The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 20 March 2012

Session 4

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HEALTH AND SPORT COMMITTEE
11th 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:

Kathleen Bessos (Scottish Government)
Nanette Milne (North East Scotland) (Con) (Committee Substitute)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy)
Alison Taylor (Scottish Government)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 20 March 2012

[The Convener *opened the meeting at 10:08*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 11th meeting in 2012 of the Health and Sport Committee. I remind all who are present that mobile phones and BlackBerrys should be turned off as they interfere with the sound system.

Apologies have been received from Jackson Carlaw, so I welcome Nanette Milne, who joins us this morning as his substitute.

The first item on the agenda is to decide whether to take in private item 7, which is consideration of the main themes arising from evidence that we have received during our integration of health and social care inquiry, and to take in private consideration of the draft report of the inquiry at future meetings. Do members agree?

Richard Lyle (Central Scotland) (SNP): In keeping with our aim of being open and transparent, we should take item 7 in public.

The Convener: Does the committee agree to that?

Members *indicated agreement.*

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Is that also agreement to the second part, which is that the draft report be considered in private at future meetings?

The Convener: Yes.

Subordinate Legislation

Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012 [Draft]

10:09

The Convener: Agenda item 2 is evidence from the Cabinet Secretary for Health, Wellbeing and Cities Strategy on a Scottish statutory instrument that is subject to affirmative procedure. Members have received a cover note on the purpose of the draft regulations, which have been drawn to the Parliament's attention by the Subordinate Legislation Committee on the grounds that certain matters could have been expressed more clearly, and that there has been a failure to follow normal drafting practice. Members will recall that, at last week's meeting, the committee considered the Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012, which the Subordinate Legislation Committee drew to the Parliament's attention on similar reporting grounds. I have already written to the cabinet secretary to raise those concerns.

I welcome to the meeting the cabinet secretary, Nicola Sturgeon. She is accompanied by Margaret Duncan, who is head of branch, ministerial support and national waiting times centre sponsorship, and by Francesca Rennie, who is a solicitor with the Scottish Government. I invite the cabinet secretary to make a brief opening statement and remind her not to move the motion, at this point.

The Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon): Thank you, convener. First of all, I confirm that I have received your letter about the regulations that you considered last week. We are looking at the issues that you have raised and I will respond to the committee as soon as possible.

I thank the committee for the chance to say a few words about the treatment time regulations. As members know, sections 9(1) and 9(2) of the Patient Rights (Scotland) Act 2011 provide that regulations must be made in relation to the eligibility for and the calculation of the treatment time guarantee. The draft regulations make it clear that patients who are eligible for the guarantee will be those who are due to receive planned treatment on a day-case or in-patient basis, and they set out the treatments or services that are to be excepted from the guarantee. They also cover calculation of the treatment time guarantee and specifically set out when the guarantee starts, the periods that will not count, when the patient's waiting time clock can be reset and when the treatment time guarantee ceases to apply. Those aspects are all modelled on the new ways

guidance and, by placing them in the draft regulations, we have made the calculation of the treatment time guarantee very clear.

On the Subordinate Legislation Committee's comments in paragraphs 9 and 14 of its report, I welcome this opportunity to make the Scottish Government's position clear. The draft regulations do not make provision for the calculation of waiting times once the maximum waiting time has been breached because section 10 of the 2011 act sets out the actions that boards must take if they make such a breach. As a result, the provisions in the draft regulations with regard to calculation of the waiting time and resetting of the waiting time clock to zero are effectively irrelevant once the treatment time guarantee has been breached. If a health board attempted at that point to reset the waiting time clock to zero, it would have no effect. The Scottish Government considers that that is clear by virtue of the enabling powers, which set out what the regulations must and may do, and also considers that the enabling powers do not permit the draft regulations to set down how the waiting time is to be calculated after the guarantee has been breached.

I also take this opportunity to confirm to the committee my intention, following the Subordinate Legislation Committee's comments, to amend the definition of "ophthalmic medical practitioner" at the next appropriate opportunity. As that committee agreed, a court would very likely arrive at the intended interpretation of the definition, but I accept that the meaning could be clearer, so I assure the committee that the definition will be corrected sooner rather than later. As I have said, we will do so at the next appropriate opportunity; I am happy to keep the committee apprised of when and what that opportunity might be.

I am happy to answer members' questions.

The Convener: Thank you. Do members have any questions?

Dr Simpson: I was holding back to see whether anyone else wanted to come in, convener.

In regard to draft regulation 4(2)(d), in which

"the patient has decided, rather than to attend an appointment for the agreed treatment outwith the commissioning Health Board area, to wait until the next scheduled visiting practitioner service",

does that opportunity have to be offered to the patient? If the waiting time is going to be breached, must the patient be offered the opportunity of waiting for the

"next scheduled visiting practitioner service"?

10:15

Nicola Sturgeon: Yes—the patient would have to be given that option.

Dr Simpson: Secondly, the word "reasonable" does not appear in relation to the mention of an offer, but I presume that that is understood. There was a problem with Lothian NHS Board—in which I know the cabinet secretary has taken a personal interest—in that the offers that were made were questionable. I will not go further than that, because we have not seen the final report, but an offer of an appointment in Cumbria or Northumbria for a minor procedure might be deemed to be not reasonable. Is there a mechanism for determining what would constitute a reasonable offer? Do patients have recourse if they think that offers are not reasonable?

Nicola Sturgeon: We intend to make the definition of reasonableness clear in guidance to health boards. The situation with NHS Lothian—as Richard Simpson will be aware—in many cases involved offers not only of appointments in England at short notice, but of only one appointment date. The intention is that two appointment dates be offered.

I am clear that the question of reasonableness is understood implicitly in what we are putting forward, but we must make that clear in guidance so that health boards are clear in general terms about what would and would not constitute a reasonable offer. The fundamental principle is that health boards cannot offer appointments that patients could not reasonably—by any normal standards—comply with, in order that the board can get round legal waiting time guarantees.

Dr Simpson: That is helpful.

I have one supplementary question. Draft regulation 8 states:

"Where a Health Board is unable to meet the treatment time guarantee within its own area, it must take all reasonably practicable steps to arrange for the provision of the agreed treatment by—"

the provisions in subparagraphs (a), (b), (c) and (d).

I have a problem with that. NHS Lothian previously had a contract for minor procedures with a local private provider, but it moved the contract to an NHS provider in England. That may have been perfectly reasonable from the board's point of view, but it was quite unreasonable from patients' point of view. I hope that there will be something on such practice in the guidance, as it is not in the regulations.

Regulation 8(2) states:

"a Health Board must have regard to the importance of securing the effective and efficient use of the health service organisation and resources."

I would have liked to see a provision that said that we should also take into account patients' time and resources.

Nicola Sturgeon: That is a fair point. It is important to remember that the regulations and the treatment time guarantee sit within the context of the Patient Rights (Scotland) Act 2011, which involves the principles and rights that exist for patients. I am happy to take that point on board and to ensure that it is reflected in the accompanying documents.

The Convener: As there are no more questions, we will proceed to agenda item 3. I invite the cabinet secretary to move motion S4M-02363.

Motion moved,

That the Health and Sport Committee recommends that the Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012 [draft] be approved.—[*Nicola Sturgeon.*]

The Convener: Do members wish to debate the motion?

Richard Lyle: I do not wish to debate it, but I have a comment to make.

The Convener: No, you are too late. Are members content to agree the motion?

Motion agreed to.

10:18

Meeting suspended.

10:19

On resuming—

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2012 [Draft]

The Convener: Item 4 is evidence from the cabinet secretary on another draft affirmative instrument. Members have a cover note that sets out the purpose of the instrument and says that the Subordinate Legislation Committee had no comment to make on it. The cabinet secretary is joined by Gillian Barclay, who is head of the older people's unit in the Scottish Government. I invite the cabinet secretary to make opening remarks.

Nicola Sturgeon: I will be very brief on this instrument. The draft affirmative instrument reflects the Scottish Government's commitment to increasing free personal and nursing care payments in line with inflation. The regulations, if approved, will ensure that vulnerable older people continue to benefit from that policy position.

Last year, we increased the personal and nursing care payments for residents in care homes in line with inflation. The regulations will further increase in line with inflation the weekly payments for personal care, which will go up by £4, to £163 per week, and the additional nursing care payments, which will go up by £2, to £74 per week. In line with our partnership with local government, councils will meet the costs of the inflationary increases—which will total around £3 million across all councils—from within their agreed settlement allocations.

The free personal and nursing care policy continues to command strong support not just in the Parliament but throughout the country. I hope that the draft regulations meet with the committee's approval and receive its support. I am happy to take questions.

The Convener: Thank you. I invite questions from committee members.

Dr Simpson: I calculate that the increase is about 2.7 per cent. Is that right?

Nicola Sturgeon: We used the gross domestic product deflator, which was 2.5 per cent. We applied the GDP deflator for 2012, which is in line with the Treasury GDP deflator for 2012-13.

Dr Simpson: Costs for care homes will be going up at a rate that is much closer to the consumer prices index or the retail prices index, which will mean an increase of somewhere between 4 and 5 per cent. Have you had discussions with local authorities about their payments to homes, outwith the personal care allowance? The allowance applies to people who are privately funded—it is a welcome measure, which the whole Parliament supports—but there is a growing gap between the charges that care homes are levying and what they are obtaining from local authorities. Have there been discussions about more appropriate inflation of the payments by local authorities?

Nicola Sturgeon: I will make a few points. First, the use of the GDP deflator is the normal way to determine such matters; there is nothing out of the ordinary in our having done so.

Secondly, I recognise the pressure that the care home sector, like other sectors, is under in the financial climate that we face. The Government works as hard as it can with local authority partners and other sectors to try to manage such pressures.

Local authorities are in the driving seat in their negotiations with the care home sector. Recent negotiations ended with a 2.75 per cent uplift. That will not remove the pressure that the care home sector is under. We want, and are increasingly trying, to involve the sector in all our discussions about how we reshape care for older people—we will come on to that general issue soon—in order

to ensure that we provide care in the right place, at the right time, and to ensure that the key players play their part.

Dr Simpson: I accept that there are difficulties in the sector. We heard from the Royal College of Nursing about a reduction in the number of qualified nurses in care homes, at a time when the level of dependency in homes is increasing. I am concerned that further cost pressures could lead to a further reduction in nursing staff. I know that the cabinet secretary is involved with Social Care and Social Work Improvement Scotland—the care inspectorate—in ensuring that levels are properly maintained.

Nicola Sturgeon: I am not trying to make a political point when I say that during the first several years of the free personal and nursing care policy there were no inflationary increases in the payments. This Government has rectified that and has been applying inflationary increases. We must acknowledge the better position that that represents.

I am not denying the existence of the pressures that Dr Simpson has described. We work with local government, the care home sector, the NHS and the voluntary sector on the issue. He rightly referred to the care inspectorate, which is just one means through which I am determined—I know that my determination is shared by everyone on the committee—to ensure that standards of care for older people in care homes are of the quality that we expect, and that older people and their families have a right to expect. Similarly, I have asked for inspections of older people's services in acute hospitals in order to ensure that—notwithstanding the pressures that all those agencies are under—we are securing and ensuring the essential quality of care for older people. I am happy to give that assurance.

Dr Simpson: Thank you, cabinet secretary. I very much welcome the Government's approach.

Richard Lyle: I, too, welcome the Government's approach. The Government is applying the correct procedure and the correct inflation mechanism, which has always been used, and it cannot be changed mid-stream. I agree with the cabinet secretary on the issue.

Nicola Sturgeon: I agree with Richard Lyle in his agreement with me on this issue. [*Laughter*.]

The Convener: As there are no other questions, we will move to agenda item 5. I invite the cabinet secretary to move motion S4M-02364.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2012 [draft] be approved.—[*Nicola Sturgeon*].

Motion agreed to.

10:26

Meeting suspended.

10:27

On resuming—

Integration of Health and Social Care

The Convener: The sixth item on our agenda is our final oral evidence session in the committee's inquiry into the integration of health and social care. The cabinet secretary has been joined by Angiolina Foster, director of health and social care integration, Kathleen Bessos, deputy director of health and social care integration, and Alison Taylor, the team leader in integration and service development, all in the Scottish Government. Do you wish to make any opening remarks, cabinet secretary?

Nicola Sturgeon: Very briefly, convener. I welcome the opportunity to be here today to have a discussion about the issue. We all accept that the changes that will be required to integrate adult health and social care will have to be implemented very carefully, with a lot of thought being applied to the general principles and to the finer grain of the detail. We are doing that in consultation and partnership with the national health service, local government, the third and independent sectors and professional bodies.

I read the *Official Reports* of the committee's two previous meetings with interest and was pleased to see that there is quite a large degree of political and, indeed, professional consensus on the issue. Many attempts have been made in recent years to integrate health and social care. Some areas have managed to do it better than others, and we need to learn from all those previous attempts and look at what has worked and what has not. We can all agree that every partnership has had the opportunity to integrate properly for the past 10 years and that while some have made good progress, others have made less. With the challenges that we face of an older population and constrained public finances, now is the time to ensure that all partnerships are integrating properly and effectively so that we have a system in place that can meet the challenges that lie ahead and ensure a quality of care for all people in Scotland, particularly older people, that is of the standard that we should expect.

I know that members will appreciate information on the stage that we have reached in the process. We are working on a consultation paper that will be published in May and which will seek views from a range of different interests on the detail of this work. As we finalise the consultation paper, it is possible that we will be able to consider some of the questions that members ask this morning, and I certainly welcome and look forward to the committee's work as a contribution to that. My officials have also been involved in very detailed discussions with stakeholders on some of the nitty-gritty issues that lie at the heart of the agenda and, where appropriate, I will ask them to reflect on the state of some of those discussions.

10:30

The Convener: Thank you, cabinet secretary. The committee appreciates those remarks and the context in which we are having this evidence session. Indeed, I hope that, in asking their questions, members will bear that in mind.

Our first question is from Gil Paterson.

Gil Paterson (Clydebank and Milngavie) (SNP): I concur with the cabinet secretary's view that the people who have given evidence to the committee genuinely seem willing to engage with and make a success of integration. However, a number of witnesses have expressed certain views about structures; indeed, one or two seemed anxious that too much of their energy would go into structural change and that a too-rigid approach might hamper integration. I realise that, even before you publish and get responses to your consultation paper, you are probably considering this very issue but, given how often the matter was brought up by the different sectors, I think that it is worth while putting it on the table.

Nicola Sturgeon: I have heard those views and have also read the discussions that the committee has had. I appreciate those concerns; indeed, I have a lot of sympathy with them and make it clear that my approach to this issue has been informed by a desire to avoid something driven by structures and structural change. Not only are we taking time to look at the detail, but I took some time between the election and the announcement of our general approach to Parliament at the end of last year to really think this through. One of the very deliberate decisions that we have made is to approach this not from the starting point of structural change but from the other end—in other words, the outcomes we want to achieve for people, the improvements we want to make and the standards of care we want for older people, regardless of where they live in the country. Outcomes form our starting point and the legislation that will help to implement these changes will very much have an outcomes-based approach.

We then considered the need to ensure joint accountability for the delivery of those outcomes. Although I stress that the voluntary and third sectors generally have a big role to play in this, it is crucial that such accountability is shared principally by the two statutory partners: the NHS and local government.

Thirdly, we looked at integrated budgets to ensure that we get away from the cost shunting that we have seen too often. With such an approach, we give those who are charged with and jointly accountable for delivering the outcomes the wherewithal and the means to do that.

The fourth principle of our change is the need for strong clinical and professional input and leadership in commissioning services. It is fair to say that both have been lacking in not all but many community health partnerships across the country.

Those are the principles that are driving our approach. Any structural change—principally, the replacement of community health partnerships with health and social care partnerships—will follow from them and, indeed, will be structural only to the extent that that is required to deliver on the principles. Our approach does not start with structure and instead sees structure as the servant rather than the master of the changes. As long as we continue with that firmly in our minds, we will avoid what people legitimately say is a concern—getting tied up for years in structural changes that direct people's energies away from front-line care.

We intend to put in place a framework, underpinned by legislation, that describes the minimum that we expect from partnerships. That minimum will be a lot more than is statutorily expected of partnerships now. However, we do not intend to hold back partnerships that want to go further or are already further down the road than others are. Flexibility will be available for areas that want to go further, but there will definitely be a common denominator below which no partnership will be allowed to fall. I hope that that explains the situation clearly.

Gil Paterson: It does. You touch on another issue that has been raised. There is a difference of opinion about whether the plan should be somewhat autocratic, set in stone and delivered with a bit of force—I perhaps overstate the position—or whether it should take a light touch and allow different parts of the country to operate in different ways. I know that the question is difficult; I find it hard to come up with a plan that covers those two aspects. Are you considering those points? Will the plan be somewhere in the middle?

Nicola Sturgeon: You refer to a core part of our thinking. As I am sure you know only too well, nothing that I do will ever be autocratic—not much, anyway.

Getting the balance right is the key. We could not and—more important—should not have one-size-fits-all, identikit provision across the country, because delivering services for people in central Glasgow or central Edinburgh will always differ from delivering services for people in remote and rural parts of the country.

We need to allow partnerships to have the flexibility to ensure that they meet their local needs adequately. However, what we have had until now has been too much of a take-it-or-leave-it, free-for-all approach. In areas where the personal relationships between the people who are involved in the different statutory agencies are good and where there is a lot of will, the arrangements work well. When such relationships do not exist or when people leave and are replaced but the relationships are not replicated, the approach falls away.

The situation should not be left to chance. That is why we are looking at putting in place a clear framework in legislation. As I said, that will not mean that partnerships must play to that core legislative framework or that they cannot go beyond it, but it will mean that none can fall below it. That will be a key difference from the situation now.

Jim Eadie (Edinburgh Southern) (SNP): Good morning, cabinet secretary. I am particularly interested in what you said about learning the lessons from the experience of integration in Scotland and elsewhere and about evaluating what has and has not worked. In developing your proposals for health and social care partnerships with joint accountability and integrated budgets at their heart, what evidence base did the Scottish Government consider?

Nicola Sturgeon: We considered a good report by the Association of Directors of Social Work on the evidence base behind integration. We have also looked at examples of what has and has not worked. To be frank, we have applied a bit of common sense and looked at the barriers to genuinely effective integration in practice. In addition to all that, every step of the way, the proposals are being informed by expert opinion—by those who manage, commission and deliver services locally. What we are doing certainly passes that test. We are taking time to continue to ensure that the proposals are informed by expert stakeholder opinion every step of the way.

Kathleen Bessos (Scottish Government): We also have the Audit Scotland report on CHPs and were mindful of the lessons that were learned from that experience. For months and months before the committee started its inquiry, we engaged with a wide range of stakeholders to unpick the barriers to integration and to find out what people would like to happen. From last summer, all the way through until the cabinet secretary's announcement in Parliament, we had a lot of multidisciplinary groups working together, involving the royal colleges, the third sector, the independent sector, chief executives, local

authorities and the Convention of Scottish Local Authorities, to try to unpick what the barriers have been and to consider what levers we need to pull. As well as considering evidence from further afield and academic research, we have had a lot of engagement in Scotland.

Nicola Sturgeon: In making this final point, I am not saying that there are not nuances in opinion or even differences of opinion on the issue, and nor am I saying that there are not some really thorny issues and challenges ahead of us as we implement the changes. However, the degree of consensus and the ability to work on the basis of the principles that I articulated earlier across the NHS, local government and other sectors have been impressive. I remember when, after the election, somebody told me that we would have all sorts of trouble in trying to progress the agenda because the NHS and local authorities would never agree and would fall out, but that has not been the experience. There is an appetite for the changes and people are working constructively with us to ensure that we get the principles and the detail that underpins them right.

Jim Eadie: One of the themes that you identified in your opening remarks was the need to align NHS board and local authority budgets, which are not currently aligned. How do you envisage that being addressed?

Nicola Sturgeon: We are suggesting not that they need to align their budgets—that is what they are expected to do now—but that they need to genuinely integrate their budgets. In effect, aligned budgets are two budgets sitting together but, often, money cannot be transferred between them. With genuinely integrated budgets, once the money goes into the pot, whether it is from the health service or the local authority, it loses its identity and can flow in different directions. That means that we will not get the situation that sometimes arises in which, for example, a local authority says that its part will be overspent, so it has to rein back; instead, the budget is genuinely integrated. How we do the integration is one of the detailed issues that we will work on through the consultation.

I am sure that it can be done in many ways, but there are probably two main ways. One is for one body to host the integrated budget on behalf of both bodies; the second is for the money to continue to sit in both organisations legally and in terms of accountability, but for it to be genuinely integrated in the sense that the partnership has free use of it. We are working through the details to consider how best to go about that. It might be that the partnerships can opt for one or other of those approaches. The key point is that we are not talking about aligned budgets any more—this is about genuinely integrated budgets.

Jim Eadie: That is helpful. Before I pass over to my colleagues, will you say a little about how you see the partnerships working to take forward the Government's self-directed support agenda?

Nicola Sturgeon: The self-directed support agenda is obviously integral to the process, although it is a separate part of our work. The Social Care (Self-directed Support) (Scotland) Bill is about to go through its parliamentary process.

The principle of self-directed support, as its name suggests, is to give people more control over their care. The principle is vital, almost regardless of how we organise the agencies that deliver the care. The partnerships that we envisage will have a requirement to deliver self-directed support firmly at the heart of what they do.

The Convener: Jim Eadie raised the important issue of evidence, evaluation and accountability, which some witnesses have raised. Last week, Theresa Fyffe of the RCN said in evidence:

"we are waiting for the pilots to be evaluated to find out how that approach has worked."

Later, she repeated it when she said:

"I referred earlier to the evaluation of the integrated resource framework, which has still to come out."—[*Official Report*, *Health and Sport Committee*, 13 March 2012; c 1145, 1153.]

Does Theresa Fyffe have a point about our ability to evaluate and endorse the pilots? Have they worked?

10:45

Nicola Sturgeon: I am not entirely sure which pilots she was referring to. I cannot remember the details, but I imagine that she was talking about the integrated resource framework pilots. The work on the integrated resource framework will be crucial to the integration of budgets in bringing health and social care together. Work is under way to map where resources are spent and where they come from to show how much money is spent across health and social care on care for older people. That work is crucial in developing our approach.

You asked whether Theresa Fyffe has a point. Everybody who makes points in this context deserves to be listened to, and she has a point. I have conceded that we must ensure that our proposals are evidence based, in that they must make sense to the people who will be required to deliver them. That is why we are taking so much time to engage and consult. I cannot speak for the RCN, but I think that it is looking at the different approaches. All of that will be very useful when we come to making the final decisions on the detail underpinning some of this.

The Convener: I appreciate and support the cabinet secretary's decision to take a softly-softly approach with wide engagement rather than an autocratic approach such as was described earlier. However, there has been harsh criticism of another lever—namely the change fund—in the third sector. We heard last week that the Government risks creating a "public sector monolith" because of the control that local government and the NHS have over the change fund. From the evidence that we have heard, it seems that the proposals are not encouraging. We know the Government's direction—the Government has made it quite clear that the third sector should be there, signing this off—but the third sector feels pretty excluded from the process.

Nicola Sturgeon: I will make some general points and then respond specifically to the point about the change fund.

I do not underestimate the work—and, sometimes, the time—that it takes to change the cultures around all of this. We are talking about specific changes that will be underpinned by legislation, but we are also talking about cultural changes to the ways in which organisations and sectors have done things. There is absolutely no doubt in my mind that the changes that we are trying to introduce will be successful only if—to state the obvious—health and social care work well together and we have genuine involvement by the third sector and professional groups, including clinical leaders who are driving things from a clinical perspective.

You characterised my approach as softly-softly rather than autocratic. I am not sure that I would characterise it as either of those. I am not an autocrat but, although I am of the view that we should do this carefully—I am determined that we will, at long last, get this right—there is a definite direction of travel and momentum behind this. Yes, we are going to consult, engage and ensure that we get the details right, but this is happening and there will no longer be any excuse for a lack of genuine integration.

I am open to hearing views from the third sector about the change fund. The change fund is still relatively new and it is a transitional fund, not something that will exist in perpetuity. It is designed to kick-start and be a catalyst for the shift in the balance of care that we all know needs to happen, and I have made it clear that the third sector must be very involved in that.

We have ring fenced 20 per cent of the change fund in 2012-13 for carers' organisations and we will be scrutinising the plans very carefully to ensure that that commitment is met. I have asked my officials to do some retrospective work on the breakdown of the change fund between the different sectors last year, because I want to ensure that we learn from how it has operated so far so that we can improve in the future and give real meaning to my desire for the third sector to have a genuine seat at the table. This should not just be a tick-box exercise; the sector should have genuine influence over how these moneys are spent.

There are bigger issues about the change fund that I will not go into at the moment—unless you want me to—including ensuring that not just the money is spent on new services in the community but that resources are transferred from institutional acute care to the community, to allow the spend to be sustainable in the longer term.

The Convener: In the evidence we heard last week, Martin Sime said that they were patronised, patted on the head and offered 10 per cent. There has not been much of a change—the ship has sailed. Cabinet secretary, the real issue here is not the objective—we are all on board in that respect—but what happens when it fails.

Nicola Sturgeon: I am not sure. I will not go down the road of trying to fit a reference to whether the ship has sailed into what I am about to say, but last year was the first year of operation of the change fund and I have just said that I want to scrutinise it to ensure that if it was not delivering a shift in resource from the statutory to the voluntary sector, or if the voluntary and third sectors were not getting their fair share of that resource, we look at how we can improve it for the future.

Our plans for 2012-13 are still in the process of being considered. I mentioned the contributions for carers earlier and we will be scrutinising the plans from that point of view. There is an open invitation to the third sector to be involved not just in local discussions—obviously that is where the real discussions on local plans take place—but in the national discussion on how we can do things better in the future, to enable and ensure a much more meaningful role for the voluntary sector. I could sit and reel off oodles of examples from my constituency—all of you will be the same—of voluntary sector organisations providing services in a way that is often more responsive to user need and more successful in keeping people out of institutional care than the services that the statutory sector provides. As we go forward with this agenda, we must ensure that such work is given due prominence and its due place.

The Convener: Thanks for that answer. Someone else might well raise the commissioning issue, too, but if not I will come back to it.

Richard Lyle: Good morning again, cabinet secretary. I welcome your comments, your proposal, your momentum and especially your comment a minute ago that "this is happening".

For too long, people have been stuck in silos. There have been two major changes to council areas that have put councils together; they have worked. There have been more than 100 changes to departments in councils; they have worked. I do not see why this should not work. You will get comments along the lines of, "We have tried it before, but it did not work," in relation to the CHPs or other projects. Will you comment on the governance structures in CHPs and how your proposals seek to resolve the situation and make it work, as I believe that it will?

Nicola Sturgeon: I do not really want to get into the business of criticising previous Governments for reforms that have not taken us as far as we might have thought that they would. All previous Government initiatives in respect of this agenda have been taken in good faith and we all hoped and expected that they would take us to a certain point of integration. They have taken us part of the way and in some areas of the country they have taken us further than they have in others. Where they have not been successful—I do not want to use the word "failed"—there was too much of a free for all and too much local choice about the degree and extent to which integration happened as well as how it happened. We had no genuine joint accountability; we still had separate silos of accountability. I do not blame health or local government for that because, in truth, on different occasions one or the other will have been more responsible, but the separate lines of accountability have meant that it is too easy to pass the buck.

Similarly, with aligned budgets that are not genuinely integrated, both organisations still jealously guard their bit of the cake. What has been lost sight of is the fact that it does not really matter whether the money belongs to the NHS or local government; what matters is how the money is spent on delivering the outcomes that we set for care. The new set of arrangements will make a difference on the latter point. That is why I have a lot of confidence—not that there will be no issues, challenges or setbacks along the way—that we will get to the point that we perhaps should have got to 10 or 15 years ago but which, for all sorts of reasons, we definitely need to get to now.

Richard Lyle: I agree that the problem in local areas has been people who are stuck in hospital and cannot get out because social work and the NHS cannot agree. We have all had many people come to us with such problems. Will you suggest to both organisations that they get together as soon as possible?

Nicola Sturgeon: They are getting together. In every part of the country there is a lot more joint working and integration than there has ever been before. My strong view is that both the health service and local government do not just accept that this is the way that it has to be done now but are up for it and agree that it is the right way to do it. We need to ensure that the legislation does not give them any escape routes that there might be a temptation to take if there is friction between the two agencies. The law must lay down certain things that they must do around accountability and integrated budgets.

In addition to the outcomes, the integrated budget is the touchstone of the approach. That will assure us that public money is being spent in the best way possible to deliver the best care possible, rather than somebody being stuck in hospital because the local authority or the health service does not want to spend the money differently to get them to a better place.

The Convener: Ranald Mair suggested last week that the joint improvement team is staffed by lovely people but maybe needs more teeth. Could it play a role?

Nicola Sturgeon: The JIT does a huge amount of good work. The teeth that will appear are the teeth that will be in the legislation: sharp teeth that make it crystal clear what has to be done and what is required. That is what is missing now. People understand, I think, what should be done, but there is no absolute requirement to do it. That is what the legislation will change.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I come back to the issues that the convener raised about the voluntary sector, which will lead me nicely on to integrated budgets.

You said that there would be legislative minimums. One way to give bite to the third and independent sector and—under self-directed support—individuals would be to give them the right to be at the table as a legislative minimum. Will you consider that option?

Nicola Sturgeon: There will be a legal right for councillors, non-executives on NHS boards and representatives of the third sector to be on the partnership boards.

Fiona McLeod: I think that that legislative minimum is probably quite important for them.

Nicola Sturgeon: That will definitely be a requirement in the legislation.

Fiona McLeod: Good. Folk will be encouraged to hear that.

You said that both health and social care jealously guard their budgets but that the integrated budget is the touchstone for making the approach work. However, we are thinking about the voluntary sector and, increasingly—under self-directed support—individuals. Representatives of the voluntary sector say that their budget is so

small that when they sit at the table they are dismissed as minnows. Of course, they bring a lot more to the table than money. Can we support the voluntary sector and individuals through the budget process and integrated budgets?

11:00

Nicola Sturgeon: Yes. My view is that, in the context of the new arrangements, the voluntary sector is there not just to speak for its resource but to influence the spend of the totality of the resource in a much stronger way than perhaps it does just now.

Fiona McLeod: I know that the convener wants to move on to commissioning. An important point in that regard is that the voluntary sector and the individual have a lot of knowledge about commissioning but not the purchasing power, yet they will often provide it: the third sector as a provider and the individual through their carer.

Nicola Sturgeon: Absolutely.

Fiona McLeod: It is good to hear that.

Dr Simpson: I think that we are covering the issues quite well, cabinet secretary. We are clear that integrated budgets will move on from the permissive system under the 2004 legislation. We had hoped that, with a good wind, integration would occur, which it has done in some areas. However, we are now moving to a position in which integration will have to happen. You will have looked at the evidence, including the King's Fund reports and the interesting Torbay experience, which arose out of adversity.

You have made it clear that the integration should happen from the bottom up rather than through a structured model that is forced on everyone. However, a big issue that concerns me is the terms and conditions of the staff involved. Is it necessary to try to integrate the terms and conditions? Perth and Kinross had great difficulty with that. Would it not be better just to leave the technical employment aspects—terms and conditions, pensions and so on—with the individual local authority and health board rather than trying to integrate them, which is hugely difficult?

Nicola Sturgeon: Our legislation is not going to require organisations to transfer staff, nor is it going to prohibit that. The lead agency model in Highland is going through the transfer of staff. I am fully supportive of what Highland is doing. Such exercises throw up all sorts of challenges, which are being worked through in Highland.

The issue you raise is one that I thought long and hard about. I suppose that it goes back to Gil Paterson's first point. If we start by saying that we are going to transfer all local authority social care staff to the health service—or vice versa—everybody's energies would be consumed by that instead of being spent on the outcomes-driven approach. That is not to say that it is wrong for partnerships such as Highland to decide that they want to do that kind of transfer. As I said, I am supportive of what Highland is doing, and if other partnerships feel that that approach is right for them, they have the freedom to follow it. However, we are not going to say that it is an essential requirement.

Dr Simpson: I think that that reassurance will be extremely welcome, and I entirely support your approach.

You have outlined accountability to you, to the local authority and to health board, and I understand that the third sector will sit on the governance body. However, I am concerned about patient involvement at all levels. Historically, we started off with very large numbers of general practice localities, which arose out of a reaction in Scotland in particular against fundholding and the desire not to have a fundholding system. Many fundholders got engaged in localities—they were the drivers. However, post-1997, when we switched to getting rid of fundholding and creating CHPs, we unfortunately lost the locality developments. The number of CHPs has reduced substantially and some of them have become huge bodies that are not that different from health boards, so the local accountability to local communities has been lost.

I am sorry to make such long and tortuous background comments but I wonder whether, in light of Audit Scotland's report on CHPs and the huge variation in their success, you will move to a much more local model or whether you will require the recreation of what the Royal College of General Practitioners calls clusters, which I have called networks and which have previously been called localities or local healthcare co-operatives. There are many names for the concept, but it all comes down to having a locally accountable model that engages both clinicians and patients.

Nicola Sturgeon: The short answer is yes—but I will give you a much longer answer.

Many expert groups have been examining different aspects of the issue, and one is about to start looking at how we ensure that we get not only public engagement, which is really important, but clinical engagement, which I want to talk about in response to your question: clinical engagement at every level from service planning and commissioning right up to the governance of the partnership boards at the top. The very clear intention is for the partnership board and individual general practitioner practices to have that kind of locality arrangement. We can discuss whether we should call it a cluster approach, locality planning

or whatever but, in my view, that level of planning, involvement and accountability will be critical to success.

Someone recently asked me whether all this meant a return to LHCCs. I would say that it did, to a point; the key difference is that although GPs will play a critical role we have to take a much wider approach and involve all sorts of clinical and professional interests. However, one of the prerequisites of success will be having clinical drivers at a locality level.

Dr Simpson: I very much welcome that response. I have to say that there is no disagreement between our parties on the direction of travel.

I keep referring to the Mitchell report, which is another scar on my back. It came out a long time ago—in 1979, I think—but I think that it is worth revisiting because it proposed a new relationship between social work and health that was never followed through. If it had been, we might not be sitting here today wrestling with these issues.

Nicola Sturgeon: I will not depress Richard Simpson by telling him how old I was when the Mitchell report was published. However, I am happy to see whether we have a copy and, if so, I will dig it out and take a look at it.

The Convener: Will the GP contract act as a barrier to any of this?

Nicola Sturgeon: I would not describe it as a barrier in any concrete sense. The committee might want to discuss this in future, but we are looking at how to make GP contracts more responsive to Scottish needs. I am not suggesting that we rip up the United Kingdom contract and start again, but if we could set and negotiate certain aspects of the contract here in Scotland we could make it much more responsive to Scottish needs. Clearly, more than anything else, we want to make the integration of health and social care a priority that the contract aids.

Bob Doris (Glasgow) (SNP): I want to pick up Richard Simpson's comments about what you have described as locality planning. We have discussed commissioning, which is a term that can make it appear a very dry tendering process and can set hares running with regard to the kind of structure that you want. Instead, the committee has been talking about co-production at a very local level.

Perhaps I can draw a comparison with community planning partnerships. In some parts of the country, there is a feeling that a central plan is being imposed on a locality. Certainly the third sector and other groups are keen for health and social care integration on the ground to start with people asking what will work in a particular locality and to give a bottom-up structure to health and social care partnerships. Should any indication of how locality planning might work be contained in the bill or set out in guidance? After all, we need to get everyone on board and ensure that the third sector, carers groups and others are not simply directed to their own percentage of the budget and that there is holistic thinking about locality planning.

Nicola Sturgeon: Commissioning is about assessing need in an area, designing the services required to meet those needs and procuring, or securing provision of, those services. I suppose that, traditionally, and not just in Scotland but in most countries, that has tended to be a top-down approach, with statutory agencies doing the planning and deciding what a particular section of the population or a particular area needs.

If Harry Burns was here, he would be going on at length about the assets approach and making sure that we are using all of a community's assets. That means two things. First, as with Richard Simpson's point, we need to inform the whole process at as local a level as possible. Secondly, we need to involve as many clinical people and members of the public as possible so that we bring to the table not just what the budget is for the services but the totality of the local community's resource. That requires a distinct shift in thinking and mindset, which is not easy. However, there is no doubt that that approach could be a lot more successful in genuinely meeting the needs of an area or a section of the population than alternative approaches.

Bob Doris: I know that you want to be flexible about what the structures will look like. Do you envisage localised budgets for integrated health and social care services so that key partners such as local GPs, carers groups and patient representatives can decide the best outcome for their local area, and so that cash will be available for redesigning the services?

Nicola Sturgeon: It will be useful to tease out such issues during the work that lies ahead. It is possible that a one-size-fits-all approach will not be needed. We need appropriate levels of devolved decision making, and I believe that local decision making is better. We will have to use the consultation to tease out what that will mean for local budgets.

Bob Doris: I will switch to the autocratic approach. I am trying to push towards more localised planning for health and social care integration but the Audit Scotland report keeps going back to how we need clear lines of leadership and accountability, with one person responsible for the global budget and for driving change at every level. That might seem contradictory. On leadership at the top of health

and social care, that one person would be accountable to you, the health board and the local authority. How do we tease out to whom the person at the top is ultimately accountable? If they are accountable to too many people, could that dilute their effectiveness?

Nicola Sturgeon: That accountability will have to be integrated. One of the key features of the system that we are designing is the single accountable officer, which will help to give form and meaning to the integrated budget. That person's accountability to me or to whoever sits in my seat comes through the health board accountability structure—and health boards are accountable to me and to local authorities already. Of course, the key point about accountability for delivery of the outcomes that will be set is that there will be accountability to the partnership board. In a sense, along with local authorities, my part in the process is to set the outcomes that the partnerships must deliver and to intervene to take appropriate corrective action if a partnership is not delivering those outcomes.

Bob Doris: I am just trying to tease out how effective that will be. When the system rolls out, there will be some great successes, whereas some areas of the country will need to do better. It is the same when anything rolls out: there is always room for improvement. How can change be driven, whether at a national level or at a partnership level, when some parts of the country do not perform as well as they should? I want to predict success but the reality is that there are 32 local authorities and some will do better than others.

Nicola Sturgeon: Central leadership for the system will be very strong. In several different contexts, we have already touched on the tension between what you have described as the autocratic approach and a hands-off approach. As I say, I do not think that we will see either of those things, but I am not saying, "Do this if you feel like it." The system will be very strongly driven by local partnerships taking ownership. That is what will happen in most cases when we get the legislative underpinning right. As a minister, my interest will be in ensuring that those partnerships deliver the outcomes that have been set. If that is not happening in any area, it will not be allowed to go by the board.

Bob Doris: Thank you for that answer. I merely put it on the record that my views on the matter have perhaps been coloured by Audit Scotland's report on Glasgow's experience, and by the cultural resistance that we have had there. I hope that, with statutory underpinning, that will change.

11:15

The Convener: On the question of leadership, the cabinet secretary has gone a long way towards confirming from the top that the legislation will set out a focus on outcomes. I presume that it will also set out a method of evaluating those outcomes and a process of accountability.

Some witnesses expressed concern—at last week's meeting, I think—that it is unreasonable to give a single accountable person in each area responsibility for all the health and social care in their area. The other side of that is that there will be a mechanism under which they will report to the cabinet secretary on a six-monthly or an annual basis. That idea is being knocked about. We need to strike the right balance. Given the challenges that we know will emerge, is it reasonable for a single person to be accountable in each area?

Nicola Sturgeon: The concept of single accountability is really important. We are not saying that one person has to deliver everything, as they will be supported by a substantial infrastructure. However, just as the chief executive of a health board is the accountable officer for that health board, or the chief executive of a council is the accountable officer for that council, it is perfectly reasonable for accountability to rest with one person. Not only is that reasonable—it is right, because it ensures that there is an organisational focus across everybody who works in the organisation on meeting the objectives for which that person is accountable.

Nanette Milne (North East Scotland) (Con): I appreciate—indeed, I was delighted to hear—what you said in your response to Richard Simpson's questions.

The proposals refer to adult services and are particularly focused on older adults. A number of people have pointed out the linkages between adult services and children's services—for example, young carers look after older relatives, and there is a transition when children go into adult services. It has been argued that the agenda should include all age groups. Is that planned for the future? Will you elaborate on where you are going, assuming that the agenda is successful?

Nicola Sturgeon: I will elaborate on that without, I hope, going on for too long. We have thought about the scope of the integration carefully and we have had lots of discussions about it. My mind was changed a wee bit during the early discussions. I came at the issue from the viewpoint that we should initially focus on older people's services, but then the point was made to me that somebody can have dementia at 55. Particularly in deprived areas, the health problems that we associate with old age can strike people at

a much younger age, so trying to separate out older people's services would create practical difficulties, and perhaps raise equality issues. The scope is therefore all adult services.

That said, I am clear that the early priorities are around the care of older people. When you see the suite of outcomes and indicators on which we will consult, you will see an emphasis on improvements to the care of older people. That is the scope that we are dealing with.

Points have been made about children's services. As we do the work, we will be very careful that we do not inadvertently unintegrate things that are already integrated in local areas. There are local partnerships; East Renfrewshire is a good example, because it has an integrated approach to all services. Nothing in what we are doing will lead to its having to unpick that. Equally, our saying that the scope is adult services does not prevent partnerships from deciding to have an integrated approach to other services. Alexis Jay, the chief social work adviser, is doing work around some of the issues to ensure that in trying to integrate adult services we do not inadvertently create issues elsewhere.

It is clear to me that the principles of integration will apply generally. I say quite openly that if we can demonstrate the benefits of integration of adult services, as I hope and expect that we will do, the direction of travel over the longer term will be towards ever-greater integration of provision. For a variety of reasons, however, it is right that we focus on adult services at this stage, as we set the legislative framework.

Nanette Milne: Will the approach lead to problems in Highland, where I think that the health board is leading on older people's services and the council is leading on children's services?

Nicola Sturgeon: Highland has decided to integrate children's services as well as adult services. Nothing that we are doing will get in the way of what Highland is doing. We have been careful about that, because, as I said, I support what Highland is doing. Our setting a legislative framework for adult services will not stop any partnership deciding to apply the same principles to children's services; what it means is that the legislation will focus on adult services.

Nanette Milne: I just wondered whether integration will be more difficult in the long run if an authority leads on adult services and a board leads on children's services. Do you foresee problems in that regard?

Nicola Sturgeon: Do you mean in Highland, specifically?

Nanette Milne: I am thinking more about the principle of a local authority leading on one set of services and a health board leading on another.

Nicola Sturgeon: The whole point is to ensure that health and social care work in a much more integrated fashion generally.

Richard Lyle: As you clarified in response to Nanette Milne, at this stage you are focusing on the integration of health and social care, not health and social work. That is not to say that that will not happen in a number of years' time, as we continue to think about the issue—I will leave that to one side.

It has been suggested that GPs did not support community health partnerships as they should have done. What do you think about establishing clusters of GPs to advise and interface with the new partnerships?

Nicola Sturgeon: I think that we covered that crucial issue in response to Richard Simpson's questions.

It would be unfair to say that CHPs did not have good engagement with GPs in any part of the country. In some parts of the country the engagement worked reasonably well; in others it did not. In south Glasgow, which I represent, GP involvement was not as it should have been. I am not saying that that was the fault of GPs or anyone else; it just did not work.

As I said, vital to the success of integration is ensuring that we have good locality planning, with clinical involvement. GPs will have a critical role to play, as will other professionals.

Richard Lyle: Maybe your officials can help me on my next question. I understand that in Orkney the director of the NHS is also the director of social work.

Nicola Sturgeon: The chief executive of NHS Orkney is director of social care.

Richard Lyle: Yes, and that lady works hard, I understand, to integrate services exceptionally well.

Nicola Sturgeon: Orkney is another example of a partnership that is getting on with and taking a good approach to integration. I have been up to Orkney to talk to people and see what they are doing. They are doing a good job—all power to their elbows. Cathie Cowan, who is chief executive of the health board, has a joint role, which helps to drive integration and probably demonstrates very well the principle of single accountability. She used to work in one of the CHCPs in south Glasgow, so she probably had a lot of perspective to bring to bear in Orkney.

Jim Eadie: You said that care must be provided at the right time and in the right place. I think that

we all agree that people need to receive care in the setting that is most appropriate to their needs.

The reality is that much resource is tied up in the acute sector, which is a challenge. About a third of the overall resource is spent on unplanned emergency admissions, and if we could save even a tenth of that we would release some £560 million over the period of the current spending review, which is a significant amount of money.

Do you agree that the success of integration will be predicated largely on whether we are able to bring about the shift in resources from the acute sector and institutional care to the community? I am mindful of the examples from your constituency that you alluded to, which resonate with me, as a constituency case of mine involves a situation in which good work is being done in terms of daycare in the independent sector but there is a struggle to find resources from local authority resource streams.

Nicola Sturgeon: The shift from acute to community is essential. To be frank, I would not mind if a third of expenditure on older people's services was tied up in hospital care if I thought that that was the right place for most older people. In a situation in which an older person needs to be in hospital, they should be in hospital. However, a lot of older people would be much better cared for in a community setting—in their own home—with the right care package.

In terms of integrated budgets, it is vital that a portion of acute spend is included so that we can effect that shift in a planned and managed way and enable services in the community to build up in a way that supports our efforts to ensure that fewer older people have to go into hospital.

Another important point, which members of the committee will be aware of, is the demographic challenge. We can reduce hospital admissions by 20 per cent but, because we have growing numbers of older people, that might not reduce the need for acute care, unless we really get ahead of the curve. The issue that you ask about would be important without the demographic challenge, but it is essential with the demographic challenge. It is a key part of our work.

Jim Eadie: Will you address that in the consultation paper?

Nicola Sturgeon: Yes. The shape, the scope and the content of the integrated budget will be very much part of it. The change fund, issues around which we have touched on already, is meant to be kick starting that shift away from acute and into the community.

Jim Eadie: Will the consultation paper refer to how we can measure progress and success to ensure that we are achieving the outcomes that we want to see?

Nicola Sturgeon: The outcomes and the indicators that we would use to measure whether they have been successfully achieved will be detailed in the consultation paper.

Dr Simpson: We have created a lot of clarity today, not least around the fact that none of us ever proposed a new national care agency. We had been portrayed as having suggested that, but we did not. I assume, however, that we will have national standards, and the cabinet secretary has made it clear that we will have outcomes, monitoring and leadership from the centre and that there will be a legal minimum requirement for representation on the partnership boards. That is all very helpful.

Presumably, the data from the IRF pilots show considerable variations. To me, variation is the big theme of the current austerity situation. If we can eliminate inappropriate variation—not all variation will be inappropriate—we will have achieved a lot. Are you confident about the way in which the IRF pilots are proceeding? Are they showing variations that are capable of being tackled more readily by an integrated process?

You talked about a 20 per cent reduction in admissions. The paper that was published by Lewis Ritchie said that that had been achieved in Nairn through an integrated process that uses what amounts to a precursor of the IRF. I know that you were just making a suggestion, but it is achievable, with the right approach.

That was just a comment. My question was about the IRF pilots and when the pilot results would be available for us to look at.

Nicola Sturgeon: I will let Kathleen Bessos talk about the IRF pilots in a second.

My use of the 20 per cent figure was illustrative—at least I got it where Lewis Ritchie got it. The point that I was making about the demographics is that a health board could reduce hospital admissions by 20 per cent, but if the number of older people is rising, the requirement for beds in acute hospitals will not necessarily be reduced. It is necessary to get significantly ahead of that curve to enable the shift of resource to take place.

You asked about variations. We are confident in the way in which the pilots are proceeding. They are showing variation. I fully agree with you about the distinction between legitimate and avoidable variation. It is my strong belief, not just in the context of the IRF work but in relation to efficiency generally in the health service, that eliminating avoidable and indefensible variation is the NHS

boards' route to meeting a large part of the efficiency requirement.

11:30

Kathleen Bessos: I will say a few words before passing over to Alison Taylor, who has had more in-depth involvement with the pilots.

In the evidence on the IRF that the committee received from stakeholders, practitioners on the ground described how important and helpful the IRF process of mapping, understanding variation and considering how the pathways of care need to evolve has been. The partners who have taken forward the pilots gave tangible examples of the practical measures that they have taken on the ground.

We think that the report on the lessons learned will be available in April. I think that enormous lessons will be learned on culture and leadership, rather than on just the mechanics of the data involved.

Alison Taylor (Scottish Government): The evidence on variation that is coming out of the IRF pilots is quite striking. Such work makes the greatest difference in places such as Nairn, which Dr Simpson mentioned. As he said, the work that has been done there builds on the original work on the IRF that was done in Highland some years ago. That reinforces the importance of the points that the cabinet secretary made about effective locality planning and the role of local clinicians, the extended primary care team and social care professionals in coming together and planning effectively for the best outcomes for the local population, all of which were factors in the shift that was evidenced in the paper that Dr Simpson alluded to.

The Convener: As there are no further questions, I thank the cabinet secretary and her officials for their attendance and their evidence.

We move to agenda item 7, which gives us the opportunity to discuss the main themes that have arisen from the extremely useful evidence that we have received during our inquiry over the past few weeks. At our meeting on 7 February, we agreed to present our findings to the Scottish Government as part of the consultation process that the cabinet secretary referred to and to use them to scrutinise any future legislation.

Do members agree that we should discuss the main themes and draft a short report that sets out our key findings?

Members *indicated agreement.*

The Convener: At this point, it might be useful to go round the table. There will be recurring themes, so if someone mentions a particular area, I do not think that it needs to be repeated, unless anyone objects. Let us start with Fiona McLeod.

Fiona McLeod: Okay. I was just starting to write down the key themes.

As the committee knows, one of the themes that I have pursued is the role of the voluntary or third sector. In addition, I have recently been struck by the role of the independent sector—I say that because I now have a family member in the independent sector. It was interesting to talk to the cabinet secretary about legislative minimums to ensure that the sectors will have an equal voice, not just in the process of deciding how a health and social care partnership should work, but in other matters such as the commissioning of services.

There are loads of issues, but I will just pick two—I am sure that members will mention others. The second issue that I want to raise, which we came to at the end of our discussion with the cabinet secretary, concerns the movement of resources from acute to community provision. As the cabinet secretary said, the acute sector will always have a voracious appetite for resources but, given the demographics, if we do not start moving resources from acute to community services, we will not be able to do the preventative work in the community so that folk do not need acute spending.

Nanette Milne: What stands out for me is the crucial importance of the lead from clinicians and social care professionals.

Drew Smith (Glasgow) (Lab): The key issue that I want to raise, which the cabinet secretary went a long way to addressing, is that it is not acceptable just to say that a culture change is required and that we will be doing well if we get the culture right. We are talking about significant sums of money in an important policy area that generates a lot of concern, particularly for families who have an older person in hospital and waiting to get out. I am encouraged by the cabinet secretary's comment that a minimum level of integration will be required.

Another aspect that I want to mention, which did not really come up today, is to do with accountability. I am concerned that the structure will be so complicated that those who are supposed to hold the service to account will find it difficult to understand everything that is involved and to get through the papers. For the public to be able to hold a service to account, it must be understandable by a reasonable person.

Dr Simpson: The discussion with the cabinet secretary has drawn together many of the themes, which has been helpful. We are moving from a permissive approach to one in which there are minimum standards and minimum requirements,

but which beyond that is permissive in that it allows individual groups to go as far as they feel they wish to in the interests of the local community. We have talked about an autocratic approach versus a permissive approach but, actually, the changes are about ensuring that we no longer say that integration cannot happen at all, which is what has happened until now in some areas—some areas have not done it at all.

A second point that has come out to me in the evidence, and particularly in today's meeting, is that we need to make the system as local as possible. The process is not about creating 14 more health boards and calling them HSCPs; it is about creating genuinely local groups that genuinely engage with their local communities.

I hear what Drew Smith says about the complexity of upward accountability, but for me the point that must come out in our report is the need to tackle the democratic deficit in the area. The cabinet secretary referred to the inclusion of not just non-executive health board members, but councillors. That happens in some CHPs, but those people need greater involvement so that we have democratic accountability. The partnerships must include councillors, patients and the third sector as well as clinicians and non-executive health board members. Our report should point out the strength of that degree of accountability.

I will not cover all the points. For now, my final point is that it will be critical to have outcomes that are underpinned by good and effective data collection. The IRF's role in ensuring effective data collection to explain variation will allow the Government and the Parliament to scrutinise the process effectively.

Gil Paterson: It is clear to me that, to a lesser or greater extent, people are looking for structural change, although many people are hesitant about it. It is not possible or practical to have integration without some form of change. Richard Simpson mentioned that point, which I would like to be one of the themes in our report.

When it comes to an accountable person, what was described sounded more like line management than a system of overseeing the process, particularly when two great regiments or disciplines, if you like, are coming together to make a single outcome. It would be better to focus on how the service is delivered. It is a bit like business; accountability should go down the line management system and people should be accountable at different stages of the process.

Richard Lyle: I agree with most of those comments. There has to be more political accountability. Some of the areas that I represent have only one councillor on the health board. There should be more accountability.

I am all for dismantling the silo mentality. I have spoken on that theme consistently. We must secure the quality and safety of integrated care. If we get that right, the public can be confident that they will get access to the professional care that they need, and that their loved ones who are in hospital or under any type of care will get the respect, help and care that they require.

Jim Eadie: I agree with much of what my colleagues have said. The key thing that our report needs to flag up and highlight is the challenge of shifting resources from the acute sector and institutions into the community, where they will make the biggest difference to people's lives. We should also flag up the change fund and, within that, the independent sector's ability to access resources. That was one of the points that emerged in last week's evidence, along with the role of integrated budgets and making that a reality.

I would like our report to refer to evaluation of the integrated resource framework in the pilot areas and how that can inform the wider issues that we have been looking at. It would be helpful to encapsulate the key principles that the cabinet secretary outlined on which there is broad agreement across the committee, such as joint accountability, integrated budgets, and the need for professional and clinical leadership. We should build on Richard Simpson's point about national leadership and guidance. We are moving from a permissive environment to one in which the system will be a requirement. It is no longer something that would be nice to do; it must be done.

Finally, we should include the outcome measures, which are the key indicators that will allow us to evaluate progress and success over time, and show what they look like. That is an opportunity for us to call on the Government to do what we think is necessary to embed change.

Bob Doris: I welcome the short and focused series of evidence sessions that we have held on the integration of health and social care, but I am conscious that we do not have a bill to look at. We will still have to scrutinise the main meat and any further themes once the bill has been introduced. On that basis, I will make a few comments.

We have spoken about the need for culture change and the cabinet secretary has given evidence that there has been culture change in some parts of the country. We have seen Highland moving forward and, in the NHS Greater Glasgow and Clyde area, we have seen East Renfrewshire move on with health and social care integration, but that has not happened in Glasgow. We have seen culture change in some areas but not in others, so I think that we need to add the caveat that we now need the statutory underpinning to

drive forward more consistent culture change across the country. We should welcome that.

The evidence sessions have teased out the Scottish Government's focus on certain elements such as a single accountable officer; driving forward integration of health and social care; and integrated, not aligned, budgets. I certainly welcome the cabinet secretary's clear comments on that last issue and think that it should be monitored when we consider the bill itself.

11:45

We have discussed how to get accountability and democracy into the system. On balance, I do not think that the proposals are a threat to democracy and accountability; in fact, they present a real opportunity to have more accountability and democracy, because carers groups, the third sector, the independent sector and GPs will have more of a role in the co-production of services at a local and strategic level.

On that point, we should return to the issue of co-production. The third sector and other groups should be involved not just in signing off a centrally produced strategic framework, but in the co-production of outcomes and service design at a local level.

Finally, the committee will need to pay close attention to the findings of the integrated resource framework pilots when they become available in April. We should commend the Government for taking forward a vital initiative in the pilot areas; indeed, one might lament the fact that it has taken until now for health boards to push intelligence gathering into service design. After all, as Audit Scotland made clear to us, the boards should have been doing that as a matter of course because they had data that they could have used in that respect. We should certainly highlight a couple of examples in which such information has been used. Thinking off the cuff, I believe that Ayrshire has used local data to locate a new health facility and Perth and Kinross has used it to further integrate health, social care and housing at a local level. The approach seems to be driving change.

You asked us to be brief, convener, so I apologise for providing such an extensive list.

The Convener: That is fine. After all, this is the opportunity for members to comment.

However, I am not looking for members to be exhaustive. For a start, we have time to read the cabinet secretary's remarks and to feed our comments to the clerks. This is our opportunity to assist them in producing a report for us. Looking at my scribbles—I have a lot of them—I think that we need to emphasise the issue of the change funds, which have been something of a driver, and the unequal partnership that seems to exist between the health boards, the local authorities and, indeed, the third and independent sectors, whose representatives were very focused in their concerns.

I welcome the cabinet secretary's comment that she is focusing on people rather than structures, which not only takes us into the whole issue of commissioning and the principles behind it but takes us back to our regulation of care for older people inquiry, in which we found commissioning to be a significant driver.

As Jim Eadie pointed out, we have heard evidence that the shift from the acute sector to primary and community care is difficult and takes a long time. The issue is certainly worth looking at.

Other issues that we return to time and time again include corporate structures; workforce planning that meets the local community's needs; accountability; measurable outcomes; and the big elephant in the room—the fact that we are doing all this at a pretty difficult time. As Theresa Fyffe asked last week, does service redesign simply mean service cuts? There is less money to spend, but that should not prevent us from redesigning services. In fact, it should be a driver in ensuring that the most vulnerable people do not pay the price for tightening budgets. We have a clear responsibility in that regard.

I think that that is all I have to say. We have had good evidence sessions in the past couple of weeks, as Bob Doris said—I see that Nanette Milne has thought of something else.

Nanette Milne: Yes. I was thinking about the cabinet secretary's response to my question about not including children's services, when she gave reasons why she is focusing on adult services at this stage.

The Convener: Yes. It will be wise to have a look at what the cabinet secretary said. I think that there are a couple of areas in which people can be diverted by the change that is happening around them, which makes things difficult. Also, telling people to focus on adult services carries a wee risk, as I think that the cabinet secretary recognised.

Dr Simpson: I do not know whether I said this. It would be reassuring if we could mention in our report that there will be no wholesale transfer of staff under transfer of undertakings and protection of employment arrangements. There will be a permissive approach, as the cabinet secretary said. If people think that the approach that Highland is taking is the right way forward, that is fine, but there will be no requirement to take such an approach. It will depend on the structures that

people locally think are most appropriate. It could be reassuring for staff to hear that.

The Convener: Henry Simmons put it well at last week's meeting, when he talked about what we are trying to achieve not necessarily being helped by upheaval. We should use the evidence that we have received, rather than look specifically at TUPE.

Gil Paterson: I hope that this is the right moment to say this. I did not think that the third sector was looking for access to resources; I thought that it was more interested in directing resources. That is what I took from our evidence session with the sector. Jim Eadie made the point about access to resources—does he agree?

Jim Eadie: We should be guided by what was said in evidence.

Gil Paterson: That sounds sensible.

The Convener: Some witnesses mentioned the share of the budget, but I think that the important point—perhaps we should bear it in mind when we consider health board budgets—was that we should monitor not people's share of the budget, but how the money is used and the outcomes. The most important question is not how much money is shifted in total, but what is the outcome of the spend. I think that Ranald Mair made that point strongly last week, and I think that Henry Simmons said that small amounts of money can make a huge difference. How the money is used is what we need to bear in mind in our future work.

Bob Doris: I concur with Gil Paterson's understanding of what the third sector was saying. The sector was not asking for more money, but was saying that when it is at the table at which decisions about service redesign are made, in the best interests of individuals and patients in the wider community, its voice should be equal to anyone else's voice, however much money people bring to the table. I understood the sector to be talking about equality of status.

Richard Simpson made a reasonable point about TUPE. However, our concentrating on that issue to the exclusion of other potential structural changes would not give the issue the right weight. I picked up strongly from the cabinet secretary that integration is about not structural change but focused legislative underpinning, to drive cultural change, and that there is no thirst for structural change at local level anywhere in the country, through TUPE arrangements or otherwise. We did not take much evidence on that side of things; the evidence that we heard was that the Government does not want to impose a structure on local areas and wants local areas to do what they want to do, based on the statutory underpinning that will be in the bill that we have yet to see and scrutinise.

The Convener: We will need to refer to the evidence. As I understood him, Richard Simpson was making a slightly different point. I thought that he was saying that the TUPE approach is ruled out. However, the witness from the ADSW told us last week that although he did not agree with the approach in Highland, where people are getting into TUPE and everything else, he did not disagree with that happening if local people had decided that it was the best way forward. Such an approach could be taken in some areas. If Richard Simpson is suggesting that the approach should be proscribed—

Dr Simpson: I was saying that it is neither proscribed nor prescribed, one way or the other—

The Convener: We can note the debate. That will be helpful to the clerks. I thank members for their co-operation. Well done everyone; we have finished in time to go for lunch.

Meeting closed at 11:55.

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e-format available
ISBN 978-1-4061-8565-2

Printed format published
ISBN 978-1-4061-8600-0

Printed in Scotland by APS Group Scotland