transfer some resources from hospital into the community and the potential to reduce bed numbers, but we have one medical ward and one surgical ward, and we are unable to reduce the number of staff needed to provide those facilities. It is therefore extremely difficult for us to transfer resources from our acute sector to the community.

Because of the nature of the service and our on-call commitments, we cannot downsize departments because we need a cohort of staff to provide a rota that is compliant with the working time directive and that will, ultimately, attract staff. Our funding constraints mean that it is difficult for us to transfer resources that could otherwise be transferred from the acute sector to primary care.

The ambulance service and access to emergency service transport are issues not just for island health boards, but for remote and rural areas throughout Scotland. Members may know that Shetland is a long, thin island with other islands nearby. The geographical challenges make it difficult to deliver an equitable service to all our local communities. It is difficult for our land-based ambulance service to provide equitable response times when it is based in the central part of the mainland. Difficulties also arise when two calls come into the ambulance service at the same time. In certain areas, we rely on our local GPs and nurses, although changes to the out-of-hours service make that quite challenging. Members will be aware of that.

11:30

NHS Orkney's air ambulance service issues are slightly different from those for us on Shetland. When the new air ambulance service was introduced, we managed to procure something slightly different from that on Orkney, through separate negotiation. However, ambulance response times continue to be an issue, as does the transfer of patients to the mainland. We are working on those issues with the ambulance service.

**Mary Scanlon:** Does a representative from the ambulance service sit at the table with you? The question is for each partnership.

**The Convener:** The question seems to call for a yes or nor answer.

**Mary Scanlon:** It does.

**Gerry Power:** No.

**Susan Manion:** No.

**Michael Johnson:** No.

**David Potter:** I also have responsibility for two managed clinical networks. Ambulance service representatives sit at the table there. For the networks, the issues are similar to those for LHPs or CHPs: access and emergency response.

**The Convener:** We could get into issues to do with the ambulance service and response times, but that is for another day.

**Mary Scanlon:** I have no further questions, convener.

**The Convener:** I am sorry to move us on, but we have other work to conclude today. I will call Helen Eadie and then Irene Oldfather, after which I will close the session.

**Helen Eadie (Dunfermline East) (Lab):** We have heard how important partnership working is for local authorities and the NHS. The Scottish Parliament information centre has prepared a briefing in which it says that a number of urban myths have emerged about the establishment of the joint working arrangements, one of which relates to governance. Is governance an issue, as a consequence of joint working? I have one further question, convener.

**The Convener:** Mr Potter wants to come in on that. [*Interruption.*] I am sorry; I am having a senior moment. I am famous for them. I call Mr Power.

**Gerry Power:** We are all aware—certainly it is the case in our partnership between the local authority and the health service—that legislation

allows one agency to manage services on behalf of the other. We tend to work in partnership: instead of working through a legal instrument, we pool resources to manage services.

At the end of the day, good governance comes down to having a good working relationship between the CHP and the local authority. As the committee might imagine, all four CHPs in Lothian are coterminous. The number of services that we manage jointly is significant. An individual does not require health services or social services or voluntary services; like everyone else, they require a range of services. To be person centred, we work together collectively, which has never been a problem. We are aware that legislation is in place should we wish to use it, but we have had no governance issues in managing services on the ground.

**Susan Manion:** Most of us will have some form of joint management arrangement. I have no doubt that there will have been some hitches to do with the process along the way, but they can be overcome through strong local partnership and strategic partnership with our council colleagues. A number of our projects involve services that are managed by nurses and social work employees.

At a strategic level, we are working with the council on the development of commissioning strategies for services for older people and other services. Reference has been made to commissioning, which has an important function and can help us to deliver not just local projects and management arrangements, but a strategic outlook to which we can sign up.

**The Convener:** You said that you are developing commissioning strategies for services for older people. I take it that you are consulting on those with the older people concerned.

**Susan Manion:** Absolutely—we are consulting local communities as part of a huge exercise in patient and public involvement.

**Helen Eadie:** My second question is about GPs, other health care professionals and local authority workers. Some of the LHCCs were outstanding exemplars of best practice. What has been lost in the transition from LHCCs to CHPs?

**Michael Johnson:** First, GPs have probably felt slightly disengaged from the CHPs, which have a much broader remit than the LHCCs had. The LHCCs had a particular focus on health. Locally, we have found that our GPs have voted with their feet. Secondly, GPs have been affected by the new general medical services contract, which has taken up a lot of GP time. GPs are focused on implementing and developing the new contract. Those are the two factors that we have noticed.

**David Potter:** From the point of view of location and structure, we moved seamlessly from LHCCs to local health partnerships; indeed, the managers remained the same. Our GPs continue to engage with LHPs, although the remit has widened, as have partnership working and the public health agenda.

Like Michael Johnson, I think that the GMS contract has absorbed GPs in their own interests on a temporary basis—

**Helen Eadie:** I will interrupt you, because my question was not just about GPs. The LHCCs that I visited and observed working comprised a wide range of local people, including local authority workers, occupational therapists and health care specialists such as specialist nurses. You have not commented on any of those other workers, which is what I was looking for.

**David Potter:** Okay. Our LHPs include all the professions that you have just mentioned—the local social services manager is a member of my management team. I am sure that other models will be similar. Just as wide a range of professionals are involved in LHPs as were involved in LHCCs, and I think that the partnership arrangements are now wider. For example, education representatives are on our wider committee, which previously never happened. That gives people in education an opportunity to speak to core health service staff, thereby widening the remit without—we hope—disengaging people who were more directly involved in LHCCs.

**The Convener:** We must move on to the final question. Further opportunities to pursue the subject will arise once we have set our brief for the inquiry.

**Irene Oldfather:** It seems to me that, from a patient perspective, one of the biggest drivers for shifting the balance of care is to reduce hospital admissions, especially among vulnerable groups. I am thinking about elderly people, especially those who have mental health problems, who research shows are particularly vulnerable to adverse incidents in hospital situations. Are enough options available in the community? What is the biggest change in community services that you would like to see to reduce the number of hospital admissions and allow elderly people to remain in the community?

**David Potter:** As I mentioned earlier, we use the multi-agency STARS approach, which is focused entirely on keeping people in their own homes. We probably need to build the capacity of such models.

**Irene Oldfather:** Are there any medical measures that could be taken? One of the most frequent reasons for the admission to hospital of

elderly people that I come across in my constituency is chest infection, for which they need to receive antibiotics intravenously. A simple measure would be to make the intravenous administration of antibiotics available in the community, which would reduce the need for elderly people to go into hospital and help to prevent all the complex problems that go along with that.

**Gerry Power:** As I have said, the issue is about the transition from one model to another. That was recognised in Lothian last year through the provision of an additional £2 million—which is not much, given the size of NHS Lothian's budget—to establish rapid response and intermediate care services in the community. Those services range from the provision of information to people who have chronic obstructive pulmonary disease to the provision of additional nurses in the community to do what you have suggested.

As part of that work, interesting innovative ideas have been adopted—in East Lothian, for example, work is being done with the Met Office so that individuals who have been identified as having respiratory problems are automatically contacted to be given information on what the weather will be like and how to look after themselves. There is a partnership arrangement between the recipient and the services that are provided. The issue is about ensuring that good information is provided right through to making available additional nursing, which would make your suggestion possible.

You asked whether the necessary services are in place. Some of them are coming into place, but it has been recognised that not all of them are in place and that investment must be made.

**The Convener:** I am afraid that I will now conclude this agenda item—we must make great progress on our draft report on the budget today. I thank the witnesses for attending. If there is anything that you wanted to say but were not able to because I have truncated proceedings slightly—bearing in mind that today's session has been a general exploration of the subject, to help us establish the focus of our inquiry—please feel free to write to me, as convener, and I will circulate your thoughts to members. Once we have decided on the remit of the inquiry and how to tackle it, we will issue a call for evidence, so we may well see you again. Thank you for participating in what has been an extremely interesting discussion. You were invited to give diverse views on delivery in different areas and that is exactly what we have received.

That concludes today's business in public. I will allow a few minutes for the room to clear before we move into private session.

11:42

*Meeting continued in private until 12:58.*

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