The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 6 March 2012

Session 4

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HEALTH AND SPORT COMMITTEE
9th Meeting 2012, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

Jackson Carlaw (West Scotland) (Con)
*Jim Eadie (Edinburgh Southern) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jan Baird (NHS Highland)
Dr David Farquharson (NHS Lothian)
Roddy Ferguson (Fortuno Consulting Ltd)
Jim Forrest (West Lothian Community Health and Care Partnership)
Dr Allan Gunning (NHS Ayrshire and Arran)
Anne Hawkins (NHS Greater Glasgow and Clyde)
Elaine Mead (NHS Highland)
Nanette Milne (North East Scotland) (Con) (Committee Substitute)
Julie Murray (East Renfrewshire Community Health and Care Partnership)
Bill Nicoll (NHS Tayside)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Tuesday 6 March 2012

[The Convener *opened the meeting at 10:00*]

Integration of Health and Social Care

The Convener (Duncan McNeil): Good morning, and welcome to the ninth meeting of the Health and Sport Committee in 2012. I remind everyone present that mobile phones and BlackBerrys should be turned off, as they can interfere with the sound system.

We have received apologies from Jackson Carlaw, and Nanette Milne is attending as his substitute. Welcome, Nanette—we are pleased to have you with us again.

The first item on the agenda is our first oral evidence session for the committee's inquiry into integration of health and social care. I welcome Anne Hawkins, who is the director of Glasgow city community health partnership for NHS Greater Glasgow and Clyde; Julie Murray, who is the director of East Renfrewshire community health and care partnership; and Jim Forrest, who is the deputy chief executive and director of West Lothian community health and care partnership.

We move directly to questions.

Gil Paterson (Clydebank and Milngavie) (SNP): Good morning, everybody. When setting up your partnerships, did you use existing arrangements or did you start from scratch?

Julie Murray (East Renfrewshire Community Health and Care Partnership): In a way, we started from existing arrangements because we had a strong partnership ethos in East Renfrewshire. However, we started from scratch, to an extent, in relation to structures. We had some existing posts in the local authority, which meant that in the new CHCP world we had some consistency and there was not a whole new management team. The team was, in part, comprised of existing local authority employees, and we had new people join us from the national health service.

We developed structures that were single arrangements in order to avoid duplication, and we ensured that the community planning and CHCP committee arrangements were aligned, so that arrangements were as streamlined as possible.

Anne Hawkins (NHS Greater Glasgow and Clyde): The CHP in Glasgow is a relatively young organisation that was established in November 2010, on the back of the previous five CHCPs. It is new and quite different. The individuals who form the management teams in the three sectors all had managerial posts in the previous five CHCPs. I had not been part of that; I moved into the role from what was Greater Glasgow NHS Board's mental health partnership. It was a new structure, with people in new roles in different parts of the city. It also had new managerial arrangements, and a new joint partnership board was formed with the council, with councillors and non-executives to oversee the arrangements.

Jim Forrest (West Lothian Community Health and Care Partnership): In West Lothian, the picture was similar to that which was described for East Renfrewshire CHCP, although the difference is that we brought together existing management teams.

As was described for Glasgow city CHP, we set up a partnership board that is made up of four elected members and four NHS Lothian appointees, and to which each of the officers and managers reports every six weeks.

The services themselves were comprehensive in that they covered primary care and community health services, as well as a number of hospital-based services; for example, the mental health services in St John's hospital.

The CHCP covers the full range of social work services: those for adults and older people and children and families, and criminal justice social services.

Gil Paterson: It is very much a mixed bag, in terms of success. Do you think that too much time is spent on structures, rather than on existing good practice? Are there lessons to be learned? That question is for the whole panel.

Julie Murray: Certainly in East Renfrewshire the CHCP was built from existing good practice and we did not spend a huge amount of time on structures. We had a community planning committee that evolved into the CHCP committee, and we had very strong leadership and all-party support from elected members—that was one of the hallmarks of East Renfrewshire's success. We developed a new management structure, but there was some consistency; in 2005, when we were first established, the existing director of social work became the interim director of the CHCP and the heads of service had been heads of service in the social work department. The local health care co-operative manager became the third head of service. I guess it was built on existing relationships.

We tried to streamline the structures. We did not have a committee structure in East Renfrewshire—we had a cabinet model. We

created a committee that was a sub-committee of the council, but because it took the place of a community planning partnership committee it did not add any layers.

Anne Hawkins: It was quite difficult in Greater Glasgow NHS Board when the CHCPs and CHPs were being established in 2005-06, because the primary care trust had been dismantled and moved to a primary care division. You asked about what could be built on, in terms of good practice. The LHCCs were good practice and could have been built on more firmly than they were. However, the whole organisation around primary care was being disestablished in order to create new organisations. We were working with more than one council, so the organisations were being established in different ways, depending on the relationship with each council. There was different good practice, depending on which council you were working with, in terms of how joint community care planning had functioned. That was another platform on which the new organisations were being built.

Coupled with all of that, the dissolution of Argyll and Clyde NHS Board came in just at the point when the new organisations were being created. That meant that there was another dimension of organisational change that had to play into everything else that was changing. As people were moving around the system into different jobs, it was inevitable that some relationships—which had probably been quite strong—in the system would change. A lot of this is about relationship building, in my opinion. At that point, it was quite a dynamic scene with everything changing and the new organisations emerging.

Gil Paterson: Let me bring all that together. Knowing the diversity in health boards and structures, do you think that it is feasible, possible and practical to provide a best-practice blueprint to make integration happen? That is not a trick question. Alternatively, do you think that—in learning lessons from the past—it would be better managed if it was driven at the local level?

Julie Murray: There is a balance to be struck: we need to pay attention to local circumstances. Different areas will have different circumstances—and different scales. What works in a small or medium-sized council area might be different from what works in one of the large council areas, although there must be an element of consistency. When CHPs were developed, there was probably less emphasis on taking a consistent approach and having consistent outcomes than there should have been. As a result, a whole lot of different models emerged that either worked or did not work well in the various areas, depending on devolution of resource, and on personalities, to an extent. There needs to be a framework of consistency across Scotland, but with room for local flavour.

Jim Forrest: I agree entirely with Julie Murray. The history in West Lothian has been slightly different, in that West Lothian did not have an LHCC, as such. There was, at the time, an integrated model between the local hospital and community services, and when the CHCP was formed it was the first of its kind in the country to bring together social policy and the health aspects of our services. The CHCP was built on an existing base of close integrated working, so West Lothian was probably more fortunate than other parts of the country in that respect. Some of the relationship building had been done and frameworks were already there, which is why we have ended up in our current position. Each local history, even within health board areas, is different, so flexibility to build up meaningfully an integrated model on the delivery side is important, but consistency in the outcomes that we are being asked to deliver is probably much more important.

Anne Hawkins: If we really want to achieve change, I would probably go for a pretty autocratic best-practice blueprint. Some big organisations that have achieved change have done so by being specific, not just about the outcomes but about how the product is manufactured, delivered, sold and so on. We have a big challenge in that if you do not have a best-practice blueprint and are not clear about what is in the organisations, money can move around the system and out of certain services. Depending on local political views and perspectives, things can get very messy and complicated, so we need a pretty rigid approach.

Bob Doris (Glasgow) (SNP): I will ask Anne Hawkins a question that follows on quite nicely from what Mr Paterson was asking about. There are opportunities to learn from mistakes that have been made with CHCPs in Glasgow. This morning, we had a briefing from Audit Scotland. Its case study of NHS Greater Glasgow and Clyde and Glasgow City Council talks about the CHCPs not putting in place a partnership agreement or a joint financial framework. There were cultural tensions, with the local authority moving to centralise and rationalise from a local authority perspective, while from a health perspective it was game on for more decentralised community facilities. Different cultures were clashing.

Did you use the word “autocratic”?

Anne Hawkins: Yes, I did.

Bob Doris: I have not heard that word in committee before. Where there is cultural resistance in local authorities and health boards that cannot be broken down, there is the need almost to impose a structure. I do not want that to sound as if I am saying that Government should

be telling local authorities and health boards what to do, but are you hinting at a situation in which if the health board and the local authority cannot do it in partnership, some third party—possibly Government—has to step in and say, "You haven't come up with your solution; here's the model—run with it"?

Anne Hawkins: What I am saying—from a health services perspective—is that past successes have involved very defined service delivery models. You are absolutely right that there is a democratic challenge. The challenge for the Government is in striking the balance between local political influence and will, and the targets and structures that it wants in order to achieve change.

Yes—the CHCPs in Glasgow had different cultures, but I believe that more time could have been spent on dealing with the cultural differences.

10:15

Bob Doris: That is helpful to know, because we must consider how much flexibility there should be in having different models of delivery across the country.

I apologise to Ms Murray and Mr Forrest as I have another question about Glasgow, because I think that we can learn from the situation there. We have talked with Ms Murray and Mr Forrest about building on best practice: I am sure that there is good practice in Glasgow, too. How are the CHCPs working with the local authority to move towards integration of health and social care before a top-down structure is imposed? Are you doing anything that perhaps even has a shared budget line?

Anne Hawkins: When we moved from the CHCPs to the CHP, we did not throw the baby out with the bath water. For example, we have an integrated addiction service for which we have not pooled, but aligned budgets. One manager manages the addiction service, but has a double reporting line; the challenge is in that he reports both to health and to social work. However, his teams have single reporting lines, so there are integrated addiction teams in each service. The service has a partnership agreement and reports to the joint partnership board, which has an overview of all the community care services, including the addiction service.

Bob Doris: Would it be helpful from a management point of view—I promise that I will ask Ms Murray and Mr Forrest a brief question—if the head of the addiction service had at their disposal a specific budget line and was accountable to one line manager?

Anne Hawkins: Yes.

Bob Doris: That is very helpful.

I have a question for all three witnesses. We have heard much about the integrated resource framework and the test areas and we heard from Audit Scotland that that is the kind of thing that we would expect health boards and local authorities to do anyway. I am sure that other members will want to ask more detailed questions on this. However, for the CHCPs or CHPs, do you routinely and on an on-going basis audit and discuss with the local authority where moneys are being spent across themes such as care for the elderly in the community, or in acute services in hospitals?

Julie Murray: In the East Renfrewshire CHCP, we have an aligned budget. I am accountable for the budget for the whole social work department and for community primary care. We make an integrated financial report to a committee every two months. We also have joint performance accountability meetings with the chief executives of the health board and the local authority, at which we look at financial reports. We are building up the integrated resource framework information; we have all the local information and we are building up information on our use of acute services. We have not been as quick to do that as some pilot areas have, but we hope to learn from that. We have the information and are discussing it with general practitioners in terms of their referral patterns.

We keep a constant eye on our resources and how they are spent. We are tracking local shifting of the balance of care between, say, care-home spend and care-at-home spend.

Bob Doris: Is there a pooled budget line for that?

Julie Murray: There are aligned budgets: I am the accountable officer for both budgets.

Bob Doris: Okay. Thank you.

Jim Forrest: In West Lothian, we also have aligned budgets. We meet with our CHCP board—which has four elected members and four NHS Lothian appointees—on a six-weekly basis. There is joint performance reporting on social policy and health. I am the accountable officer for both, and we have fairly rigorous discussions around how the money and resources are being used.

We also report quarterly on our resource transfer spend and where that comes from. There has been significant work on the change fund and on reshaping care for older people, in terms of the performance matrix for what we get for our money, and the quality of service for individuals.

Like everyone else, we in West Lothian have been reporting on delayed discharges; we have—touch wood—probably conquered the delayed-discharge problem in that we have consistently hit the national targets.

We need to concentrate our efforts on better managing of demand for hospital and care home services. The length of stay in our hospitals is short, but clinicians are probably still admitting people to assess whether they need to go into hospital, rather than admitting them having assessed them. We need to get that balance right. Those are some of the things that we are focusing on.

In reshaping care for older people, we have gone down a similar road to other parts of the country in using a re-ablement model in which we encourage high intensity input when it is needed and a level of independent living that the person feels is suitable to their needs.

The Convener: We have heard about local government budgets, health budgets and the strategies that you and others have worked out. How are the third and independent sectors involved in development—as opposed to delivery—of strategies?

Anne Hawkins: From a Glasgow perspective, the two areas in which those sectors are probably most involved in debates and discussions are in reshaping care for older people, through the work on the change fund—which Jim Forrest just spoke about—and in mental health, where they are members of the mental health strategic overview group. The change fund necessitates the third sector's being signed up to the spend profile and the investment, which has given the sector a much more specific role that has—to go back to an earlier point—been defined by Government. Those are the two areas that immediately come to mind.

Julie Murray: In East Renfrewshire, the third sector is involved in all the planning groups for different client groups, such as the mental health planning group and the older people's planning group. As Anne Hawkins said, reshaping care and the change fund have given us more to plan with and have really developed our relationships with our local volunteers and our carers.

What we found really helpful—I think that the third sector organisations would say this too—is the public partnership forum that we have developed as part of the CHCP. The forum includes interested individuals and individuals who use the services that we provide, and third sector organisations are also represented on it. They also sit on our CHCP committee. The third sector has two members of the forum, so it is around the table at the most senior level locally. As a consequence, the degree of partnership has strengthened over the past few years.

We also have a relationship with third sector organisations as providers of services, and we have providers forums. However, that is a slightly different relationship, although it is also developing into more of a partnership than a procurement relationship, which is to be welcomed.

Jim Forrest: As I mentioned earlier, in West Lothian we have been working quite closely with other providers on the change fund and the overview. In the overview group, the independent sector is represented by Scottish Care. Carers of West Lothian has a representative in the overview group, and Voluntary Sector Gateway is also involved in the group.

On structures, we have a partnership board with four elected members. Our PPF has actively participated in the board and reports to it. We have representatives of the PPF and the voluntary sector on the sub-committee on health and wellbeing in West Lothian and there are representatives of Voluntary Sector Gateway on the community planning partnership board.

In substance misuse services, we have a partnership model in which health, social care and the third sector all provide services and have participated in the overview of those services.

The Convener: Is the third sector involved in the decisions, strategy and key principles? Do representatives of the third sector sit on community health partnership boards and so on? Do they just influence the process through consultation and involvement at lower levels? Who makes the final decision on the key principles of the organisation?

Julie Murray: In East Renfrewshire, the third sector is involved in forming the strategy and the approach, and is also represented on the CHP committee, where strategies are endorsed. It takes part at a variety of levels.

The Convener: We have heard that the change fund has boosted that involvement, so I assume that before that fund's existence, the third sector's involvement was less.

Anne Hawkins: As Julie Murray said, in Glasgow, the joint community care planning groups are where the third sector has most influence. There are community care planning groups for every community care group, which is where the day-to-day decisions are made about where money is to be spent and how the balance of care is changed. Those decisions are approved through committee processes; generally, what comes out of those groups is accepted as being the way forward. That is where the third sector gets the best opportunity to exercise influence.

The decisions around reshaping older people's care take place in what is, in effect, a planning group, as part of the planning process.

Jim Forrest: The third sector has been keenly involved in substance misuse services and mental health services in West Lothian, and its members have been trailblazers in many ways.

The change fund and reshaping care for older people have boosted the involvement of the third sector in older people's services. There is no doubt that some of those principles will be helpful as we move forward.

West Lothian Council has set up a senior people's forum, which involves voluntary sector groups, among others. There is a budget that it can use to examine how the services spend money and target various areas. That is in its infancy at the moment, but it has improved the principles and has helped to target some spend.

The Convener: Third sector organisations have made representations to us individually and collectively on how they view their involvement in the process and the change fund, in which the budget is held predominantly by the local authority and the health board. They have made the point that, if they were more involved, they could get better value from that. I am sure that you have heard that view and understand it.

Jim Forrest: Yes.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am not sure whether I should make a declaration of interests, but I used to work for Glasgow addiction service, and my son still does. Further, as Jim Forrest knows, I used to work for the West Lothian drugs and alcohol services, which we succeeded in integrating.

I want to ask about democratic accountability, which has been touched on already. One of the discussions is whether we have a national care agency, which is a sort of overarching NHS-type body—perhaps an NHS mark 2—or, more important, whether we convert the CHPs into a democratic body. West Lothian already has councillors on its CHP. What sort of representation from councillors, patient groups and third sector bodies do you have on the CHPs? What sort of democratic accountability exists in the governance arrangement?

10:30

Julie Murray: Our CHCP committee includes five elected members and two non-executive health board members. As I said, there are also public partnership forum representatives, one of whom is also the voluntary sector representative. We have staff-side representatives from the NHS and local authority trade unions. There are also various professional representatives, such as GPs, a clinical director, the chief social work officer and, I think, a pharmacist. The committee is diverse, but it is a good debating committee.

We have a concurrent partnership arrangement. Although the committee meets as a committee and has a single agenda, only the five elected members are the council's CHCP committee. That is the arrangement that was available to us legally. Therefore, although it feels like a whole committee, if it came down to the wire, the five elected members would make the decisions on local authority funding. Having said that, we have not come to a vote on anything so far.

Anne Hawkins: For Glasgow, we have a large committee that includes three councillors—one from each of the sectors—and the councillor who is the NHS board local authority member for Glasgow. There are also four non-executive members plus the chair, who is an NHS non-executive member of the board. We then have six PPF representatives—two from each of the sectors. That was purposeful because, to give those people the confidence to participate, it is better to have two per patch rather than one. We then have the representatives from each of the professions—pharmacy, general practice and so on. It is a big committee. That is the committee that is required under the scheme of establishment.

In addition, as I said, for the joint overview of health and social care, we have a joint partnership board, which has no public representation—it is purely councillors. It has four councillors, which is one from each sector plus the councillor who is on the board, and four non-executive members plus myself and the director of social work as members. Everyone else is in attendance. Those are the two bodies that have councillor representation. The committee also has public representation.

Jim Forrest: In West Lothian, our community health and care partnership board has four elected members and four NHS Lothian appointees, to whom I report, as do the heads of social policy and health, in their general management roles, and various other managers and officers. Under the guidance, we have a CHCP sub-committee, which has a minimum representation of 18. There are one or two additions to that. The vice-chair of the CHCP board, who is a councillor, attends the sub-committee as the elected member representative, and the chair of the board also chairs the sub-committee. The sub-committee involves GPs and various others such as pharmacists and it has voluntary sector and PPF input. We must have that sub-committee, which is seen as the stakeholder group that produces

reports and proposals for the board of governance—the CHCP board—to approve.

Outwith that, I report to and sit on two policy development scrutiny panels in the council—one for social policy and one for health and care. The chair of the health and care panel is an elected member on our CHCP board and the vice-chair of the CHCP board sits on the sub-committee, so there is a link there. Various council officers and health managers report to those policy development scrutiny panels.

Dr Simpson: That was very helpful. I wonder whether I could trouble the witnesses to provide us with a diagram of that and written comments about the system's effectiveness, the barriers that exist and the legal changes that they want. I am very concerned that we have a local system that is democratically accountable. I take Anne Hawkins's point that Glasgow now has a single—and absolutely massive—CHP and I would very much like her to comment on the differences between the previous system of five much more local CHCPs and the new one.

Of course, as Anne Hawkins has pointed out, we started the whole process back in 1999 with local healthcare co-operatives. As Audit Scotland and other reports have made clear, one of the big problems has been the disengagement of general practice, which is critical to delivery of the sort of integrated care that we need. Are your general practitioners involved? If so, how did you manage it? Are they enthused or disengaged? It was not the case in West Lothian when I worked there—those GPs were very engaged—but the word that I am getting back is that in many areas they tend to be rather disengaged from the process.

I have a final tiny supplementary. Is your primary care data adequate to provide you with the management information that you need? Perhaps at that point I should declare an interest, as my son works on primary care data collection.

Julie Murray: It is fair to say that when the CHCP was established in 2005 many GPs were grieving over the loss of LHCCs. Getting GPs re-engaged has been a long process but I think that, in East Renfrewshire, we are getting there. Our GP forum is well attended and we have invested in a primary care development worker who makes contact with practices, attends all the practice manager's meetings and so on. Again, the change fund has enabled us to buy more sessional GP time to help us to develop our thoughts around older people's care. One of the challenges in engaging GPs is funding such activity—after all, to get folk involved in planning, you need to be able to fund locums—and I very much want that to be recognised in the new locality structures.

Although data has improved significantly to the point that we are now able to have conversations with practices about their referral patterns, it could improve even more. We have worked so hard with our GPs that we are about to redesign our older people's services and services for people with long-term conditions around clusters of GP practices, because we very much want a universal gateway of primary care around which we can build additional and specialist support. As a result, we have had some really constructive conversations with GPs and have recruited advanced nurse practitioners to work alongside them to identify patients most at risk of, for example, admission. We have also aligned social workers with GP practice clusters. I see that as the way forward; indeed, I would like it to be the way forward for a whole range of services other than older people's services. The primary care team and the GP serve as the universal access point for everyone in the community, and having that support and back-up from social work services can lessen the stigma for the people we want to reach out to and their carers. That is a big advantage of CHCPs.

Anne Hawkins: In Glasgow, the GPs were quite disengaged from the CHCPs, because they felt that the overwhelming agenda of the partnerships was social care and they felt excluded from local managerial processes and committees. Although it has been a board-wide endeavour, it has still taken us some time to establish GP locality groups in a way that ensures that they can exercise influence over local provision of services. That has now happened; things are certainly developing; and across greater Glasgow and Clyde GPs have different levels of enthusiasm for the role and are taking different approaches.

I should also point out that there are two GPs on our committee—a GP representative and the GP clinical director; that has been helpful, but I have to be perfectly honest and say that they have still to exercise influence in those roles in the committee setting.

The data has definitely improved. So far, we have concentrated on the data for general practices, which is about their use of health services and secondary care services; we have looked at readmissions and emergency admissions. We have produced practice profiles for each practice, which enable us to discuss with them their local population and their use of services. That process needs to move to the next stage at which all the social care information is integrated into it, but I think that that would be perfectly possible if we were more joined up.

Jim Forrest: In West Lothian, one of the NHS Lothian appointees on the CHCP board that I

mentioned earlier is a GP. In addition, the clinical director of the CHCP is a GP and reports to that board.

We have a number of roles for lead GPs in prescribing. GPs are heavily involved in our medicines management committee. Our primary care and community forum consists mainly of representatives from each of the practices who are GPs. They come together monthly across all 24 practices in West Lothian.

One thing that the GPs grieved for when the CHCP was set up was that, when there was an integrated model in West Lothian, they felt that they had much closer contact with the acute care consultants and managers. We have set up an interface group to bring together managers, GPs and clinicians in the secondary care services monthly to look at any pathway issues, how we should develop services and how we should improve referral patterns and so on. That has been established in the last six months and is starting to be a productive forum for not only GP but clinician engagement across primary and secondary care. That will be important.

Like Glasgow, we have worked with each practice to establish a practice profile for their population and to consider how they are using services and how they might redesign services in the future. We get them involved to deliver the outcomes that we need. That is broadly how we engage with GPs.

Over the years, a significant number of GPs have been involved with lead roles in either the integrated models or the LHCCs. The issues are how such roles are funded, how many are needed and what it is productive for them to get involved with. We need to focus our efforts on targeting that appropriately.

Dr Simpson: I have two brief comments. First, clusters, locality groups and integrated work have been mentioned. I know that West Lothian is different, because Sir John Brotherton set up the model of a hospital that was partly staffed by GPs, which was a very specific model for West Lothian.

I hope that we can return to the issue of clusters and locality groups. That approach is exactly what the Royal College of General Practitioners suggests—it calls it networking, although such groups used to be called LHCCs. The name does not matter; it is about getting groups of GPs together in a cluster that they feel is appropriate and getting them working closely alongside social work. The Mitchell report recommended that back in 1979, but the recommendation was never implemented. We have a lot of catching up to do.

The Convener: I do not think that that was a question.

Dr Simpson: No, it was not. I thought that I had asked enough questions.

Jim Eadie (Edinburgh Southern) (SNP): Audit Scotland's "Review of Community Health Partnerships" states that

"Only a relatively small part of this total NHS budget is devolved to CHPs".

It also states that

"CHPs have limited responsibility for managing social care budgets."

I am grateful to West Lothian for specifying the size of the budget, which I think is £170 million. What is the aligned budget in each of the other CHPs or CHCPs? What percentage of the total health and social care spend does that represent?

Julie Murray: I do not know whether I can answer the second question about the percentage of the NHS board's budget. Our budget is about £85 million, which is split half and half. In East Renfrewshire, the entire council social work budget is within the CHCP. The other half is the NHS budget, which includes funding for a lot of local community health services. We have some specialist services that are hosted for us by other CHPs in Glasgow, some of which are becoming devolved. The NHS budget includes funding for all the primary care prescribing, all the family health service contracts and all the community health services that we manage locally—district nursing, health visiting, mental health, addictions and so on. The CHCP does not have any budget for acute services.

10:45

Jim Eadie: What is your answer to the second part of the question?

Julie Murray: Our budget is 100 per cent of the council social work budget. I am not quite sure what percentage of the total health board budget—which amounts to several billion pounds—it accounts for.

Jim Eadie: Could you write to us on that point?

Julie Murray: Yes, certainly. I imagine that, without the hospital budgets, it would be proportionate to our population.

Jim Eadie: I ask for the information so that we can put the activity of the CHPs in its proper context.

Anne Hawkins: I am not sure that I can answer your question.

Jim Eadie: You must know what your aligned budget is. Can you help us with that, please?

Anne Hawkins: The budget for the addictions service is the only aligned budget, because ours is a CHP, not a CHCP.

Jim Eadie: Right.

Anne Hawkins: I can write to you with that information; I do not have it at my fingertips.

Jim Eadie: Okay, so Glasgow must be a bit behind the CHCPs in terms of the range of services that it provides. Is that right?

Anne Hawkins: Glasgow moved away from a CHCP model.

Jim Eadie: That brings me on to my next question, but I will hold on to it until I hear from Mr Forrest.

Jim Forrest: The total is given in our submission. The CHCP budget includes all of the social policy budget, which is probably about 20 to 25 per cent of the council's spend. The overall NHS Lothian budget is £1.2 billion. The percentage of that that is spent on health in the CHCP is small—I could not give you an exact percentage. As in East Renfrewshire, it covers all the community services, as well as the prescribing budget—approximately £28 million—and the general medical services budget, which is how we fund premises, salaries and infrastructure in general practice.

Jim Eadie: Thank you for those answers, each of which has been helpful.

Audit Scotland also pointed to the fact that there was variation in the extent to which NHS boards had devolved services to CHPs. The Glasgow example illustrates that point. Each of you has outlined the types of service that have been devolved. What is the process for deciding which services are devolved to CHPs? How is it reviewed over time?

Julie Murray: I am trying to think whether I was around at that level in 2005. I think that the process is still evolving in NHS Greater Glasgow and Clyde. Initially in 2005, the services that were devolved were those that were run locally. Since then, there has been further devolution of budgets for services. For example, in East Renfrewshire, from April we will be responsible for our own child and adolescent mental health service; up until now, we have got a bit of the service from Renfrewshire and a bit of it from Glasgow. Over time, we have been allocated more budget.

NHS Greater Glasgow and Clyde has used a resource allocation formula, which has been quite helpful. Previously, some of the budgets were historical and were based on LHCC budgets. We have been working through a process of ensuring that each local authority or CHP area in the greater Glasgow and Clyde area gets the budget that is required for its size of population and its demographic profile. There are challenges with that, because there are ups and downs, and it can take some time for those to smooth out. That process has certainly been useful in providing clarity and ensuring that we have the right amount of funding to provide a service for our population.

As I said, the process is evolving. Things are still changing. We are becoming responsible for certain services that it makes sense to manage locally. For example, some integrated children's services are more specialised and it does not make sense to devolve them to two or three members of staff. Those will be hosted by other CHPs on our behalf, but we are clear about the resource that needs to come to our area. There is almost a service agreement about the service and budget that will be delivered on our behalf.

Anne Hawkins: When the CHPs and CHCPs were established in greater Glasgow in 2006, there was also a mental health partnership. There were nine CHCPs and CHPs and the mental health partnership, which retained responsibility for the beds and some system-wide roles that were not devolved into the CHCPs and CHPs—all the community services were, but not the secondary care services. With the change, in November 2010, all the operational responsibilities of the mental health partnership were devolved into all the different CHPs although, as Julie Murray said, some specialist services such as forensic services and in-patient services remain, as a whole, hosted. They could not be devolved anyway—that would be impossible. Equally, parts of wards cannot be devolved. The budget could perhaps be devolved, but the operational responsibilities cannot be devolved; therefore, some services remain hosted.

Last year, the rehabilitation community service moved from acute services, where it was in 2006, into CHPs. We have hosting arrangements with each of the CHPs whereby different CHPs or CHCPs take responsibility for the overall management of a service, albeit that people are working in local areas. That is one of the challenges for the way forward. Where there are very small services, to run them in the most cost-effective way and ensure that their standards, supervision and so on are at the required level, hosting has worked quite well for us. It is challenging to see what could be done in a totally devolved model.

Jim Forrest: In West Lothian, at the beginning of the process of setting up the CHCP, because of the previous integrated model, many of the services were coterminous with the council boundaries. All the primary care and community services as well as the five mental health wards in St John's hospital were devolved to the CHCP.

The Tippethill and St Michael's community hospitals were devolved to the CHCP and consultants from St John's hospital manage the transfers in and out of those units; therefore, there is close integration of the CHCP and acute services there. One of the other differences in West Lothian is the fact that I have responsibility for managing all the allied health professionals—those in community services and those who provide services to the wards in St John's hospital—meaning that there is close integration there as well.

All those services were devolved to the CHCP, and we think that that model has worked well in West Lothian. Given that we are part of NHS Lothian services, the hosting arrangements apply across NHS Lothian as well. For example, I manage the salaried and community dental service for the whole of Lothian as part of my portfolio, although it is not part of the CHCP as such. The clinical director and the managers come to my management team meetings and report through my management board and onwards up to NHS Lothian. That is an example of how we have organised things there. It was helpful that there was integrated working in West Lothian, as that made some of the decisions easier. That is where the agreement comes from.

Jim Eadie: Thank you. Is there a good understanding among the various stakeholders and partners of the resources that are available?

Jim Forrest: Yes—from a West Lothian perspective, there is.

Julie Murray: The matter is quite transparent in our finance papers. We take the public partnership forum through them and elected members are aware of the resources; therefore, the situation is reasonably clear.

Anne Hawkins: I agree. A comprehensive finance report is produced, which is completely open. That is reported regularly in a range of settings, so the situation is very clear.

Jim Eadie: Thank you.

The Convener: Thank you for giving us an insight into your roles.

I am glad that you feel that things are open and understandable. It might just be me, but I get the impression from your responses that corporate governance must be a tremendous challenge with regard to the budget lines that you are in charge of and which you can influence, and the people over whom you have an influence. Your responses seem to confirm some of the challenges that have been noted in our briefings, and to suggest that corporate governance is a very difficult part of the process.

Financial planning must be equally challenging. Would any of you like to comment on the challenges that are involved in corporate governance, financial planning and resource transfer?

Anne Hawkins: I will start with financial planning, which—as you can imagine—is quite challenging in greater Glasgow, given the number of community health partnerships.

Part of my role involves co-ordinating all the CHPs. In the past year, we have taken a much more joined-up approach to our financial planning, which now involves working across all the partnerships from a health perspective.

As you know, each board faces a different level of financial challenge, so we have worked with our teams to look at our financial plan. Each CHP will take forward a range of redesign activity, and savings will emerge from that. The integrated CHCPs will work in two ways: with the cross-partnership financial planning process, and with their social work responsibilities to look at the consequences from all that.

I think that the joined-up approach is working well. However, I accept that it is much more complicated in an integrated CHCP because there are effectively two masters and therefore two sets of financial challenges to pull together.

Julie Murray: I agree. Greater Glasgow and Clyde is probably the most complex area in Scotland, and corporate governance is a challenge. One issue for us in making savings as a relatively small CHCP is that there are not significant economies of scale.

Much of the NHS resource that we have at our disposal is staff. Redesign can take time, and it is complicated, but I think that it is working. As Anne Hawkins said, we have developed a system that allows us to manage local priorities while considering the potential advantages of working across CHP boundaries within the NHS redesigns, and it certainly works better.

In East Renfrewshire we do not face challenges and arguments around resource transfer and how it is used in integrated CHCPs. We understand where it is within people's budgets, and it is prioritised in relation to the outcomes that we are trying to achieve.

For an integrated management team it makes enormous sense to have that system—although I would go further and have a pooled budget—because we can avoid any of the cost shunting that sometimes goes on. We know that if we make a saving in one area, it might impact on another area, and we need to keep an eye on that. That is particularly the case with older people's services. Our head of health and community care is

responsible for care at home budgets, residential care and day care, and for older people's mental health teams and district nursing, so they can see things as a whole.

Trying to make savings in a small area is a challenge. One of the big challenges under any new arrangement will involve the need for real clarity in how the parent organisations choose to make savings and invest. East Renfrewshire Council has invested significantly in older people's services over the past few years, and we would want to be clear under any new arrangement about how each parent organisation is identifying resources and savings targets.

11:00

Jim Forrest: In West Lothian, I report to the chief executives of NHS Lothian and of West Lothian Council. I am based in West Lothian civic centre with the council's other executive directors and I am two doors away from the council's chief executive. My CHCP management team and the health and social policy team are in open-plan offices that are next to each other in the civic centre, so the daily working relationships are on-going and close.

I report to the council executive and the full council. I am also a member of NHS Lothian's executive management team, and I report there. As was described by Anne Hawkins, I am the co-ordinator between NHS Lothian and the council, with a key role to play.

There are arrangements for financial reporting to the CHCP board, which has equal participation by elected members and NHS Lothian appointees. However, the planning cycle brings challenges, as councils and health boards set their budgets at certain times. The scale of the economic challenge that we in West Lothian faced meant that we had to come up with a contingency strategy and undertake extensive public consultation in a process that we called tough choices. I had to be part and parcel of the policy development and scrutiny panel meetings, at which members of the public could question the proposals that were made. It took considerable time to put that together and look at how we would make the required social policy efficiency savings.

At the same time, given the financial challenges that we face, the NHS had efficiency targets for health services. Trying to harmonise both processes and get the timing right, so that we were not seen as cost shunting, for example, brought its own challenges. Across the CHCP's senior management team, which involves representatives of the health service and the council, we had to work fairly closely so that the proposals that we made had a strategic fit and did not place an undue cost burden on another service. That took a fair bit of time and a degree of challenge to sort out.

There is an on-going challenge. I make a plea for the proposals in the forthcoming legislation to harmonise financial planning at a strategic level for councils and health boards and to try to simplify the process. If integration is to work, we need to have a reasonably straightforward strategic process that we can implement locally and which allows us to come up with the plans and the detail to deliver on proposals.

As I have explained, from a corporate governance point of view, the reporting arrangement is fairly complex. I will make another plea. We have decision-making committees on which the parent organisations are represented equally. That gives councils more of a challenge, because a decision-making committee of a council must be two thirds elected members. That needs to be changed if we are to have truly equal integrated partnerships. That would probably make a number of corporate governance aspects more straightforward and streamlined.

The Convener: I will call Nanette Milne, who has been patient. After that, I will give Anne Hawkins and Julie Murray an opportunity to comment on the Government's proposals before they have to leave.

Nanette Milne (North East Scotland) (Con): I will be fairly brief, because Richard Simpson dealt with a number of the questions that I was going to ask about general practice. I should say that my husband was a GP—he is retired now—in Aberdeen when the LHCCs were replaced. I remember the consternation at the time, because people felt very much involved with LHCCs. Far more practices were involved in the subsequent much bigger organisation, and people did not feel that it had the same handle on the local side of things.

I am encouraged to hear that things have moved on, at least in some parts of Scotland. However, I am concerned that there still seems to be a fair amount of complexity. I think that at least two of the witnesses said that the committees that include GPs are still big committees. What input can an individual GP or group of GPs have in such committees? The role and input of GPs will be extremely important if we are to shift the balance of care.

How much of a time commitment from GPs is involved? In my experience, the average GP wants to get on and treat their patients. Will the time commitment be a turn-off for them?

Are other members of the primary care team involved in committees, or does the GP have an umbrella role for staff? Does the current GP

contract have any influence on GP involvement? I have asked a few questions.

Jim Forrest: I think that the largest committee in the primary care forum in West Lothian mainly comprises GPs. The idea is to have a representative from each practice, on an on-going basis, and to debate the issues and make proposals for the decision-making group, which is the CHCP board. I have found that most practices in West Lothian want to be involved and do not want a single GP to give a representative view for all practices. The challenge is how we ensure that at least one or two GPs are on the forum in which decisions are made. We have worked at that constantly during the past five or six years.

You are right to say that most GPs want to get on with seeing their patients. However, they also want to be involved. It is about striking a balance. We need to have productive meetings, to which it is worth coming, and we need to enable GPs to see that their ideas have been taken account of in the decisions that have been made.

West Lothian was a wee bit different from other areas, in that we did not have an LHCC. We had an integrated model, and we have tried to build on that and keep the level of involvement as we move forward.

Julie Murray: We have two GPs on our committee—one is our clinical director, who is salaried in the NHS. They are certainly not shy about making their views known. What is important is not necessarily involvement in the detail at committee but involvement in design discussions at an earlier stage. We have faced a wee bit of a challenge in resourcing sufficient GP involvement, although we have taken over managing the protected learning time that we have in East Renfrewshire, so we are able to shape the agenda and use that time to try to get GPs to contribute thinking and have proper discussion.

There is a time commitment for someone who gets very involved with CHCP work. We have been able to fund some GPs to do that, particularly in relation to the reshaping care agenda, which has been a real opportunity. Two GPs have each given us a session a week, to help to shape the future for older people in East Renfrewshire. Their input has been significant.

We have forums for involving other members of the primary care team. We have senior nurse networks and allied health professional leads, who have been very much part of redesign and organisational development activity that we have undertaken. We also created the let's take time to talk programme, through which we invite GPs and their primary care teams to come for table-top discussions on topics of interest every two or three months. I think that the approach has been helpful, not just in giving people information but in developing relationships. As Anne Hawkins said, relationships and trust are key to much of what we are talking about. We cannot legislate for that; we must build relationships and trust.

The GP contract has not been of huge help to us in what we are trying to achieve. Some GPs will say that if something is not in the contract, they will not do it. There is scope for looking at what can be done to change that in Scotland. We have local enhanced services, which we try to develop with GPs so that the approach is tailored a bit more carefully. However, the GP contract has not been of assistance.

Anne Hawkins: It is important to appreciate that, in NHS Greater Glasgow and Clyde, not everything that is done with GPs comes under the umbrella of any particular CHP or CHCP. Quite a number of GPs work only part-time, so they have many opportunities to do other things as the other part of their job. For example, they can work on a part-time basis in the addiction service, in prison healthcare, in the nursing home service or in acute care. GPs do a range of sessional work and they also play a part in a number of planning fora. For example, there are GPs who have sessions to participate in managed clinical networks. GPs have many opportunities and routes to exert influence other than by being a straightforward clinical director, which involves, as Julie Murray said, having a managerial role and a fixed number of sessions.

In the Glasgow CHP, we have four clinical directors, which equates to 21 sessions of what is in effect managerial time. What we have tried to do across NHS Greater Glasgow and Clyde is ensure that the clinical directors take responsibility for different streams of work. For example, one will be the cancer lead and one will be the person who works with diagnostics. A lot of their work is about the interface with acute care, deprivation or health improvement and is not so much about work with social care, it is fair to say.

The GP contract is always changing. The most recent work on it, which was on the relationship with acute services, has had an impact on everything and has looked at, in particular, how older people are cared for and what more can be done for them at home. There are opportunities through the general medical services contract that can be used.

Nanette Milne: So it is work in progress.

Anne Hawkins: Yes.

Drew Smith (Glasgow) (Lab): My question is also on the issues of governance and accountability in the system. I heard what was said about the range of partnerships for professionals to engage with and influence one another and to

understand what is going on. That said, the structure is still pretty Byzantine. I wonder whether it is truly possible to have accountability in a system that can be difficult to understand. I am thinking about whether front-line staff know their place within an organisation, how decisions are taken and how things are changed. I am thinking, too, of the care of older people and families and how those people can engage with a system with such a complex structure when they have concerns.

That takes us on to the role of elected members on boards. How achievable is it for a board to have a percentage of elected members who can sit with professionals who do that kind of thing all the time as part of their day-to-day work when they engage in networks, influencing and partnerships? Is it possible for people who do not have that as their sole focus to drive accountability and ensure that things work as they should?

Julie Murray: It is our experience that that is what the CHCP committee in East Renfrewshire does. The elected members sit with the professionals. Clearly, NHS Greater Glasgow and Clyde is a complex organisation, but our staff and the people who use our services look to the local area predominantly. If we create clarity and say, for example, "This is where decisions are made about local community health and care services," and if we create a bit of branding and identity around that, people will start to identify with it—they have done so.

People who use our services do not care who the provider is. They just want to receive good, local, responsive services. If we can create that identity locally, albeit that we rely on other places to deliver some services, we can be the local voice of the NHS within the CHCP area. I think that that makes it easier for people to navigate the system.

Drew Smith: Can I clarify what I am getting at? Where the system works well, that is fine, but when something is going wrong, are the governance arrangements sufficient to do something about that and correct it? Is it good enough for the system to be driven by people saying, "Well, the relationships are good and personalities here work well together"? What happens when they do not?

11:15

Anne Hawkins: In NHS Greater Glasgow and Clyde, as well as the committee arrangements for the CHPs and CHCPs, we have what is called an organisational performance review process, so there is an officer-led process as well. I think that we need that belt-and-braces approach.

In the integrated CHPs, the chief executive of the council and the chief executive of the health board lead the process, with officers supporting them, and the CHP management team sits at the other side of the table and reports on its performance against all aspects of the development plan, including the health improvement, efficiency, access and treatment targets and outcomes that have been established for the CHP.

That detailed process happens twice a year, although we are changing it to three times a year. Those reports are then submitted to the CHP committee, so it sees the comprehensive report that is submitted to the OPR process, then it sees the critique that is produced from an officer perspective afterwards, which says, "You're not doing well enough on this target. What is your remedial action?" The system is quite robust.

As well as that being reported to the committees, where people can scrutinise it and say where we need to pay more attention and bring more regular reports and so on, it is also reported to the board. From a board perspective, all the reports are sent to and scrutinised by our quality and performance committee. Each CHP has to attend the quality and performance committee once a year to report on its performance and be questioned by the individuals who are part of that committee.

There are quite a number of places where there is a more structured approach to the scrutiny of performance, certainly in the health system and the joint committees. I cannot speak—

Julie Murray: And in the audit committees.

Anne Hawkins: Clearly, each council will have its own arrangements for that.

Jim Forrest: I speak from a West Lothian perspective and as a member of the executive management team of NHS Lothian. There is a meeting every fortnight, and every second meeting—once a month—is a performance management meeting, at which performance management across NHS Lothian, including the community health and care partnership, is scrutinised in terms of both delivery of the HEAT targets and the outcomes and the financial position. There are similar processes across the council.

What we have tried to do in the community health and care partnership is to give the board a suite of performance reports so that, as well as the financial reporting arrangements, there is fairly close scrutiny of all the targets.

There is also a dashboard system that comes up on an officer's desktop to tell them if they are not doing well enough, as Anne Hawkins put it, in a certain area. It will show them if the performance has moved from the green area, where we always

want it to be, into amber or indeed red, and it asks them what remedial action they are going to take. That happens for each of the various indicators that fall within their remit and area of responsibility.

Outwith that, as well as the involvement that we described earlier, the CHCP board meetings are held in public and all the papers that go to the board are put on the CHCP website so that members of the public can see them. They can also phone in or e-mail via the website to ask questions and we will pick up any concerns or complaints that they have.

I report quarterly to representatives of each of the community councils in West Lothian and I take with me a member of the management team of St John's and the head of health services for the community in West Lothian. Where there is an agenda, the community councils can put whatever they wish on it, from hospital services through to community services. I chair that meeting and I am open to any questions from the community council. If it wishes any papers from the CHCP, it can get a copy and it can ask questions in advance. That is how we organise things.

The Convener: We have covered nearly all the themes that we wanted to cover. As there are no more questions from members, I give Julie Murray and Anne Hawkins the opportunity to say whether they believe that the Government's proposals will assist in tackling some of the issues that they mentioned, such as corporate governance, the GP contract and cost shunting, which was a new one on me. The only other theme that I will raise is whether you have concerns about the Government's proposals on adult services. In addition, if you have anything that you want to impart to the committee before we finish this evidence session, we would welcome it.

Julie Murray: I think that in East Renfrewshire we hope that we can just hunker down and get on with things and that the Government's proposals will strengthen what we do, so we welcome them.

I have just a couple of points. Single accountability is crucial. There can be no undermining of that, because it is important that a single person is responsible. Further, attention must be paid to the fact that, unless we invest time in organisational development and training and in culture change, they will not happen on their own. Leadership is important in that regard.

The initial focus on older people is understandable, but the danger is that, if that is the minimum, it might fracture existing services and management systems. Personally, I cannot see any reason why we cannot put all social care services in with NHS services from the off; to do otherwise could create different structures and arrangements and there might be duplication. The services should all be in together.

It is important that we strengthen GP and other clinical involvement and professional social work involvement, but we must recognise that that will need to be thought through and resourced properly.

Anne Hawkins: I hope that the evidence that the committee has heard from us has put into context my introductory remarks about having a fairly rigid approach. It is clear from the evidence that we have heard that size is an issue. When Jim Forrest talked about going to every community council to report on the CHP, I was thinking about how many nights I would be out, never seeing my family, if I did that in Glasgow. I think that it would be beyond my ability.

Obviously, we have not seen the detail of the consultation paper yet, but I would like it and the Government to be clear about what is in and what is out and I want careful thought to be given to the consequences of excluding some of the services that we already have in the CHPs and CHCPs. There will be consequences for how we manage the services and there will be the potential for further managerial structures to be set up, which we would like to avoid. We want to keep the management as streamlined as possible.

I fully support having the single accountable director role, because it will ensure clarity about who is accountable and responsible for what. I also support keeping the governance arrangements as straightforward as they can be. Building on all the experience that has emerged over recent years to create the blueprint for the governance arrangements will be very useful.

I strongly recommend that the financial resource be devolved to the new organisations, so that money is not scooped out of them part way through the year. The devolved money should be there for the year so that people know what they are working with.

The Convener: Mr Forrest, you have the last word.

Jim Forrest: If I gave the impression that I go to every community council meeting, I have perhaps misled you. What I said was that representatives from each of the community councils meet me once a quarter. I share Anne Hawkins's view that there would not be enough nights in the week to meet each community council.

I am enthusiastic about the proposals to integrate health and social care services and believe that that is the way forward. Having a partnership agreement and a proper framework with proper principles, conditions and criteria is entirely the right way to go. Enhancing the role of

the single accountable officer is welcome. However, there are a number of challenges.

Overall, in the financial planning, the delegated decision making must be clear so that there is an equitable partnership between the health service and the council, which would be a major step forward, rather than having to rely on our relationships locally and work around what we have. We have the building blocks just now, particularly in council areas such as East Renfrewshire, West Lothian and Glasgow. The issue is how we build on that without making massive structural change. Putting together practical views on some of the aspects that have been mentioned would be helpful for us.

The Convener: Thank you all very much for the time that you have given us and the evidence that you have provided, which I am sure will be useful for the inquiry.

11:26

Meeting suspended.

11:29

On resuming—

The Convener: I welcome our second panel. Elaine Mead is chief executive, and Jan Baird is transitions director, at NHS Highland; Bill Nicoll is the general manager of Perth and Kinross CHP, NHS Tayside; David Farquharson is medical director at NHS Lothian; Dr Allan Gunning is executive director, policy planning and performance at NHS Ayrshire and Arran; and Roddy Ferguson is director of Fortuno Consulting. Given the size of the panel, please do not all feel compelled to answer every question. Of course, if you have an important or contrary point to make, do not feel that you must suppress your comments.

Richard Lyle (Central Scotland) (SNP): I am sure that the witnesses listened with interest to the evidence from the witnesses from CHPs and CHCPs. My question is for Elaine Mead, although that does not stop others commenting. The submission from NHS Highland was interesting. You said:

> "the reality has been a consistent duplication of effort as the decision making processes lie in two parallel organisations and result in a protracted process across the organisations."

You went on to say:

> "the Public Sector organisations look to their own services in terms of priority and fail to recognise the impact that efficiencies in one organisation may have on another organisation which delivers services in a joined up way."

I have consistently commented on the silo mentality. In relation to decision making, how can the health and social care services that make up CHCPs come out of their organisational silos?

Elaine Mead (NHS Highland): That is an interesting question, which gets to the heart of integration. In Highland we are completely committed to moving towards having one organisation. We think that having single management and a single budget is the solution to resolving some of the difficulties. It is inevitable that when staff are working—with the best intentions—for their own organisations and within the financial constraints and responsibilities of those organisations, decisions that are made in one organisation have knock-on consequences for the other and there is not a focus on the best interests of the individual.

The integration that we are proposing in Highland—a fully integrated model with a single budget—will give us a solution to the silo thinking that you described. Let me illustrate that with the straightforward example of a delayed discharge. Managers in a hospital might think that for their council colleagues to find funding for a package of institutional care for a person is a good resolution, because it moves the individual from the hospital bed and releases the bed for someone else. That might be fine, provided that the institutional care is what is required for the individual. Equally, colleagues in social care might think that because they have six weeks before they need to make a decision to move a patient on, a hospital bed is a safe environment for the patient for those six weeks.

The process of putting together a package might not always take six weeks, but in the context of pressures of business and financial constraints, you can understand that our social care colleagues might be persuaded to take longer to consider the individual's case. Neither outcome is beneficial to the individual patient or client. If there is a single budget, with single management, both parties will be focused on the client or patient, and there will not be cost shunting—I heard the previous panel use the term—from one organisation to another.

We endorse your view on silo thinking. The issue is fundamental to us in relation to integration.

Richard Lyle: You have answered my next question, which was about accountability and separate organisations contenting themselves that they have followed the due process that they have laid down while, in fact, moving the case on to someone else and shutting their eyes.

Elaine Mead: I do not think that that is a deliberate act. It is part of the current set-up that the two processes are not in parallel and,

fundamentally, not focused on the needs of the individual who is at the centre of the work.

Richard Lyle: While I have you in my sights—

The Convener: Richard, you have developed an interesting point. Perhaps some of the other witnesses from the health boards might like to come in on it.

Richard Lyle: I apologise, convener. I am sure that others want to develop the point about the silo mentality.

Bill Nicoll (NHS Tayside): The Tayside partnership for the integrated resource framework covers all three local authorities in the area, the three community health partnerships and NHS Tayside. Our philosophy is built on the importance of services for the individual. We talk about the single care pound being spent in the right way every time and on the right services, so our approach to the integrated resource framework is to understand how people use health and care services and resources.

In some respects, aligning health and social care is only one part of the equation. As was mentioned earlier in the meeting, it is important that we consider the relationship between general practice and acute care, for example, and the fact that many of the journeys that older people in particular take through the care system can involve the whole spectrum of the system in a single journey. We are trying to understand what those processes look like for a given population and to make local decisions that are based on that knowledge and information. In particular—to go back to what was said earlier—it is important to bring in the influence of general practice much more at a local level.

Across Tayside, we strongly support the concept of a single accountable officer and a single integrated budget, but we would like to ensure that that resource reflects the total consumption of services and resources, not simply what is in each locality for health and social care. If we think about it in that way, we can allow general practitioners and other professionals to work as a locality team with a clear understanding of how the population consumes resources. There is significant variation in that across every area.

Some of our work involves creating a culture change and moving to a different way of making decisions at a locality level based on the needs of a given population.

Dr Allan Gunning (NHS Ayrshire and Arran): The tack that we have taken in Ayrshire is to pursue joint commissioning plans between the health board and the councils. The integrated resource framework plays into that because, beginning with older people—as we will—it is important to understand the joint resource that is available. However, it is even more important to understand the outcomes that we are trying to achieve and to agree them jointly.

The third part of that concerns delivery of those outcomes, so it is really important that we understand the delivery chain—we find time and again that that is the case. In essence, that involves understanding how microteams can deliver improvements.

Agreeing those three things in partnership—the size of the pot, the outcomes that we are trying to achieve and how we will deliver them—gets us out of the silo thinking that Richard Lyle described.

Dr David Farquharson (NHS Lothian): In NHS Lothian, the work on the available data on activity and spend is extremely important, because one way of breaking down barriers is absolute transparency about where the activity is being performed and where the spend is. From an operational point of view, the staff will have much more confidence in any changed infrastructure if they have that level of detail.

The Convener: Do you have anything else, Richard?

Richard Lyle: No. I am quite happy with those comments. I will reserve something for later.

Dr Simpson: I have a specific question for Bill Nicoll. Mr Nicoll, your back was scarred—to use an expression that has been used in the past—by the events in Perth and Kinross in the early years. Am I right in thinking that you were heavily involved in the attempt under the joint future programme of the early 2000s to create integrated services? If that is wrong, I will move on, but if it is true, why did that programme fail? What happened? That was, if you like, the flagship first effort of the joint future group to produce a totally integrated service.

Bill Nicoll: Yes; for a time I managed the entity known as care together, which was an innovative collaboration that brought all the traits of what is currently in the proposal to bear in that area. I would not like to think that it failed. We succeeded in moving the agenda forward significantly, and the successors to the initiative were the West Lothian arrangements and other examples across Scotland. You have heard from CHCPs that have picked up on and worked with those traits.

We did not consolidate on the improvements that we made in Perth and Kinross largely because, at that time, the work was fairly ground-breaking. We had to rely significantly on the effectiveness of working relationships, and changes in personalities could have a significant bearing on the sustainability of that effectiveness. I guess that my comment is that, whatever

arrangements we put in place for the future, we need to ensure that they are robust so that the commitment is continued and so that changes in political representation on a council or changes in leadership within an organisation do not frustrate the aspirations and ambitions of the services and the people within that community to get to an integrated service approach. Some of that experience must be taken into account when building health and social care integration.

Dr Simpson: My other question is about Highland, which is pushing ahead rapidly with a merger, and is running into criticisms from Unison and other union representatives about the speed at which the merger is taking place. I know that one of the problems for Perth and Kinross was that it took a lot of negotiating time to get an alignment of the staff and a feeling of comfort about people doing similar jobs on different pay scales, and so on. Have you had any talks with Perth and Kinross about the fact that the negotiations around that stage took between 18 months and two years and were difficult? Have we learned from Perth and Kinross's difficult experiences in pushing ahead in Highland?

Jan Baird (NHS Highland): We have not had specific talks with Perth and Kinross, although we have looked at the literature and what has happened across Scotland over the years. We set ourselves a tight timescale from December 2010, when we launched the merger, to April 1 this year, when we expect to make the transfer of staff and budgets and so on.

It is important to realise that we are setting up our services for redesign. We will not have new, redesigned services from 1 April, but we will have systems, staff and budgets in the right place to enable us to progress with the redesign of those services. Although it looks like we have set a tight timescale, we have not been establishing the new service. The work that we will do during the next couple of years within the commission that we have set up will be about redesigning the services and working with colleagues in primary care, secondary care and, of course, the independent and voluntary sector to look at how we deliver services in the future quite differently from how we delivered them in the past. We need to take time over that considerable difference and make sure that we engage the right people to take the changes forward.

Elaine Mead: Four union colleagues work as part of the steering group on the programme board. Inevitably, there will be difficulties and differences of opinion. Generally, however, our trade union colleagues have been supportive of the direction of travel and have been involved in the detail. We discuss a lot of detail on the programme board. There have been some concerns about the speed of the merger, as Dr Simpson suggested, but there have not been so many concerns around the harmonisation of jobs and roles. It has been more about protecting people's professional careers, ensuring that terms and conditions are correct and looking at people's pensions. A lot of what we have been doing in Highland will be relevant to other organisations as they start to look at the same issues.

We began the journey thinking that there would be a number of absolute show-stoppers for what we were trying to do, and I think that our union colleagues felt the same. However, we have worked through matters piece by piece and issue by issue and I think that there are few issues outstanding with which our trade union colleagues would have difficulty.

11:45

Dr Simpson: It is 10 years on from what happened in Perth and Kinross—I think that the formal arrangements dissolved in 2004. Although we learned a lot from that, we do not seem to have learned enough, which is disappointing. Some people picked up bits of what happened and took them forward.

As you go along, are you recording all the things that happen? For example, are you recording the show-stoppers that you have overcome so that others may be able to learn from that if we go forward with what is, in effect, what Anne Hawkins called a more autocratic—that is not the right word—a more leadership-led approach of saying, "This is where we have to go"? Are you keeping a careful record of that and are you reporting it to a specific person in the Government? Are Government observers involved in seeing what you are doing so that we can learn from it?

Elaine Mead: The answer is yes. Since the day we started we have collected information as part of not only a risk register, but an issues log. Everyone, including members of staff, is allowed to register issues as they come to mind. I ask Jan Baird to give us a bit more detail on that.

Jan Baird: That practice was initiated at the outset with staff. As we have gone through the process, the issues have been taken forward in the various working groups.

Kathleen Bessos has represented the Government on the programme board from the outset, and there has been considerable support from the central legal office as well as the Scottish Government around some of the legislative changes in the form of regulations that we have had to put in place, particularly around the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007.

Dr Simpson: That is helpful. Can you provide us with a summary of the issues log? I do not want absolutely everything, but it would be helpful if we could see what sort of issues you have addressed. That would be most welcome.

Jan Baird: I am happy to do that.

Bob Doris: I do not want to focus only on Highland, because there are various test sites. If the questions drift towards Highland, please pull us back and chip in with specific experiences from elsewhere.

We have the integrated resource framework and the data has been collected to work out where money has been spent, whether on the elderly or on children's services. Different test areas will have collated different information. We are moving on to the next stage. Highland has had a lot of publicity regarding service redesign and the lead agency model, but witnesses here represent other areas, too. Can the witnesses say whether something will change in every area in April? You have the data, so can you give me one example of what is changing in each area, based on the IRF?

Bill Nicoll: I will talk about Perth and Kinross. Before the Government's proposals were announced, the decision had been taken to establish a transitional board to take forward a new partnership in Perth and Kinross. The board has now met three times and has taken forward specific proposals that are pretty much in line with the Government's proposals.

We have carried out major tests. For example, we have established in Highland Perthshire a locality team that is working on a multi-agency basis and using the IRF data as the driver for that. It can see the entire activity and resources associated with, and the variations and differences between, whole populations, right down to practice level. It knows the different types of services and resources that are being used by general practitioners and which ones are being bypassed.

The important point about that—to return to my earlier comments—is that we have implemented the infrastructure for a lot of health and social care resources in those localities. The pivotal decisions taken by general practitioners when delegating activity to secondary care—acute care—are critical if we are to make an impact.

We need to re-engage general practitioners and pool the activity and resources back into the local population, in order to make more use of local community care infrastructure, make it more resilient and build confidence that it is a viable, strong alternative to admissions to hospital; otherwise, I do not think that it is too strong a view to say that we will end up with a busted flush. We cannot deal with the demographic pressures unless we make those changes, which is why the IRF and our changes are focused very much on creating multi-disciplinary locality teams.

Bob Doris: Bill Nicoll jumped in first on that and his comments lead to some obvious questions. I am not glossing over the vital role of GPs, which we heard about in an earlier evidence session. I know that their budgets work somewhat differently.

A locality team is identified by using the IRF and all the available data, which enable you to map out a service redesign for better provision. Some of that money will come from the local authority and some will come from the health board. Has a figure been put on that? Is it an aligned budget or a pooled budget?

Bill Nicoll: It is different in some respects. A pooled or aligned budget simply describes the totality of services within a given locality, but it does not describe the costs or activities associated with all the patient or people journeys through the health and care system, because they access resources and services in the acute sector that do not necessarily sit in their locality.

We are trying to develop a consumption fund for each locality, in order to describe the resources and activities that they consume, and to reprofile them in a different way that saves the more expensive costs of unnecessary or unplanned journeys into the acute sector. We want a far more planned, organised approach to the locality through, for example, the virtual ward approach, to ensure that we can manage each locality as far as possible. That means that we need to see the whole resource, not simply a pooled budget for health and social care in a local area.

Bob Doris: That is worth exploring. I understand that using referral processes and community care would enable us to see the potential notional savings, but you need to put a number on it.

We are currently spending X and have quantified the potential cost-shunting as a result of our services not being designed as appropriately as they could be. The figure Y will come from the local authority and the health board and will sit in a pooled budget. Is the system that you are moving towards one in which one person will be responsible for the delivery of that budget across the board? I want to ensure that, after doing a lovely mapping exercise, we do not end up in a situation in which nothing really changes. What will change?

Bill Nicoll: I am talking about a pooled budget-plus, whereby the pooled budget is the total resource consumed by a locality's population. In our view, you need to have that pooled budget at an area level, but you also need to be able to provide information down to the local level, to allow the teams to drive the changes.

Bob Doris: Do any of the other witnesses have similar experiences?

Dr Gunning: I have three specific examples. In Ayrshire, we have mapped about £895 million-worth of expenditure across health and the three councils, right down to CHP level. We have, therefore, been able to analyse variation and have seen change over time.

For example, we have tried across the CHPs to arrive at a measure of fair share of resource against spend and, since we opened a community hospital down in Girvan, resource has shifted towards South Ayrshire. We also see variation in the spend in North Ayrshire. I am not saying that the IRF has driven the decision that our main capital scheme in the next three years will be a community hospital in North Ayrshire, but it has reinforced that decision, and we would expect resource to shift in that direction. That is the first example of the IRF and specific change.

I will also give two examples that are condition specific. One of our deep dives was into chronic obstructive pulmonary disease services, for which we have redesigned the pathway and gone down the road of co-creating health, which is a much more structured approach to involving users in their care. That new model involves retraining clinicians as well as supporting patients. As a consequence, a hospital-based respiratory consultant is now working in a community setting. The IRF allowed us to cost the pathways before and after.

Another of our deep dives was into learning disability services, in which we found considerable variation between care packages for individuals who appeared to have similar needs. That work allowed clinicians and microteams—I come back to them—to look at our attitude to risk. More important, it allowed and empowered discussion with service recipients about where their priorities lie and provided a clear understanding of where resources go. Given the self-directed care policy, the IRF informs everybody much better about where the resources go and, more important, how they can be better used.

Bob Doris: What about the willingness of local authorities and the health board to align budgets to drive such change or to pool a budget and make one person accountable for it?

Dr Gunning: The deep dives have been on the basis of aligned budgets. The three CHPs, the councils and the health board in Ayrshire have agreed to prepare joint commissioning plans that are pan-Ayrshire but have a local strand for each of the three localities. The first plan that we have done is on older people's services, and we have agreed to set up a pooled budget to underpin that, because that is fundamental. I return to the point that we must understand the outcomes, how we will deliver them and what resource is available to do that.

Dr Farquharson: In Lothian, the success of the Midlothian dementia project is being based on baseline data from the IRF. We will follow carefully the success of that project.

Bob Doris: I will not take any more of the witnesses' time; I am sure that some of my colleagues will follow up issues that have emerged.

The Convener: The subject is interesting. We have identified opportunities, but the British Medical Association Scotland says in its submission that although it

"sees potential benefit in integration,"

which has just been described,

"the potential for an adverse impact on healthcare is not hard to see."

The BMA worries about the impact on health services and

"is also concerned that local authorities may need to use health funding to meet the costs of a significant amount of social care provision".

Mr Ferguson identified the issue of getting a clear definition of fixed costs, which will not shift from the acute sector and, in a lot of cases, will remain. The political difficulties of addressing that were highlighted—rightly, because when politicians like me and others around the table hear that our local hospital is reducing its bed numbers or will no longer provide some services, we get more than excited about that. Will you speak about that, Mr Ferguson? You covered it substantially in your review.

Roddy Ferguson (Fortuno Consulting Ltd): That relates to a previous point that was made. Under the IRF, pilots of new financial mechanisms were expected by April last year. On whether those will be in place for this year, the answer is that they almost are, or that the direction of travel has been agreed but they are not really there. There remains no evidence that the expected pilots are in place. The issue is the timeframe and how realistic expectations of how long a process of change takes are.

In our interim report we noted that there has been no real resource transfer. Within the IRF, people have considered where efficiencies could be created in one part of the care setting, but resources are not being levered in from elsewhere. Information is an issue, as are the mapping data, which consider costs and activity. The costs are for buildings and staff so, although it is easy to move figures around on a bit of paper to make cost savings, actually moving resource from

one part of the system to another involves changing staff or closing buildings or wards, both of which approaches generate significant public and political concern.

12:00

Elaine Mead: It is also about changing clinical practice. Our work on the integrated resource framework demonstrated to us that there is significant spend by clinicians on things for which they ultimately have no financial responsibility. For example, an independent contractor's referral of a patient to a hospital setting might have no financial consequence for the contractor's business, but it has a significant consequence for health and social care spend.

My point is that it is about not just how budgets are aligned but how clinicians are engaged in the spend and having people working across the health and social care continuum who understand the impact that a decision in one part of the system has upstream or downstream in another part of the system. That is fundamental for us.

Our new model of health and social care partnership will bring together community and primary care services, social care and secondary care. Clinical colleagues will have to have a discussion across the whole of the health and social care continuum, so that they can understand the impacts. We think that bringing things together will start to give us a better understanding of and intellectual debate about the best way to spend every health and social care pound.

The Convener: I understand that. What experience and success have you had in engaging people in secondary care, given that the organisations that represent such people are highly suspicious about what is happening and think that money will be shifted from health budgets to community care, with secondary care losing out in consequence?

All the political parties that are represented on the committee agree, I think, that integration of care is where we need to and must get to. There is no political division on that. However, there are barriers. What success have people had in involving hospital doctors and consultants? If an elderly patient arrives in hospital on a Thursday or Friday, they can be in all weekend—sometimes they never get out.

Bill Nicoll: Perhaps I can give you a couple of examples. Perth and Kinross has one of the dementia demonstrator sites, in Strathmore. The issue was that we were using 90 per cent of the staffing resource to see 10 per cent of the patients, because we were admitting a small number of patients to a dementia admission and assessment unit in a community hospital.

The team itself took the brave decision that it needed to be out there working in the community, led by the old age psychiatrists. The team is very much wedded to the step model of care for dementia, which starts with pre-diagnosis and moves through diagnosis to post-diagnostic anticipatory support and care. Basically, the entire staff covering the dementia beds in the community hospital were retrained and moved lock, stock and barrel to a community team, which now sees in the community all the patients who require support. The team is pushing at the thresholds for identification of dementia and is providing immediate post-diagnosis support. That is an example of how a hospital-based service can be transformed into a community-based service that covers far more patients.

The other examples are around medicine for the elderly, whereby geriatricians working in a local area support general practitioners' decisions on issues such as polypharmacy reviews. The local enhanced service involves general practitioners working with care homes, but with geriatrician support. We must go further. I would like our medicine for the elderly service to be much more of a community service than a hospital-based service.

I could give many more examples, but those are a couple of examples where the secret is clinical changes or changing the clinical teams rather than having a debate at the margins about how many beds will shift the balance of care.

The Convener: We would welcome examples in writing, if you do not have time to give us them during the meeting.

Dr Gunning: There are some clear examples in Scottish history of a hospital-focused model being transformed into a community-based approach to care. Learning disabilities is a prime example, but mental health services have also been completely transformed. In the mental health service in Ayrshire, we have recently been able to reduce considerably the number of acute beds by putting robust crisis response teams in place, so that the service is there in the community when the recipient needs it and there is no need for a hospital admission. That approach has been very successful.

Those programmes were underpinned by the availability of bridging finance. In other words, new models of close partnership working between health, local authorities and others were put in place while there was an ability to bridge existing models. That takes quite a lot of heat out of the situation. Use of that methodology and the change funds would allow us to replicate that approach in

acute services, because the strongest argument is that the new service is in place and the old model is no longer required, so why would we continue to provide it. That is the strongest way of demonstrating clinical change.

Dr Farquharson: I have one example involving NHS Lothian and the City of Edinburgh Council. Through very close working with physiotherapy and occupational therapy within community and social care, the length of stay for orthopaedic rehabilitation of older people was decreased by 38 per cent and for patients with stroke by 31 per cent. From the clinicians' point of view, that meant that there could be a 44 per cent increase in throughput for orthopaedics. That is an example of improving patient flow through the healthcare system from secondary care to primary care and back to the patient's home.

Gil Paterson: My question relates to one that I asked the previous witness panel. It seems to me that in the past everyone did their own thing. We do not have the benefit of the Government's consultation, but how would you feel about going forward with a blueprint to follow? Anne Hawkins from Glasgow City CHP believes that an autocratic blueprint should be devised to achieve best practice.

I understand what she was saying, because she was relating such an approach to that taken in industry, where clear guidelines are given and targets set. People are told: "This is the best approach—follow it." Different parts of a company worldwide may deliver the same thing and want to be consistent. Would that approach work? I can see where it would work in Glasgow, where I understand the situation extremely well, but would the same model work in Shetland? I do not know and I would be grateful for your views.

Jan Baird: We recognise that Scotland is varied and diverse. When we were developing a model for Highland, we wanted the best model for the people of Highland and that is what we still advocate. We can focus on the principles of what we are trying to achieve and the outcomes that we want, which should be common to us all. However, how we deliver those outcomes should be left to local decision making because the areas are so different.

Having listened to the earlier discussion about how we are doing different things and the changes that we need to make, I think that we must be able to think about the outcomes that we are achieving and not focus on measuring all the inputs. We have become tied to measuring inputs as a measure of success, but that is not a measure of success. The measure of success is what makes a difference to the patient, the client, the family and the carer. We need to get smarter at assessing that.

Bill Nicoll: I agree that we need to have core characteristics in place, although we cannot have a one-size-fits-all approach. We are a national health service and we operate in a relatively small country, so we can effect consistency across that system, but that should not prevent local variation in delivery on the ground. It will be interesting to see what happens with the work in Highland and how other models of care partnerships evolve over time. The important thing is that they should all have the common characteristics that we are looking for, including single, visible accountability, an integrated resource budget and clinically led teams working on the ground.

Gil Paterson: Would you call that a blueprint? That is what it sounds like to me.

Bill Nicoll: If, by blueprint, you mean something that gives people discretion around the fine detail of the approach, I would support the use of that term.

Dr Gunning: A number of rocks cannot roll if this is to be successful. Pooled budgets, which allow a clear understanding of the resources, are essential. Single accountability and a clear understanding of the desired outcomes are also essential. Further, if we do not achieve closer clinical practitioner engagement through these changes, we will have wasted our time, as that is the single most important ingredient, rather than the structural issues.

There has been a lot of discussion about the mark 1 CHPs. We must bear in mind the fact that those were introduced when the new general medical services contract was coming in, so there was an alternative element that could affect the business platform of GPs. We need to be wary of any other things that might influence the focus at a really important time.

We cannot have a blueprint for delivery, because the delivery change can be understood only at a local level. We have spent a long time talking about health, but we know that the structures within councils vary greatly. Some places have a traditional social work department, some have a social work and education department and some have a social work, education and housing department. Therefore, a different methodology will have to be applied to arrive at best-fit solutions on the local authority side as well as on the health side. It is important to bear that in mind.

Jim Eadie: The evaluation of the integrated resource framework sites found that there was no preferred funding or financial mechanism in Ayrshire and Arran, Tayside and Lothian. I accept what witnesses have said this morning but, unless we have the fully integrated model with a single budget, will we be able to achieve the outcomes

that we wish to see? My question is directed at those witnesses who have not yet come out in favour of the Highland approach.

Dr Gunning: As I said earlier, understanding and pooling the resources are fundamental to moving integration forward. In Ayrshire, we produced a workbook for practitioners that described the range of financial arrangements that could be put in place, from straightforward grants through to pooled budgets. We did that to help individual clinical teams to decide which model would best suit them. That groundwork has been important in increasing the understanding of the issues in Ayrshire. Certainly, starting with older people's services, we have agreed to a pooled budget approach. I think that our work in the IRF and mental health services will take us down the same line.

Jim Eadie: You are confident that that would achieve the shift in resources from the acute sector and institutions, where they are currently focused. I am thinking of the examples that you gave earlier of learning disabilities and mental health services.

12:15

Dr Gunning: Yes. If you understand the totality of the resource that is available, you understand the outcomes that you are trying to achieve and the delivery chain for those outcomes. As a natural consequence of that process, you will shift the resources accordingly.

Jim Eadie: I am interested in hearing from the other witnesses on that.

Dr Farquharson: I am not sure that a pooled budget will necessarily be a panacea. We require a change in culture to implement integration successfully. I would not want to concentrate on pooled budgets as the main vehicle; we must ensure that we have a very different culture that puts the patient at the centre. Jim Forrest's work in West Lothian provides examples of different models that work very effectively.

Jim Eadie: And in Tayside?

Bill Nicoll: Tayside is clear that there are opportunities to deliver that culture in all sorts of ways. Without a doubt, the lead agency model is one solution.

To return to what my colleague Dr Farquharson said earlier, we must connect with the local will and the local systems and processes. For example, Perth and Kinross Council has housing and community care services and education and children's services. How does our partnership deal with such an arrangement, in which there is one health board and one local authority but the two elements are arranged—for good solid reasons—in such a way?

As long as the core elements—single accountability and a single integrated budget—are in place, we can go forward, however we choose to organise the service and the integrated teams that work with those integrated budgets. We need to minimise the number of different models and solutions, and we must learn from Highland Council and the CHP models that already exist.

Jim Eadie: You seem to be suggesting that one size does not fit all. Are you saying that what works in one part of the country may not work in other parts?

Bill Nicoll: The blueprint—having in place core characteristics for the partnerships that embrace all the possibilities—is the way forward. We do not have a single answer at present.

Jim Eadie: Notwithstanding Dr Farquharson's perfectly valid point about the issue being broader than funding, I will stick with funding for the moment. Do you all agree with Dr Gunning that the change fund can provide a form of bridging finance that helps to shift resources from where they currently are to where they need to be spent in the future?

Bill Nicoll: The intention of the IRF was to bring in what was described in the initial documentation as parachute payment funding, which is another way of describing bridging funding. Allan Gunning's comments about how that has helped with mental health and learning disabilities are significant in that regard.

We must guard against simply using the change fund to build extra capacity without having the ability to transform services. We must strive within the 95 per cent—or even less—resource that we will have in future, which has been our chief executive's mantra.

We must use the change fund genuinely to lever change: to create a different profile of services that people actually use; and to reduce demand and pressure, and reliance, on expensive and unnecessary admissions to hospital.

Dr Farquharson: It is also important to ensure that some good outcome matrices are associated with the change fund so that success can be clearly demonstrated.

Jim Eadie: That is helpful. Mr Ferguson, do you have anything to add?

Roddy Ferguson: One of the difficulties with the IRF was that it was pilot funding and it was seen as short term. Introducing large-scale structural change based on short-term funding is a big ask. The change fund was reported to have

more significant longevity, and funding on that model is seen to be more likely to shift resources.

Elaine Mead: We have been interested in the change fund and found it a helpful form of additional funding, but we have been clear that we want to see a significant return on investment. You might be aware that Highland asked to see programmes of work that would give us up to a 3:1 return on any investment from the change fund. That is challenging. It has been challenging to get colleagues even to think differently about where they would make that investment.

A good example of the payback is the work on virtual wards. The same probably applies in Perth and Kinross. There has been a significant shift, in that we have seen a return of up to 12 times the minimal investment in some community-based services that are led by consultants, through reductions in both emergency admissions and length of hospital stay for older people. If we use the change fund wisely, we can broker significant benefits, but it takes time, as my colleagues have said.

Jim Eadie: That was helpful. I have a final question for Dr Farquharson. One of the themes in your written evidence is the need for strong leadership, which has been a recurring theme in the evidence that we have heard. In your submission, you discuss the joint director post that is shared between NHS Lothian and West Lothian Council, and you discuss the joint management team. Is that an example of the strong leadership that you envisage? How do you see that work being replicated and applied throughout the Lothians?

Dr Farquharson: That is one form of strong leadership, but I also think of it from the clinical point of view, with the engagement of general practitioners and secondary care as well as social care. That is essential in changing the culture of how we work. The NHS in which we were all brought up over the past 30 years needs to change, but teaching people new tricks is sometimes difficult. That is where strong leadership is required.

Elaine Mead: In addition to the engagement of clinical colleagues, the development and support of the voluntary sector and independent organisations will be crucial as we develop services that are much closer to home and which provide support and independence for older people. We must focus on that, as well.

Jim Eadie: You mention in your written evidence the development of a core data set. Is that critical to obtaining the activity and spend data that you mentioned?

Dr Farquharson: Such a data set is fundamental. We must ensure that there is transparency so that we can demonstrate to clinicians—by which I mean all health care professionals—exactly where the money is being spent and where activity is being transferred to and from.

Jim Eadie: Is that an aspiration, or are you taking steps to deliver that within NHS Lothian?

Dr Farquharson: We have all the mapping data. The next step is to make best use of it. It is work in progress.

Jim Eadie: Will you say a little more about your plans?

Dr Farquharson: I have already mentioned the dementia project, and we are using the baseline IRF money to demonstrate improvements in outcomes.

Jim Eadie: Are you happy to write to the committee on the subject?

Dr Farquharson: Yes.

Richard Lyle: I will try to be brief. We have heard about culture and political drive—I think Bill Nicoll mentioned them earlier. I have been impressed by all the NHS representatives, who seem to have embraced the policy. Has anyone read the Scottish Association of Social Work's submission to the committee? Maybe you do not have it. I find its comment on structural change interesting and appalling. In councils over 30 years, I have gone through at least a hundred structural changes, but the SASW tells us that we have done it wrong. It states:

"Structural change rarely produces the anticipated improvement that policy makers and managers seek."

Do you think that the Scottish Association of Social Work will embrace the policy in the way that you, as officers in the NHS, seem to want to embrace it?

Bill Nicoll: I hope that I am here to represent the partnerships across Tayside and that I am not simply here as a health person. My sense is that all our colleagues in the partnership embrace the change. I have read the submission from the Scottish Association of Social Work and statements from the Association of Directors of Social Work on the matter. The change will be significant for everyone. Perhaps the point that the Scottish Association of Social Work is making is that structural change alone is not sufficient. It is not enough to co-locate people in one building and give them a single budget and it is not even enough to have a single accountable officer if we cannot effect a culture change that allows people to work together almost seamlessly.

As someone who was involved in the process very early on, as Dr Simpson mentioned, I understand fully how important it is to get

everyone to embrace the required culture of working. To get all the clinicians engaged, and to get everybody in front of the 8-ball, is a tall order and a tough task to get right. I am sure that many of those machinations are being gone through in the Highlands as we speak. I hope that the Scottish Association of Social Work's point is simply a reflection that structural change alone is not sufficient and that we need to work with everyone in embracing change. We require a culture-change programme as much as we need to get the money and the organisational set-up right.

Elaine Mead: I am happy to comment on that. I am disappointed in the Scottish Association of Social Work's submission. Structural change is not necessarily right for all areas, but I am delighted to report that, yesterday, I was in front of at least 48 of my social care colleagues who welcome the opportunity to practice in a different way.

As colleagues have said, the issue is not just about the structure. Fundamentally, it is about focusing on what is right for us in the Highlands and the people of the Highlands. Although there are sensitivities and anxieties because we feel that we are breaking new ground, I have been extremely impressed by how well health and social care colleagues are embracing the new way of working. We will have to find a completely new way of working, with a new language of integration, and we look forward to that.

Roddy Ferguson: The message that we picked up in the evaluation was that structural change or the mapping data will not in themselves achieve the aim. Having the mapping data and better information on cost and activity will inform decision-making, but it will not, in itself, transfer any resources. We explored that with front-line staff as best we could. We found that, for anybody who is involved in the integration process, there is a big "So what?" question. The mapping data says that costs should go here or there, but people ask, "Does this affect me and can I affect it?" If the answer to both questions is not yes, people think, "Structures might change, but so what? That doesn't affect me and I can't affect it", so change will not happen. That is one of the big barriers that we found.

From a clinician or GP's perspective, people ask, "Does the change give better outcomes for my patients, make me better at my job or make my workload easier?" If it does not do any of those, it does not really affect them professionally. That is probably replicated among clinicians, social care staff and so on. Unless the "So what?" question is answered, the structural change and mapping data will not bring about the expected or anticipated change.

12:30

Dr Gunning: It is easy to make broad statements about change—particularly structural change. The old saying that the costs are always understated and the benefits are always overstated is probably not too wide of the mark, but we must get away from that broad-brush approach. We need to understand what the problem is that we are trying to fix. If there is clarity on the problem that we are trying to fix and everyone recognises that it is a problem, the issue comes down to how well the change is led and managed.

NHS Ayrshire and Arran has already demonstrated that we are willing to look at our arrangements. In fact, we refreshed the community health partnership model in 2008, because we felt that the previous model was not quite delivering the outcomes that we sought. In partnership, we redesigned and refocused our approach.

Richard Lyle: Thank you.

Dr Simpson: I have a technical question that relates to the integrated resource framework evaluation report. Are the data that we are collecting adequate and are we collecting the right data? I know that that is a huge question; I am not looking for a straightforward answer. As someone who has been a general practitioner and a consultant and who has been subject to data collection in both those roles, I am not convinced that either set of data is particularly satisfactory.

Roddy Ferguson: I will start and others might want to join in, as they see fit.

On the positive side, progress has been made with data collection. The effort that has been put into the data-mapping process has helped to increase the transparency of the data. It has also brought about a better understanding of the limitations of the data, which has helped to inform conversations. If someone claims more than the data can support, it is useful to know what the current data can support and where they reach the boundary of usefulness.

I will give an example that Allan Gunning may know about from his experience with NHS Ayrshire and Arran. It involves CHP data and the NHS Scotland resource allocation committee formula. Analysing the difference between actual spend and what a fair-share spend would look like works at CHP level, but if you probe the NRAC formula below that level, you start to run into more and more problems. That is one example of the limitations of the data. That understanding has improved things.

NHS Lothian has taken a much longer-term and more ambitious approach to the data and has

drilled down across all its services to patient spend. As I understand it, there continue to be limitations on that data around the allocation—meaningfully and in an agreed way—of GP community care costs at patient level, but discussions might come out of that. That is a journey that we still have to take.

At the baseline stage, when different test sites were allowed that focused on the board areas and the corresponding local authorities, those sites found it helpful to have flexibility at that level to come up with their own data management systems, because they already had different data management systems. That raises questions about issues such as benchmarking across the country and duplication of effort, which have not been resolved, either.

Dr Gunning: As Roddy Ferguson said, when we pushed the NRAC formula down to general practice level for the major care programmes and prescribing spend, the variations were so large that it looked as if there were obvious limitations on the use of the NRAC model at that level of detail. The methodology exists, but we found that we were spending more of our time trying to explain whether a variance was a real variance or an imagined variance that was to do with the model. We felt that that was becoming counterproductive and that there were other routes to getting that information at GP level.

The trick is how we turn the data into information that is meaningful for the users. In Ayrshire and Arran, we have found that the spend per weighted head of population has been quite powerful, particularly with elected members, because it gives a common currency across health and the local authorities, and for each care group. It allows members to look at one page of data that tells them that measure across all services and across all three CHPs. That seems to tell them something that they did not know, which is part of the trick here—giving information that is meaningful to users and which gets them thinking about resource utilisation.

Bill Nicoll: Sometimes, searching for accuracy in data can be spurious and we can get lost down a side street. Data have to be good enough to make a point or to be usable, and must be able to be subjected to a fair bit of scrutiny. When you present people with information about variation, and that information is attributable only if data have been adjusted in the way that Dr Gunning has described, and when it all comes down to the way in which local systems behave and perform, you have to be able to demonstrate that the data are sufficiently robust.

In Dundee for example, the tradition has been that patients mainly stay with their family doctor. However, they may have moved around the area a lot, so tracking the patient journey to a particular population can be fraught with difficulties. However, it is important that we do so, because that is the decision-making system that will determine the person's care journey. There is a limit to how much spurious accuracy and detail we need from data; data will already have given us a fairly rich picture of what is happening in our health and care systems, and sometimes that is good enough for me.

Bob Doris: I have a general question for everyone, but first I want to ask our colleagues from the Highlands a specific question on the lead agency model, in which the NHS will take responsibility for all adult services. The local authority will have statutory obligations in relation to provision of adult services but, with the best of intentions, it will be farming out those to NHS Highland. Will that lead to legal difficulties in relation to structures, models and the need for legislation?

Jan Baird: We say "delegating" rather than "farming out".

There was a conversation earlier about pooled budgets, but we are not talking about a pooled budget: we are talking about a delegation after an agreed commission. In the case of older adults, for example, NHS Highland and Highland Council agree on the outcomes and NHS Highland is then asked to provide the services in order to reach those outcomes. The council will delegate the function to the NHS, as well as the required resource. The budgets are then used together within the NHS. It is a bit of a technical point, but that is not a pooled budget. NHS Highland is responsible for delivering the services, but accountability for the outcome is with both the council and the NHS. Our governance structures reflect that, with elected members and board members both having responsibility. I am talking about all client groups—children's services and adult services.

Elaine Mead: I can give committee members a practical example of the kind of thing that we come across. In taking responsibility for social care services, we have had to consider how those services are run at the moment. At a meeting, somebody asked me what would happen with complaints, and I said that they would go through the normal NHS route, but somebody else pulled me up and said that, in social care, there is a specific escalation, requiring a lay member and a councillor to be aware of any specific social care complaint. We were not cited at all. We have had to log each issue that has come up, and then work out a way through it. In the example, we came up with an arrangement whereby we would run the complaint through our NHS process but would escalate it back through the Highland Council

route if that was required. Often, we are breaking such new ground that we do not even know some of the issues that will arise, until we actually come across them.

Jan Baird: Mr Doris asked about delegated functions and statutory responsibilities. Amendments are going through Parliament just now on some of the regulations on adult support and protection. For example, the function of mental health officers cannot be delegated—regardless of our wanting to move the function into the NHS—so we have looked to develop a dedicated MHO service in the council. People will remain employed by the council but will be deployed in the NHS into the integrated teams.

Bob Doris: Thank you, that was helpful.

I suspect that we could go on exploring the issue at length, but you will probably be glad to hear that we will not do so today. As we did for the previous panel, we give the witnesses an opportunity to put any final comments on the record. Given that there are six of you, it would be good if you could be brief. Can you also say whether you think that the Government's proposals—the full details of which are not yet known—will make integration of health and social care easier?

Dr Gunning: I will kick off. From what I understand about the workstreams that are being set up to support the production of the consultation document and the bill, the main bases are covered.

My parting shot is that I am concerned that we should pay enough attention to clinical and practitioner engagement. I do not want that issue to get lost in all of this.

Dr Farquharson: I want to stress the importance of information sharing between the health service and social care, to ensure that we have the evidence and that all the appropriate details are passed down when a patient is discharged from hospital and gets home.

Elaine Mead: It would be remiss of me not to point out that in Highland we are also looking at the Highland Council becoming the lead agency for children's services. I realise that that is not in the scope of the current discussion, but I wanted to put down a marker. If the objectives and outcomes that we aspire to for older people's services are valid, they are also valid for children's services, so we encourage people to consider the issue.

Bob Doris: It is helpful that you have put that on the record. We were going to ask whether that should be the next step, after the work has been done for older people's services.

Jan Baird: I want to reiterate what was said about the importance of a focus on outcomes and evidencing through performance management. We need to make significant changes and I applaud the intention to do so. That is what we have acknowledged in Highland; we have not changed direction but are focusing on the outcomes that we had for the getting it right for every child and joint future programmes, although we recognise that we need a different mechanism to get us there.

Bill Nicoll: I echo the comments that Julie Murray—I think—made earlier. If we limit our aspirations to older people's services, we will miss an awful lot of opportunities, given the work of CHPs and the significantly devolved services that are operating close to their local communities and local authorities. The work has to embrace all that.

I also want to pick up on the point about the importance of integrated children's services. If we are to make big steps forward, we must incorporate all the activity that is already devolved to local areas and build on that work.

Roddy Ferguson: We talk about integration as though it is one thing that applies at one level and breaking it down to different levels breaks up integration. The IRF focused on health and social care and seemed to have a broad remit, but it did not get into the health promotion side of things. In the context of demand for services, there is a big issue about the role of health promotion, so there could be broader integration in that regard.

We talked about engaging front-line stakeholders. It is about bringing things down from a macro level to a much more micro level. At care-pathway level or locality level the approach makes sense and people can network with a manageable number of people, rather than across an institution that is too big to effect change.

The Convener: I thank you all on behalf of the committee for your attendance and valuable evidence.

We take item 2 in private, as previously agreed.

12:44

Meeting continued in private until 13:16.

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