The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 13 March 2012

Session 4

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CONTENTS

HEALTH AND SPORT COMMITTEE
10th 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:

Theresa Fyffe (Royal College of Nursing Scotland)
Dr John Gillies (Royal College of General Practitioners Scotland)
Phil Gray (Chartered Society of Physiotherapy)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Andrew Lowe (Association of Directors of Social Work)
Ranald Mair (Scottish Care)
Martin Sime (Scottish Council for Voluntary Organisations)
Henry Simmons (Alzheimer Scotland)
Lynn Williams (Princess Royal Trust for Carers)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Tuesday 13 March 2012

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

Subordinate Legislation

Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012 (SSI 2012/36)

The Convener (Duncan McNeil): Good morning and welcome to the 10th meeting in 2012 of the Health and Sport Committee. I remind all those present that mobile phones and BlackBerrys should be turned off as they often interfere with the microphone system. Apologies have been received from Drew Smith.

Agenda item 1 is consideration of a negative instrument. The Subordinate Legislation Committee has drawn the regulations to the Parliament's attention on the basis that certain matters could have been more clearly expressed and there has been a failure to follow normal drafting practice, but it has not called for them to be annulled. It is disappointing that these issues have arisen and I am sure that the committee will wish to monitor the implementation of the patient rights complaints procedure to ensure that it works effectively for patients and their representatives. Do members have any comments?

Jackson Carlaw (West Scotland) (Con): As one of a number of members serving on this committee who have previously served on the Subordinate Legislation Committee, I would like to add force to your remarks. The briefing note that we have received from that committee is quite sharp in tone. Although it does not call for the regulations to be annulled and leaves it open whether the issue is just a difference of opinion about interpretation, it is important that the implementation and monitoring of the procedures are effective. I think that there is an issue with the drafting and I do not think that the Scottish Government's response was wholly satisfactory. I think that something more could have been done. I am content for us to proceed on that basis but, as we received a briefing on the regulations that is comprehensive and quite pointed, I think that we should note that.

The Convener: Does the committee agree that we do not wish to make any recommendation on the regulations, but that we will draw the Government's attention to the committee's comments on the record this morning?

Members *indicated agreement.*

Patient Rights (Scotland) Act 2011 (Commencement) Order 2012 (SSI 2012/35)

The Convener: Item 2 is consideration of an instrument that is not subject to parliamentary procedure. It is a commencement order that brings into force certain parts of the Patient Rights (Scotland) Act 2011. Does the committee agree to note the order?

Members *indicated agreement.*

Integration of Health and Social Care

The Convener: Item 3 is our inquiry into the integration of health and social care. I welcome the panel of witnesses who are with us this morning. We have Lynn Williams, policy officer for Scotland for the Princess Royal Trust for Carers; Martin Sime, chief executive of the Scottish Council for Voluntary Organisations; Ranald Mair, chief executive of Scottish Care; Annie Gunner Logan, director of the Coalition of Care and Support Providers in Scotland; and Henry Simmons, chief executive of Alzheimer Scotland.

Given the time constraints, if there is broad agreement on an area, it will not be necessary for everybody to verbalise that. If you do not answer a particular question, we will assume that there is broad agreement on the points. That may help us get through.

Gil Paterson (Clydebank and Milngavie) (SNP): Good morning, everyone. From the written evidence that we have received, I think that we can already see a common theme of concern about structural change. The Alzheimer Scotland submission pretty well sums up what has happened in the past. I will read from it and let folk comment. The submission states:

> "We consider there is an inherent danger in focusing attention on the structural reorganisation essential to create full integration; this would be a hugely costly process. It would also be the main focus of attention for the next couple of years, at a time when it is essential to concentrate efforts on demographic changes."

Given your experience, what are your perceptions of what happened in the past and how should we go about it in the future?

Martin Sime (Scottish Council for Voluntary Organisations): I begin by broadly agreeing with Alzheimer Scotland's statement. Concern has been expressed by the third sector that the time and energy spent on dealing with structural matters, organising the legislation and so on will somehow detract from the time and energy spent addressing the need to make change on the ground and at the front line where it really matters and has an impact on individuals. That is bound to be a feature over the next couple of years, but it leads one to ask whether structural change is necessary and should be the top priority and how it fits with the need to make changes on the ground. The current focus—certainly in some quarters—on structural change is misdirected; such change must have a point, must be seen in a wider context and must be part of a narrative that is about compelling change on the ground.

That said, the other question is whether the current structures are sufficient to engender the necessary changes on the ground. One has to conclude that there are outstanding issues with regard to the integration of health and care systems and to wonder whether that is really to individuals' benefit. I commend to the committee Iain Gray's article in today's *Scotsman*, which is a personal story about one of his relatives and their experience of the health and care systems. I think that his comments will resonate widely with individuals who have faced difficulties in that respect. We might need a certain amount of structural change, but any such change should not take the focus away from the front line.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): I, too, broadly support the comment in Alzheimer Scotland's submission. Our message to the committee is that this project is about better outcomes, not about integration; integration should be seen as a means to an end rather than the end in itself. It should be about the integration of health and social care, not just the national health service and local government, although I think that we will find that that is what the legislation will mostly be about.

That is partly because that is where the money for health and social care lies. However, we would argue that that is not where all the assets are; those assets include families, unpaid carers and third sector organisations—and I am sure that Ranald Mair will also include independent sector organisations in that. Indeed, most social care is delivered not by the NHS and local government but by the independent sector. We will want to consider the detail of the legislation and the various structural issues in the context of how far they draw those assets into the partnership instead of simply being a narrow matter of two public sector organisations sorting out arrangements between themselves.

Ranald Mair (Scottish Care): I add to the unanimity behind the view that we should not pursue structural change. Any proposed change should relate to the clarity of the outcomes that have to be delivered. Certain planning functions need to be carried out in an integrated way but, as those from third and independent sector organisations have made clear to the committee, any integration must involve us as much as the two statutory parties. Otherwise, we will have a public sector monolith that third and independent sector organisations will find even harder to engage with.

Integration must empower the people who use and need services and the third and independent sector organisations that deliver the bulk of the services. Considerably more than half of the social care workforce is now in the voluntary and private sector and, whatever one's views about the merits of such an approach, the fact is that the bulk of

care services is not being delivered by local government. Because of that, the model of integration cannot be structural; structural change cannot co-ordinate such diffuseness and one might have to look at, for example, integrated planning.

The proposal to have an individual jointly accountable to councils and health boards also creates the danger of driving the perception that structural change is necessary. I was at a discussion with chief social work officers who were struggling to see how anybody could be the responsible party if they were not overseeing a department or organisation that was integrated. We must clarify what that role is intended to be accountable for. It may be appropriate to have somebody who is accountable for the change agenda and for the elements of integration that are being sought, but we must make it clear that there will not be somebody who is responsible for all health and social care delivery, because that would be an impossible task, particularly if we want to keep structural change to a minimum.

Lynn Williams (Princess Royal Trust for Carers): I broadly agree with Alzheimer Scotland's statement and the other witnesses' comments about the need to focus on people.

From our perspective, we want to make a few points. First, the focus on carers and service users is critical. We can get bound up in looking at structures, budgets and processes. In fact, at a recent event run by the Coalition of Carers in Scotland, which involved about 70 carers, one carer stated:

"It is people not systems which will make or break integration."

We should think about how the current system operates from a carer or service-user perspective. In preparation for this meeting, we looked at what kind of journey an unpaid carer might take through the system as it works now and at the terminology and the different processes. We looked at matters such as single shared assessment, community care assessment, financial assessment, eligibility criteria, occupational therapists and physiotherapists. There is a range of professionals and terminology.

The driving force behind the plans must be how the system works for people at ground level. We know that integration will happen, so how do we turn the focus away from structures and back on to the experience of people for whom the system sometimes works but sometimes does not?

Another quote from the event refers to the challenges that we face. One carer stated that there is a

"Great need to stop layer after layer of bureaucracy/ladder to climb when wanting help."

Families must still face and tackle significant bureaucracy to get the support that they need.

I emphasise Annie Gunner Logan's point about our existing assets. We have more than 600,000 adult unpaid carers in Scotland, without whom we would have to find £10.3 billion to replace that care. How do we ensure that, as part of the focus on integration, we have a strong focus on prevention? The vision in the Christie commission's report about the role of prevention in, for example, ensuring that carers are supported so that they can look after themselves, keep well and continue caring, cannot be missed.

Henry Simmons (Alzheimer Scotland): Our submission goes on to say that there is a lack of any coherent set of principles and values to govern change. Gil Paterson asked about historical issues. The primary social work legislation is still the Social Work (Scotland) Act 1968, which has been amended so many times that we have lost the core principles behind it. The biggest amendment was made by the Community Care (Scotland) Act 1990, which has since been amended. That legislation transformed the way in which the sectors operate and link with each other.

We should spend time considering the principles that should govern the legislation. It has been suggested that there should be a more technically orientated bill. I urge the committee to think carefully about trying to get a coherent set of principles that guide us through the change. Our experience is that every good piece of legislation that has come out of the Parliament has principles that can govern and guide practitioners as they implement it. That is an important part of the argument to support our statement.

Gil Paterson: Further to that, how would we achieve successful integration? Some comments have touched on that point, but can you develop it a bit further?

10:15

Ranald Mair: The information that the committee sent out contained all the right questions, such as, "What is your evidence of what works?" The processes that we have set in motion with reshaping care and the change fund need to embed what has become evident even in year 1, which is that we can oblige people to sit around a table, but that does not in itself deliver change. It is the cultural shift in how people work together to deliver locally that will be important.

My hesitation is about driving things forward through legislation before we have embedded and evaluated what we have set in motion. We have self-directed support coming through, which is a huge change in the landscape, with its agenda for empowerment and personalisation. Will we

evaluate that before we embark on the next phase? This is year 1 of an intended four years of reshaping care and the change fund. Will we allow change to be embedded and evolve before asking what more is necessary by way of legislation to consolidate the gains?

I dare say that the Government has a bottom-line perception along the lines of, "If people don't get their act together and there are recalcitrant councils, health boards and partners that seem unable willingly to move the agenda forward, do we have to drive it?" but there is a danger in considering models of integration from places elsewhere in the United Kingdom that are not role models for most Scottish authorities and areas. Do we want to be saying, "Look, this model has worked in north-east Lincolnshire and Torbay—it's great," rather than evaluating what we have set in motion ourselves in Scotland?

Bob Doris (Glasgow) (SNP): You say that we should not import models from elsewhere in the UK and should not say, "This works there, so it will work in Scotland." I understand that a key part of the bill states that there should be community health and care partnerships but that the structures should be left to be decided locally because there is a desire not to import models from elsewhere. Is that flexibility a strength of the bill?

Ranald Mair: If it becomes clear that what is being provided is a permissive framework, within which local partnerships between health boards and local authorities—and the other partners, including us—can determine what will work in a particular area with locality planning, service delivery and engagement with carers and service users, and if we get the mix right and allow things to evolve, that is fine. However, I fear that there is more of a desire to create the change from the top down, rather than allowing it to emerge from the bottom up. I encourage the committee to ensure that the model of change that we pursue does not become a top-down exercise.

Martin Sime: Some of these issues were rehearsed by the Christie commission, in respect of public services more generally and public sector reform. The outstanding question about a permissive approach to achieving integration is what happens when relationships break down. That is one of the weaknesses that we have just now. Not many people will want to talk in public about such things, but relationships do break down and services suffer. Therefore, we must all ask ourselves at what level, and on what scale, intervention should be made to require proper partnership working and a local integrated approach.

I am not in favour of a one-size-fits-all blueprint, because Scotland has many different circumstances, geographies and needs. However, to simply say, "Get on with it," without any regard to what happens next is roughly where we are just now. There are parts of the country where the relationships between health and care are not good, and yet there is no compelling narrative about how those deficits will be addressed.

The Convener: There is no check by the regulator, so there are no consequences of failure, are there? How does that flexible model work without any such consequences? What makes things happen?

We have spoken about evidence. We have single outcome agreements, the change agenda, community planning and so on; Bob Doris and I went through a lot of that in the former Local Government and Communities Committee. However, we cannot measure any of it, so how will this model be different?

Ranald Mair: I have one thought about how we do it. We are entering year two of the change fund, in which the emphasis is on joint commissioning, and each partnership must bring forward its proposals on that.

When the committee was considering the future of the regulation of social care, some of us voiced the idea that the regulation of commissioning was important. The joint commissioning plans will embody capacity planning and questions such as how local areas view their needs, how much care of which sort they will want, how much of that care will be provided in-house and how much will be purchased externally, and so on.

Tight scrutiny around commissioning practice is a fairly central plank of how we ensure and satisfy ourselves that things are happening, so it is one possible vehicle for addressing the issue.

Annie Gunner Logan: To return to Bob Doris's point about the bill, I am aware that there is a bit of humming and hawing going on because there is not a bill yet—there has been only an announcement.

I followed the committee's discussion with the panel last week about the relative merits of an autocratic approach—that was the term that was used—versus something that is more flexible such as a blueprint or a set of requirements. Henry Simmons has helpfully introduced the concept of a set of principles so that the flexibility is based around principles and outcomes to be achieved rather than someone laying down the law. I guess that part of the committee's inquiry is about precisely how the bill will be couched in those terms.

Commissioning, which Ranald Mair has just mentioned, will be at the heart of that. I will take five seconds to record my appreciation of what the

committee did during its previous inquiry to make that a very visible issue, and the same issue will be central to the current inquiry.

Lynn Williams: To return to Gil Paterson's question, it is difficult to know what success or successful integration would look like. I return to the point about people's experiences on the ground. The Age Scotland submission highlighted the shunting about between services that people experienced; I found that quite a powerful way of describing what happens.

To return to the convener's point about accountability, one of the key success points would involve where that accountability lies. When things go wrong, to whom do people go? Do they get some redress to make the system work better?

I agree with Henry Simmons's point about the need for strong principles to underpin the system. We need clear outcomes, one of which must recognise the fact that unpaid carers are significant providers of care and must therefore be treated as equal partners in care. As things stand under the Community Care and Health (Scotland) Act 2002, those carers are regarded as key partners in care.

In reading Audit Scotland's recent report on commissioning, one thing that struck me was the impact of how commissioning works on people on the ground. When times change, and service and quality change, how are people being involved—to return to the Christie commission report—in determining what services they are getting? There is clearly a drive to transform health and social care, but I emphasise the impact on people's lives. What type of outcomes do they see for themselves? We need to underpin the system with a vision for that.

Henry Simmons: The question is incredibly difficult to answer in full. I think that it needs to be broken down into several different sets of questions. There are elements that could probably be integrated without too much difficulty, and there are definitely integrated ways of working that we could adopt right now. Many people are doing that. We have to look at the areas in which good work is being done and ask ourselves why that is the case and what we can learn from it.

We do not yet know exactly what it is that we are saying we will integrate. Are we talking about acute care? Are we talking about integrating all adult care with acute care? Are we talking about primary care? The sector that we are discussing is so vast that there is no single answer, and it would be wrong to try and find one. We should start by asking what we want to achieve and what journey we have been on.

I return to the point that, in many ways, self-directed support is a solution to the lack of state resources. It would be better to combine the state resources that we have with personal resources. There is merit in thinking through how we can make the integration agenda work to promote the self-directed support agenda, and how we can avoid having a structural debate that might lose sight of some of the very positive work that has been done in Scotland over the past few years on self-directed support.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): Good morning. I want to concentrate on the fact that you represent the voluntary sector and on how we ensure that your contribution as huge service providers is not just recognised but becomes part of the policy agenda.

Gil Paterson quoted Henry Simmons's submission. I have quotations from all your submissions, which can be summed up by the SCVO's comment that we need to look at increasing the capacity of the third sector itself. I was involved in that many years ago, during the hiatus in my time in Parliament. I tried to do capacity building for the voluntary sector so that voluntary sector organisations could sit on community health partnerships as equal members of the partnership. I wanted there to be a two-way process whereby third sector organisations could sit round the table and be seen not only to have a right to be there, but to have a connection back to the people whom they served and to be an authoritative voice for them.

I am taking the long way round. In the context of governance, we have talked about principles, outcomes, commissioning and self-directed support. That seems to follow on from what we heard last week, which was that the issue is not about structures. How do we ensure that, under those headings of principles, outcomes and so on, the third sector has an equal voice? It must have an equal voice.

Mention has been made of the change fund. I am conscious that every change plan must be signed off by the third sector. If I were still in the third sector, I would not be happy to be asked just to sign off a plan; I would want to be involved in the process of producing it. Can we have a wee run-round on that?

Martin Sime: There was a lot in that question, particularly from a third sector perspective. I will divide the work of the third sector into three domains. There is the role that it plays in providing services and supporting people, which is sometimes misunderstood—it is not all about commissioned care. Although the third sector plays a significant role in delivering care that is commissioned by local government, there is the growing and positive development of third sector organisations working with people who have long-term conditions on self-management and self-help.

In addition, there is the broader contribution that the third sector makes to stronger communities and the capacity in those communities to support individuals.

Sometimes it is unhelpful to lump together those three domains, because the third sector's contribution and the way in which it works in partnership with public agencies can be quite different in each of them. We need there to be a better understanding, particularly among our health and care colleagues, of our contribution in all those domains, so that one paradigm is not dominant.

10:30

Quite a lot of work has been done recently to improve the infrastructure side—the second domain—which relates to the way in which the third sector is organised to engage with health and care locally. We have a long way to go to improve relationships with health boards, but the Scottish Government has recognised the demand and has been doing a lot of work and thinking on getting health boards more attuned to working with the third sector successfully. There is a long history of third sector engagement with local government; although it is still patchy in some parts of the country, in others the partnership is very strong with all sorts of different relationships.

However, if we are trying to make health and care work more effectively for individuals, there are certain outstanding questions about practice in the field, unintended consequences and the cost shunting issue that Lynn Williams mentioned. These are critical resource issues; indeed, a story that keeps coming back to me is how, when it was making cuts to its budget, the local authority in Dumfries and Galloway decided that it could no longer support the community transport operation that was run by the third sector in the area. A councillor appeared on television, saying, "We can only afford to do the really important stuff." Of course, six months later, it transpired that the NHS was having to send ambulances out into rural communities to pick up people for outpatient appointments at considerably greater cost.

That little story illustrates some of the complexities and unintended consequences that are involved. We are dealing with difficult issues of disinvestment in community capacity; as people will tell you, the most important thing we can do to address demographic matters is to build capacity in communities to enable people to stay out of the health and care system. However, that is the very area that is suffering from the biggest disinvestment. The public expenditure squeeze is making it difficult for local authorities and, to some extent, health boards to invest in things that are not needed for emergencies or for the front line. Although prevention and community capacity are critical at this time, they are suffering the most and, although that is where the third sector can make the biggest contribution, if you look at the change fund you will not see large amounts of investment going into community capacity. That is a great disappointment.

As part of its engagement in the infrastructure, the third sector is sometimes required to sign off plans. Sometimes that is easy for the organisations involved; sometimes it is difficult. We are beginning to organise our infrastructure more effectively to ensure that all the different people who represent the third sector in the system are talking to one another. However, on occasion, we are not seen as an equal partner, and we need to move on such situations. For example, on the local joint strategic commissioning that Ranald Mair mentioned, the third sector has not yet been guaranteed a seat at that table, despite the fact that such commissioning plays a critical role and is supposed to cover priorities for not only investment but disinvestment.

In this process change is inevitable. We must enable new resources to be brought to the table and, in fact, everyone recognises that there will have to be some disinvestment in secondary care if we are really going to rise to the demographic challenge.

Annie Gunner Logan: As the committee knows, my organisation looks after contracted service providers and many a time and oft before this and other committees I have rehearsed the way in which the relationship is a buyer-supplier one rather than a partnership. Improving that relationship absolutely hinges on commissioning, and I totally support Martin Sime's comment that we need a seat at the table when joint commissioning strategies are drawn up. Otherwise, as Ranald Mair suggested, health and local government will become a superpower buyer and the power imbalance will be even more pronounced than it is at the moment.

As Martin Sime made clear, the third sector's other role is to take demand out of the system. Just last week, I was having a discussion with some procurement professionals, who were talking about their desire to purchase prepared meals—what used to be called meals on wheels—in bulk across a number of authorities in order to push down the price and so on. That was a discussion about procurement; the discussion about commissioning would centre on the question why they wanted to give people seven days of frozen prepared meals at a time and then not see them again, and why they were not investing in lunch clubs, voluntary action and other such community activity. That is where I see the

difference between procurement and commissioning.

The other day, we had a discussion with a number of third sector colleagues about whether we should stop using the word "commissioning", because it is so confusing. It seems to frighten the life out of health service colleagues, who associate it with privatisation, while local government colleagues think that it is to do with purchasing. However, we are actually talking about investment decisions. There must be third sector and community involvement at that level, so that the question is asked not just how we get stuff and put it in place—who is the best supplier—but why it is being bought in the first place.

If the published bill contains technical stuff about who has a seat at the table on partnerships, for example, that is where we want solid strategic input, but that is not all that it will take. As Henry Simmons said, it is about how people work together locally.

Ranald Mair: I want to pick up the point about sign-off. The change fund plans were seen as involving important empowerment: there was some guarantee that the third and independent sectors would have a say. Fiona McLeod is absolutely right. A person cannot sign something off unless they have been involved throughout the engagement and development process, but the sense of having at least a point at which a person would have a clear say has not been unimportant, and it has led to quite significant negotiations and shifts as the plans for the coming year have gone through the process.

Members might expect me to remind them that the independent sector is both voluntary and private. We have a bit of a love-hate relationship with the private sector, but it is hugely significant in care delivery. The bulk of care home provision certainly remains in the private sector, but not with large corporate organisations—we have discussed that before. There are two or three large corporate organisations involved in Scotland and 250 individual owner-run care homes. Retired nurses have invested their savings in developing nursing homes, for example. We have a mixed economy of care, and we must consider how to hold on to it, make it work, and encourage people to feel part of a collective system.

The issue is less about whether provision is public sector, voluntary or private; rather, it is whether the provision is part of an integrated approach to delivering care in a locality, and how we can move beyond a turning-the-tap-on-and-off relationship between the statutory bodies and the third and independent sector organisations that deliver care. If budgets are tight, the tap can be turned off, and that can force organisations to the brink. The question is how we can get long-term, sustainable planning. It has been said that some of that can be done through an integrated approach to joint commissioning at that level to plan what will be needed.

I echo the point that Annie Gunner Logan made. There is no significant shift in year one from in-house to external spend. The bulk of the spend by the change fund partnerships—the £70 million—is in-house spend. The figure is over 90 per cent. The percentage of money that has been spent through the change fund on either the voluntary sector or the private sector to develop new capacity has been minimal. We need a long-term approach that values the diversity of provision and involves looking at areas' needs in an integrated way.

Lynn Williams: I would like to pick up on a couple of points that Martin Sime made about the role of the voluntary sector. In doing so, I return to Fiona McLeod's question.

I come from a public sector background, and when I visit carers centres, I am struck by what they do with such small amounts of money, the return on that investment for statutory partners, and the impact on people's lives. The voluntary sector plays an important role in the prevention agenda that Martin Sime outlined. For example, carers centres take demand out of the system.

How do we support carers in their role? I will give an example. Glasgow City Council and one of our carers centres did some joint work on demand prevention and the importance of carers assessments. Through that work, the carers centre supported carers directly through a self-assessment process. It signposted carers to local supports such as a local Alzheimer's project and the direct purchasing of respite. Only about three of the 120 carers—the number was in single figures—required a formal statutory intervention. Carers were signposted to other things in the community that helped them to sustain their caring role.

The other role that the voluntary sector can play is around preventing the tipping point. If an older person is at a point where they are not coping at home—perhaps they need help with the garden, they want to get out or they feel isolated—things such as community transport are critical. Those things do not cost a lot of money, but they have an essential impact on people's lives by sustaining them at home.

The work that the trust and other organisations in the voluntary sector do helps people to cope with the situation that they are in and prevents them from needing statutory support.

Henry Simmons: There are several elements to the voluntary sector. The interface organisations have tried to represent the community capacity

organisations, and I think that that is a really worthwhile challenge.

Our issue is perhaps slightly different. We have 4,000 members in Scotland, and 10,000 signed-up supporters. We contribute £3.5 million-worth of fundraised income to nurses, advisers, a helpline and a research centre. With that level of contribution, we expect to be included and involved in national discussions about dementia, and we are. Because of that, we can use our resources in a much clearer and better way, by working collectively with the resources in the system. We can point to the gaps and the issues that need attention.

I will give a good example. Six years ago, we offered funding for dementia nurses in acute hospitals. The consensus was that there was no problem in that area. Now, the issue is recognised as one of the biggest that we have to tackle, and it is a top priority in the national dementia strategy.

Organisations that are similar to Alzheimer's Scotland should play a similar role and be a leading force for change, because they have a lot to contribute. When we are engaged with and listened to, our contribution is much more valuable. We must encourage our members to engage locally with other community capacity activities and interface organisations. There is a genuine need to have that twin-pronged approach all the time in working in the voluntary sector.

Fiona McLeod: Can I sum up what you have said and ensure that I have got it right? We should not concentrate on structures and physical changes or spend money on that. We should set down clear principles, but those principles must establish that, nationally, the third or independent sector has a key role to play and must therefore be a part of every process from top to bottom. Does that sum it up?

Ranald Mair: Yes.

Martin Sime: Yes.

The Convener: Thank you, Fiona. That was helpful. You have won over the convener.

10:45

Jackson Carlaw: By way of an extension to that, I suppose, it seems clear from all your submissions and from what you have said this morning that everybody sees the opportunities that the change will present and the benefits that can accrue from it. However, that is underpinned by an anxiety about the chaos that could be wrought if we do the wrong thing. Some of that anxiety is fuelled by the feeling that the structures stifled the noble ambitions for the CHCP process and edged out some of the vital contributions that would have made it altogether more effective.

I am struck that everybody supports Henry Simmons's view that principles need to be established around which any developments can then be constructed. At some point, however, the various organisations and parties will require leadership. Where do you think that leadership should come from? Who or what would command the confidence and respect of your organisations, and what form should that leadership take?

Martin Sime: I am not sure which part of leadership you are talking about, but I have a few reflections to share. The third sector is more engaged with public sector leaders now than at any other point in my time in the voluntary sector. We are an integral part of the Scottish leaders forum and the workstreams that flow from it. We are engaged in health and care. My convener is part of the ministerial strategy group for health and care, and Annie Gunner Logan and I sit on the national delivery group, so there is evidence that the third sector is part of the leadership for policy and strategic discussions.

It is difficult for the third sector to play such a leadership role in relation to public sector resources. We do not bring budgets to the table; we bring human capacity, innovation and the ability to mobilise communities. I happen to think that those resources are just as valuable as large sums of public money. They are certainly more sustainable, given that public money is in decline. More needs to be done by leaders in the public sector to recognise, nurture and support those community capacities.

I am not a great fan of more individual leadership. There is a lot of that in the public sector. In fact, some of the integration agenda is about sorting out the egos of different leaders in different public bodies. Frankly, that stuff leaves me cold. Leadership in the third sector is a much more diffuse and contested issue, as it should be. We have leadership in communities—a lot of people are making a difference on the ground—and our obligation is not to direct it and channel it, like the big society initiative south of the border, but to find ways to support it and to nurture and recognise the contribution that people are making.

I spoke to representatives from Age Scotland yesterday, who said that they had 200 groups of older people involved in activities around the country. The challenge that we face is how to increase that to 400 groups. How do we increase the number of people who make a difference to their community? What do we need? How can we support the many organisations, such as Lynn Williams's, that are trying to help make that happen?

Henry Simmons: You absolutely need leadership, and you need it right from the top, but anyone who is engaged in managing teams and

organisations will tell you that you also need vision. You need a collective vision of what you are trying to achieve, which takes us back to the argument about principles.

There are fantastic leaders in every sector, including local government and health. The difficulty that we face is that people are, almost covertly, applying strong visions to their area that we cannot scale up, learn lessons from or use throughout Scotland. If we could do that, we would probably be in far better shape, because some of the work that is being done and some of the lessons that we can learn from one another are fantastic. What we lack is a vision of leadership and what it is that leaders will drive forward.

It is not impossible to achieve that. There is enough consensus about prevention, self-directed support and self-management, and about how health and social care could be different. I do not think that we are a million miles away. The leaders to deliver the vision will follow, but we must first get that vision.

Ranald Mair: I have two quick points. I sit on the Glasgow reshaping care steering group. There has been a difficult, at times fraught, process involving people across the health board, the local authority and the third and independent sectors trying to get an act together. However, there has been progress in creating a greater level of awareness and of trust and possibly a capacity to lead change in a Glasgow context—providing that that is not second-guessed by anyone further up, given that we have a health board that straddles not just the Glasgow change fund but other partnerships in the area. However, I think that there is the beginning of something. I go back to what I said earlier about embedding some of what we have set in motion. The change fund partnerships could lead on moving the process forward, if we nurture that approach.

I echo the point that was made about the notion of citizen leadership. Within reshaping care there is a heavy emphasis on community capacity building and co-production. That emphasis is not just on what we do but on how we do it; it is about asking how genuine we are about empowering people to have a greater say. Self-directed support has the potential to give people greater say in their individual care, and community capacity and co-production give people a collective say in their care. Some of what is proposed in the legislation is about asking how we do locality planning with local people—and asking them what they want and need.

I am sure that Henry Simmons is right that there needs to be an element of leadership from the top down and that we need to nurture that in an integrated way. However, we ultimately have to allow a lot of leadership from the people who will use the services and who live in the communities that we serve.

Annie Gunner Logan: When I am asked a question about leadership, I am tempted to start naming people—to say, for example, that the person in X position would be the one to exercise leadership. However, I am more keen to listen to anyone who talks about the outcomes that are to be achieved, the need for change and improvement and how the third sector can be part of that than to listen to somebody who is interested in protecting their own territory or in arguing about who should be in charge. One of my worries about going down into the technical detail of the legislation is that a lot of the discussion will be about who is in charge and who has the right to be accountable for budgets and so on. It will be very counterproductive if the project becomes mired in that sort of debate.

Just to echo Ranald Mair's point, citizen leadership is absolutely what is behind the Social Care (Self-directed Support) (Scotland) Bill. At an individual level, if we take that seriously and we implement its provisions with vigour, the people in the lead will be those who have support needs in the first place. There will be more potential in that bill to bring about change and improvement at an individual level than in any integration bill. Now—there's a statement.

Ranald Mair: Well done.

Annie Gunner Logan: I might get into trouble for saying that, but there it is.

Lynn Williams: Just to pick up on Annie Gunner Logan's point, the Social Care (Self-directed Support) (Scotland) Bill will obviously be considered by the committee in due course. There is potential in the bill for recognising that people should have more control over what they get. However, the issues in the bill around support for carers need to be looked at and resolved because there is no parity of esteem in terms of the recognition of their contribution.

That may be for another discussion, but we continually hear about how important unpaid carers are to the whole agenda, yet there remains, to an extent, a lack of recognition of that contribution in legislation. We need to consider whether there is an opportunity to strengthen that bill or whether an integration bill can address that issue.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): The tenor of the evidence from all the witnesses is that structural change is not necessarily the solution, but we have had a permissive system for nine years, which has allowed budgets to be aligned and pooled and allowed people to work together. Everybody has said that that should happen, but here we are,

faced with the demographics that we all expected back in the first parliamentary session, when we said that integration had to take place and set up joint future groups, which were piloted in Perth and Kinross. We did all that work but, 10 years on, we are debating exactly the same issues.

I hear that you are all against structural change, but there is frustration on the political side. We ask how much longer we can wait for integration to happen on the ground. Why is what is happening in West Lothian, South Lanarkshire, the Clackmannanshire mental health scheme and the other good examples that we have heard about not being replicated across the country? Will a further period of the permissive approach achieve that?

Where is the key to this? Instead of saying that budgets can be pooled or aligned, should we require that to happen? How do we drive that? What is the role of the Parliament or the law? Our discussion is a preliminary to identifying that role. How do we drive the approach so that we or our successors do not have to sit here debating the same thing and saying that integration would be lovely and wonderful and that we all think that it is a good idea?

Ranald Mair: I understand some of the frustration about the pace of change not being great; we probably share some of that. However, people are now acutely aware of the opportunity cost of not changing. The health and social care system faces bankruptcy. Integration will not in and of itself solve that—the Parliament and the country still have very hard questions to address on the future funding of care for older people—but it is clear that continuing to provide care as we have done is unsustainable. The iceberg is looming and people are trying desperately to turn the tanker around.

We have set in motion some work through self-directed support and through the change fund. This year, the fund has dangled a carrot of £80 million, which is quite a significant sum, and we have told people that, if they want to access that money to lever much greater change, they must act together in a new way with a new sense of partnership about what they do. We have all referred to joint commissioning plans and their regulation to ensure clear accountability for integrated planning of what will be needed and how that will be secured.

Some steps might require more legislation further down the line, but the danger is that, rather than continuing to say, “Here’s the end that we’re trying to get to; let’s look at the various means of contributing to it,” we say that legislation will solve the problem and we become preoccupied with that, as opposed to nurturing on-going efforts to improve things on the ground.

Henry Simmons: If we started afresh, there is no doubt that we would start with something like a fully integrated system. The trouble is that we have the biggest crisis that we have ever faced in local authority funding and in health services. Front-line staff are being stretched to the limit. We must not disempower them by confusing their psychological contract or employment contract issues with getting the job done.

In every sector, the front-line staff are the only people who can deliver the creativity in the use of resources that will get us through the situation. By creativity, I mean thinking about and doing something special and well with every £1 of state investment, alongside the natural and community supports that are in a person’s life. That is the only way in which we will stretch the resources that are in the system.

11:00

The best way of getting people to drive that change is to make them feel secure and committed and to work with the whole workforce to get the best out of them and get us through this crisis. Perhaps when the crisis is over, we might take another look at the matter but making structural changes at a time when we need to rely on our workforce to get us through the next five, six or seven years is perhaps not the best course of action. That is why we oppose this change.

Martin Sime: Dr Simpson has just asked the critical questions. The system is struggling with the question of how to drive change and clearly there are different ways of addressing that. Seven or eight years ago, I was invited to join the high-level shifting the balance of care working group and we heard from Derek Feeley, who is now chief executive of the NHS, but who had at the time just come back from America with his analysis of how Virginia was addressing the demographic issue. When he applied that analysis to Scotland, he concluded that our health and care system was heading over a cliff. Since then, we have all been searching for a model convincing enough to allow us to face that demographic challenge. It is a matter of regret that, seven years down the line, we are still in the same place. We have now lost seven years against that demographic challenge. Of course, the other issue is that, in the time of plenty, we had the means to change things but the argument for change was not as strong; now that we are not in a time of plenty, the challenge that we face is tighter.

The truth is that no one knows what the demographic impact will be on Scotland. I have not seen any updated analysis; indeed, it is another matter of regret that, as local authorities and health boards are developing local change plans, we cannot measure whether such plans are

sufficient to meet demographic pressures. If you want to drive change, the first thing you need is a pretty convincing idea of where you want to go.

Secondly, there is the whole question of the dynamic and whether the centre itself drives change. A bit of the Scottish Government thinks that it drives change in health boards but, of course, local government does not accept that change can be driven centrally and, as a result, any local joint arrangements contain a degree of health board and local government autonomy. Complicated issues of ownership and control with regard to the ability of Parliament, Government or anyone else to drive these changes need to be dealt with.

However, what has changed in a debate that we have been having in health and care for 30 years now—or at least as far back as I can remember—is the development of self-directed support, personalisation and asset-based approaches that actually give power to people and support them in making decisions for their own lives that best meet their own needs. That is a much more persuasive narrative for change than any top-down approach from the centre that deals with all Scotland's public bodies and all the different dynamics. I have actually stopped asking myself the question of how we can drive change from the centre because in the current circumstances I do not think that there is a convincing story for delivering that.

The Convener: Where is the drive for self-directed support coming from? Many people come to me complaining about the lack of flexibility or the lack of packages, but no one has ever asked me whether they could have power over their package. In fact, many people do not want that or could not use it if they had it. I agree that it is a nice idea but certainly some people out there are worrying that, instead of empowering people, it is simply a means to some cost-cutting end. People are certainly not banging down doors to get self-directed support.

Annie Gunner Logan: As the bill that has now been introduced makes clear, this is by no means an obligation. If you do not want to direct your own package or have that level of control, you can simply say, "Go and arrange something for me." Of course, that is where the importance of commissioning comes back in, because choice and control can happen at the service level as well as at the resource level.

To come back to Richard Simpson's point, I have to say that I share the frustration about the joint future group, partly because I was a member of it. The fact is that the discussion that we had then was very similar to the one that we are having now. What strikes me about the initiative is that it focused almost uniquely on structures and ran aground on very technical issues. One of the biggest issues, which people could not see their way past, was the harmonisation of terms and conditions for NHS and local government staff. That became a huge thing, which blocked the entire process.

We are not saying that there is no single structural change that could ever make something better; what is needed is evidence to support structural change, rather than the imposition of a particular model. In its meeting last week, the committee discussed whether there should be an autocratic approach or a blueprint. There are elements within which a structure could be designed.

I am certainly interested in integrated budgets. From the third sector point of view, I think that that is how resources will be released to invest in community action and take demand out of the system, in a way that would not happen if there was no integrated budget. It might be decided that an integrated budget was a requirement of any particular model, if for no other reason than to ensure that halfway through the process people could not pick up their ball and go home with it, which is what has happened on a number of occasions.

However, evidence of investment that will take demand out of the system would need to be part of a proposal for a new structure, wherever it was and whoever was involved in it. What is important is the blueprint that sets out the principles and requirements of the approach, rather than what the structure looks like.

Dr Simpson: I agree with the point about integrated budgets. You and Martin Sime gave classic examples of cost shifting, which is exactly what occurs if everybody does not look at the budget in the round. That goes on all the time so, without integrated budgets, the approach will not deliver.

Can I do a Fiona McLeod and summarise?

The Convener: You can try. She has a good success rate, though. You are putting yourself at risk.

Dr Simpson: We need national care standards, we need the principles of integration and what it might look like, and we need effective, regulated, joint strategic commissioning, in which everyone is engaged. Below that level, we must have integrated budgets, so that people cannot pick up their ball and walk away.

In my constituency, there was a proposal to replace meals on wheels with frozen meals, and people wrote to me to say, "That has just isolated me, because my contact has gone. And anyway, I can't work a microwave." It was unbelievably thoughtless of the council to go ahead with the

change, but it saved money, which was the bottom line. Such decisions are driven not by care and how people are affected; a council's angle might mean that it prioritises things quite differently from how a carer or an individual might do—I am sorry; that was not a summary.

The Convener: Other people want to come in, and your summary has not attracted the consensus that Fiona McLeod's did. Well done, Fiona.

Henry Simmons: SDS is not about the mechanics of how people control budgets; it is about enabling people to get a personalised service, which has been really difficult for many people to do in our current health and social care system. It is a difficult challenge for health boards and local authorities to commission services en masse that deliver personalised care.

The shift to personalisation is about saying, "If you give me access to some of the resources that you are prepared to commit, I can combine them with my resources, to much better effect." A local authority social worker cannot walk away if that happens and indeed will be a critical component in the process of helping the person to work out how best to use their combined state and personal resources. The approach will give us double value for money. Currently, people are offered services that do not suit them, which are delivered at a time and in a way that does not help them. If the value of the service is £150 a week, we can see that that amount of money can go an awfully long way towards keeping people engaged with more natural, community-based and creative support.

That brings me back to the point about front-line staff. They are the only people who can help with the process, so they need to be secure and engaged in supporting the creative approach that I am talking about. Society needs to accept that we might end up with people doing very different things with the resources that they have, to secure outcomes that are very much in line with what they need and want. The self-directed support movement is not about the mechanics of the budget; it is about transforming our view of health and social care services.

The Convener: I am not interested in the principle. As a vision, what you describe can work, but I remind people that we have been here before. The Health Committee that I was a member of six or seven years ago considered self-directed support, including why it was successful in Highland but not in the central belt. We are not against the vision; what I was questioning was what Martin Sime said about self-directed support being a driver for change.

If there is a lack of demand because a large part of the population neither needs nor wants to employ people and set up the package, and there is opposition from local authorities through the Convention of Scottish Local Authorities and from trade unions, what is the difference between that scenario and one in which social work and health do not work together because they cannot get the contracts to function properly and therefore manoeuvre their way around the problem and leave it to one side? I am interested in whether this is a driver because, as you have heard, I am not convinced that it can be.

Ranald Mair: We must clearly distinguish between self-directed payment as an option within self-directed support, for people who want to control and manage their own budgets and employ someone to do their care, and the principles of self-directed support, which is about the personalisation agenda. If we combine the idea of integrated budgets—budgets pooled by the statutory agencies—with the principles of self-directed support, the money has to follow the person and be there to provide the package in the setting in which the person wants to be, combined, as Henry Simmons said, with whatever assets that individual brings. The principles of self-directed support are not just about the two statutory partners having an integrated budget but about the money being used in a personalised way.

I might share a lot of your uncertainty about the merits of self-directed payment and the likelihood of the majority of older people wanting to take it up as an option—they probably will not—but what is important is the principles of self-directed support, including the greater say and flexibility in how money is spent on an individual and how their care is secured.

Henry Simmons: I will give an example of why we think that self-directed support could be a good driver. Sadly, in our country, residential care is considered a big dependency, and we are not very creative and do not take risks too well. We ran a pilot in Ayrshire, which worked with about 19 or 20 families who had been told that a relative had reached the stage at which residential care was the only option. We designed individual service arrangements for those families who did not want residential care at that time. We saved a remarkable amount of money in each situation, but we also gave the individuals a good bit more time to live at home with their families.

When people want to engage with a different way of working, the merit of such an approach is that we can get a massive return for the family, and save tremendous amounts of money compared with the cost of residential care. We are talking about £10,000 per year per person on average. If we scale that up, it is a driver.

The Convener: We can have a debate about the fact that this can work for certain people,

including younger people, when planning for long-term care. As a committee, we have a responsibility to consider some of these issues and we look forward to doing so in another debate aligned to this one. However, I wonder whether it can be scaled up and whether it is a driver. I am not opposed to the idea, in which there is much that is attractive, with continuity of care being provided via packages that suit the individual and the family, but can it meet our expectations?

Martin Sime: I will make one quick point about that. Last week in the third sector—in the group that Annie Gunner Logan mentioned—we discussed the conspicuous absence of older people's voices. The more we are able to engage older people nationally and locally, to make it their concern and to put their voices at the centre of all the changes, the more it will be possible for older people to understand better the changed approach to self-directed support. In other words, a trade-off needs to happen. We need older people's voices in the system anyway, but we must also work with older people more pervasively than we are doing just now to get them to understand the opportunities, the challenges and the issues. Those are two sides of the same coin.

11:15

The Convener: The committee welcomes that support for our recent inquiry, which was about putting elderly people's rights at the heart of whatever we purport to do for them.

Jim Eadie (Edinburgh Southern) (SNP): I return to the change fund. Mr Sime said that there has not been a large investment in community capacity through the fund, and Mr Mair helpfully highlighted that more than 90 per cent of current expenditure through the fund is in-house.

I have a question for both of you gentlemen. Why are we in that situation? I recognise that the points that you make are not special pleading on behalf of the third sector, but rightly highlight the role that it can play in helping us to achieve our objectives, such as more people being looked after in their homes and in the community rather than in institutional care or in hospital.

Why has the third sector been excluded from the change fund? What, specifically, have you done about it, and what do you intend to do about it? What can we as a committee do to help you?

Martin Sime: There are a lot of questions in there. We were part of the discussions that led to the development of the guidance for the operation of the change fund in its first year. As Ranald Mair mentioned, third sector organisations have been part of the process locally, along with the independent sector.

With regard to outcomes and actual spend, we are seeing where the balance of power lies. Health and care managers have a set of operational priorities—particularly at a time of declining budgets—to do with people in the system who need care and support, and they will seek to deploy any resources that they can find towards those priorities. I have heard it said that the entire change fund should be used to address delayed discharge from hospitals, perhaps by engaging with residential care in a more strategic partnership. It would be possible to spend £70 million on any one of those priorities.

The third sector comes along and says, "What you really need to do is to invest in community capacity to keep people out of the system", and in general we get patronised, patted on the head and offered 10 per cent of the change fund. That is what has happened. We have been seen as a necessary but rather inconvenient adjunct to the delivery of health and care services and the major budgets.

Last year, SCVO published an analysis of the change fund, which led to quite a lot of disquiet and concern about the outcome. We have tended to see the change fund as the beginning of a wider process. The Cabinet Secretary for Finance and Sustainable Growth put £500 million on the table for reforming public services; the change fund was the advance party, but it did not change very much. The response was, "Oh dear—we need to take this more seriously."

We have just had a look at the plans for the second year of the change fund. They are general, and it is difficult to draw a line between where the different levels of investment will be made. I think that they show a marginal improvement in investment—

Jim Eadie: Is there an issue with the criteria being such that you are not able to bid effectively, or are you not sufficiently skilled up to be able to do so?

Martin Sime: The issue is the priority that the statutory partners locally give to different forms of intervention. They prioritise the emergencies and the things that need to be addressed or done to cover up for budget cuts in other areas. There is a culture of seeing the change fund as a way of meeting public sector priorities, rather than setting out on long-term change.

I have looked over the change plans, but I have no reference point to say whether they address the demographic issues. In essence, the change plans are wish lists in an area where short-term public sector management is the dominant culture. We need to make long-term investments in community capacity. The investments that are being made through the change fund are for one

year, or maybe three if we are lucky. They are simply an adjunct to the projectitis from which the third sector suffers. We need long-term investment in community capacity to keep people out of health and care institutions because, otherwise, we will face financial meltdown. That imperative has not got through strongly enough. The third sector has tried hard to make those arguments locally. It has made small breakthroughs in some parts of the country and there is some good practice.

Another issue, and one on which Lynn Williams might want to comment, is the commitment to spend 20 per cent of the change fund on carers. That was watered down in guidance—which the SCVO resisted and opposed—that states that, rather than the 20 per cent going to carers and carers organisations, any intervention that makes life easier for carers, including medical interventions, will qualify. That is the kind of thing that goes on in diverting the fund away from its purposes.

Ranald Mair: There have been a number of issues in year one. The change fund had to hit the ground running, and it was almost easier for local authorities and health boards to spend money in-house, because they could do that quickly. The money was there to be spent and, given the budget pressures, the temptation to do that was great. It was almost easier than going through other tendering and commissioning processes. There were fewer good, quick mechanisms for putting money into the third and independent sectors. There have been difficulties around that. There is also the business of people getting their act together at a local level.

It is not only the change fund moneys that are important. The fund is about 1.5 per cent of the total health and social care expenditure. Rather than simply asking how the local partnerships have spent their proportion of the £70 million or £80 million in the change fund, the Parliament and the Government should demand that those partnerships say how the spend has levered change and what is different in their total expenditure, in how they use their money, and in their relationship with the third and independent sectors in that regard. The bigger prize is the shift in total expenditure to make better use of the total pot of resource at a local level. That requires a greater focus on and accounting for the change that has taken place.

Annie Gunner Logan: Martin Sime said that we have had a look at the change fund plans. I have read about three quarters of them, but I will give just one example that illustrates some of the issues. In one plan—do not ask me to say which one it was, because I cannot remember—at least some of the spend under the enabler heading was on technologies to monitor the time that private companies spend on home care visits. With that technology, when the home carer arrives, they punch a number into the telephone, and they do the same on the way out. The object is that the authority pays only for what it gets. However, there is nothing in the plan about the substance of those visits or how they will change anything. That is just one of a number of examples that show where the spend is going.

Most of the change fund plans that I have seen give significant recognition to the third sector, but whether resources follow that is a different question. I know that you will speak to the president of the Association of Directors of Social Work later today. I have said to him that, from the perspective of the third sector, the change fund process feels like being a guest at a wedding—at the centre are local government and the national health service, and everyone else is at the periphery. In Andrew Lowe's authority, there is huge recognition of the third sector and lots of good community capacity activity is going on, but it still feels like we cannot see where the third sector's influence is with regard not to running projects but to driving the investment decisions that are being made at the top, strategic level.

Henry Simmons: We got a bit of a shock when the first change plans were announced, because only 3 per cent of the money was going to be spent on dementia. There are 84,000 people with dementia in Scotland, and that number is set to double. There are no drugs that modify the disease, so human intervention has to be the main form of intervention.

At that point, we started to talk about the national dementia strategy, which had post-diagnostic support as a priority. Working with local partners, we sought a national commitment on that. We have seen a change in so far as people are beginning to understand that a good investment in the area can save considerable sums of money, but not until seven or eight years have passed. A year's post-diagnostic support costs about £2,000, but it can delay the person's admission into residential care for two or three years. That is a return of about 60:1. The evidence for that is not absolute, but it is good. We have been arguing for that initiative and we have seen growth in the amount that is invested in it, but there is not much other evidence of that type of initiative.

The issue is not just about our providing a service; it is about our helping to pull forward some of the existing structures. We want local authorities, allied health professionals and social workers to be engaged with people with dementia in post-diagnostic work, and not for them to be so hampered by eligibility criteria that, by the time they see someone, it is so far down the line that

they cannot use their skills. Equally, we want community psychiatric nurses and other people who are at the front line at the point of diagnosis to have their time with the patient extended, so that they can work with people as they go through the journey across the year.

A settling-down process is occurring, and more solid debate, argument and investment are taking place. However, we are not yet where we want to be. I support what has been said about some of the difficulties around the wider issues, but I argue that, if we take a combined approach, the third sector can influence in a better and more creative way the use of local authority and health resources, rather than always being the recipient of those resources.

Lynn Williams: I would like to respond to what Mr Eadie and Martin Sime said about the 20 per cent of the change fund that is to support carers. When that was announced, we welcomed it. It puts into context the contribution that unpaid carers can make to the agenda that we are concerned with and to change plans. For the committee's wider inquiry into integration, there are lessons to be learned from how that has operated.

In some areas, the role of carer support in achieving some of the vision in the change plans is recognised, and carers organisations have a seat at the table. However, that is not always the case. Some of that comes about not through risk aversion but through an unwillingness to recognise that we come with an evidence base on the impact of direct carer support that is just as strong as clinical and other evidence bases. The same will apply to integration. Integration will not happen without recognising and supporting carers, because they are a critical resource.

The issue about representation is wider than just the change fund. It is about a recognition of the expertise, based on their experience of people's real lives, that local organisations can bring to the table on the planning and commissioning of services.

One of the biggest lessons from the change fund process is that there is expertise that is perhaps not being used to best effect. We must continue to recognise the impact of direct carer support and the need to help people to sustain themselves at home and to stay at home for longer. That is connected to the kind of points that Henry Simmons made about community assets and community capacity.

11:30

With the change fund and the change plans as they stand now, some partnerships will struggle to decide how they spend the 20 per cent of the fund that is supposed to support carers. It is easy to sit in an acute setting and say, "We will invest in an additional consultant so that we can get people out of hospital more quickly." That is fine, but who will pick up the pieces at home? How are we supporting family members through the discharge process so that people can get home much more quickly, stay at home and be happy there?

We can learn a lot of lessons about integration from how the change fund and the change plans are developing. We must look at those developments a bit more closely.

Jim Eadie: I have a quick supplementary for Mr Sime and Mr Mair. What further steps do you intend to take to influence the process in a way that allows the third sector to increase community capacity?

If the convener will indulge me, I also have a specific question for Mr Simmons on post-diagnostic support.

Martin Sime: In some ways, the ship has sailed as far as the change fund is concerned, although we will publish another analysis this year of what the change plans say that they will invest in. We would like to get statistics and information so that we can tie that down to ensure that it represents what has happened on the ground, because in the first year of the change fund there was quite a significant underspend after local government created draconian procurement processes for working with the third sector. The process seems to take about six months, whereas the partnership arrangements and grant-funding arrangements that we used to have could be used virtually overnight.

There have been delays in committing the spend, but I hope that we will find that this year's change fund will be more efficient at committing the spend and will commit it over a longer period now that there is a budget for three years. The problem is that, once the change fund makes those commitments for three years, there will be almost no new developments thereafter, so the fund will effectively be silted up.

We need to come back to the analysis that it is about not the change fund but the change plans. It is about the joint strategic commissioning process, which looks at what services are required in the longer term and where disinvestments need to be made. The nature of the debate is about to change and the focus will no longer be on the change fund.

Ranald Mair: I agree with those points, but I am not quite as pessimistic in the sense of thinking that the boat has gone. If it has, it is with some of us on it, although we maybe fought over the lifeboats.

We are in there at a local level through the individual change fund partnerships. We have required to campaign for some elements of resourcing to make that possible, because co-ordinating our sector's input to the change fund locally and nationally is quite a big task. We must maximise our effectiveness locally.

The partnerships must be asked to account for not only how they have spent the change fund but what that has meant for the use of their total budgets. There should be transparency about how that process has helped to grow capacity across the third and independent sectors. Partnerships should be asked specifically to account for that.

Slightly more teeth might have to be given to the joint improvement team. There are very nice people on the JIT, which has a role to support what is happening on the ground, but whether it has the teeth to challenge partnerships is a bit less clear. One issue is how accountability is manifest between the local partnerships' actions and the Government's intentions.

Jim Eadie: That is very helpful.

I have a brief question for Mr Simmons on the guarantee of one year of post-diagnostic support that he called on the Scottish Government to provide for every person who is diagnosed with dementia. Did you say that that would cost £2,000 per person?

Henry Simmons: On average.

Jim Eadie: That is for 84,000 people in Scotland.

Henry Simmons: No. Each year 7,000 people are diagnosed with dementia, so it would probably be for about 10,000 people. Our argument is that a whole new layer of staffing structures does not need to be put in to deliver that but, if that were put in, it would probably cost only something like £8 million across the country. That is a worst-case scenario.

Our preference is for existing staff, combined with health staff, the local authority and the voluntary sector, to take up the challenge and deliver a good set of interventions that will give everyone who is diagnosed a named and trained person plus peer support and natural support through community connections, all of which should operate together. If we do that, people will move forward in the next couple of years with some stability.

Jim Eadie: What has been the response from the Government? How successful have you been in persuading it?

Henry Simmons: The cabinet secretary announced at the dementia forum that she is intent on doing what was proposed, and Michael Matheson announced at the Scottish dementia clinical research network that there is a commitment to it. We await a more formal announcement.

The Convener: Is there anything that our witnesses wish to discuss that we did not raise in our questions?

Annie Gunner Logan: One thing that did not come up today, although I am sure that it will be discussed as the proposals are developed and progressed, is to what extent integration is seen as something that will benefit older people and to what extent it is about the entire panoply of adult care and support and, beyond that, criminal justice and children's services, because there will be knock-on effects in those areas.

We understand the priorities for older people's care—I know that the committee does as well, because it held an inquiry into the matter—but an awful lot of other services might be trailed along in the wake of the proposals, which are not based on the priorities for other groups. I want to put that on the table, because it will become more of an issue as we proceed with the proposals.

The Convener: We heard about that in evidence last week, as well. Are there any other comments?

Lynn Williams: I go back to what carers are saying about the agenda. A comment was made at the event that I mentioned earlier that, whatever things are to look like—we do not know that yet, because we have not seen the detail—the changes that we drive this time must be for keeps. Let us not make changes and then, five years down the line, change things again, because we are talking about people's lives and services that they value.

We should learn lessons from where integration is happening elsewhere. When we consider the plans, shape them and start to deliver them, we must consider how we communicate with people on the ground and their families. There must be effective communication on what the vision is, what the outcomes will be and what services will look like. How can we ensure that that communication underpins the agenda?

The Convener: As no one else wants to comment, I express our thanks and appreciation for the witnesses' attendance and the evidence that they have provided.

11:39

Meeting suspended.

11:46

On resuming—

The Convener: I welcome our second panel of witnesses: Andrew Lowe, president of the Association of Directors of Social Work; Theresa Fyffe, director of the Royal College of Nursing Scotland; Dr John Gillies, chair of the Royal College of General Practitioners Scotland; and Phil Gray, chief executive officer of the Chartered Society of Physiotherapy. We move straight to questions from committee members.

Richard Lyle (Central Scotland) (SNP): Good morning, ladies and gentlemen. In its submission, the ADSW says:

> "We acknowledge the cross party drive for increased integration of health and social care as a potential solution to the immense challenge that faces the whole public sector"

and sets out a proposal based on the principles of "Achieving the best outcomes", "Early intervention", "Personalised care", "Supporting and empowering" and "Seamless pathways of care". The submission then sets out a nine-point plan. However, having read the plan, I see no difference from what we have done before. Can you tell us what is different about the plan and your feelings about the integration of care?

Andrew Lowe (Association of Directors of Social Work): I would be very pleased to do so.

The ADSW approached this debate with great vigour last summer and continues to be very keen to play a part in it, because we are committed to improvement, because we understand the financial context and because we want the best thing for Scotland's older people. There is no question about any of that and, in fact, we were delighted to see in the cabinet secretary's announcement in December many of the principles that we had argued for over the summer. I make it very clear at the outset that we are an ally in the desire to integrate and move things forward.

In our submission, we set out a number of points that we felt were important in making integration work. They are founded on evidence; indeed, committee members will have seen the evidence paper that we commissioned from the Institute for Research and Innovation in Social Services. I beg to differ with your suggestion that what is set out in those nine points is no different from what we had before in community health partnerships and then community health and care partnerships, whose boards largely functioned as a sub-committee of the NHS board, and in which the sense that there was parity of esteem or that the local partnership and the national agenda were working together was not always clear. That can be evidenced in a number of the partnerships around Scotland that broke down.

As a result, we felt it very important to have joint accountability to national and local leaders—in other words, to Scottish ministers and the local authority. I think that that is an innovation; I certainly have not seen it before. The evidence suggested that an integration proposal's strength resided in the Government owning what belonged to it; it would set the framework and give the direction and drivers for change, but would say to local partnerships, "You find your own creative way forward." After all, that is how adults learn and how we are most likely to achieve success.

The fact is that Glasgow is not Galashiels. The different circumstances in which we live require us to be able to create rich and vibrant partnerships that work for us in our localities, so we think that it is important that the Government sets the framework and provides the strategic leadership, together with that which is provided by the local partnership.

I agree with Richard Lyle on some of the things that we say about joint strategic commissioning. You could say that there is nothing much new in our proposal and that it has been tried before. However, it has not been set within the current context. I keep going back to this, but the proposals now include integrated budgets and joint accountability. If you can make that real in legislation, the joint commissioning arrangements will work like never before. The proposals already include some strong moves in that regard.

As I have said, I think that the joint financial governance framework for which we are arguing is new. It is not easy and you will not need me to tell you that local authorities often have to move money around in order to meet the demands on children's services and learning disability services. Once we lock in the resource for older people, local partnerships will face challenges in how to meet demand in other areas, but we will resolve that if we follow this course.

We argue for accountability meetings to be held on a six-monthly or annual basis. We asked ourselves how we would make that real. Scottish ministers used to routinely hold annual accountability meetings in which they would meet patients, clinicians and managers and hold them to account for progress in their area. They had variable success, but if we made such meetings subject to the joint leadership arrangements that we have proposed elsewhere in the partnership, there would be a strong possibility of ensuring that appropriate leadership and governance were applied to the arrangements and our ability to drive them forward.

At the same time, that would respect the individual differences that lead Orkney to want to go in one direction and Highland and the Scottish Borders in another. That is part of the richness of Scotland. Our proposals are far from being a reiteration of what has gone before; they stand on the shoulders of what has gone before, but we are offering something distinctively new.

Richard Lyle: Do you honestly believe in or agree with any form of integration?

Andrew Lowe: With respect, that was my opening utterance—I absolutely believe in integration, but I think that it needs to be locally led. My whole career has been spent on the interface between health and social work. I am absolutely committed to integration, but I am very much against it being driven externally and nationally.

The Convener: Richard Lyle's question was directed specifically towards Andrew Lowe, but perhaps we can broaden the discussion. A concern in this and the previous session of Parliament—the witnesses may wish to respond to this—is that the whole process will be caught up in the debate about governance, budgets, structures and who is in charge. Lots of the submissions allude to such concerns, but we have to look very hard for who should determine and drive the policy in relation to the third sector, carers or patients rights.

Theresa Fyffe (Royal College of Nursing Scotland): That is a fair point. We talk about what went wrong in the past. People say that they do not want to go back seven or 10 years, when we started this and got nowhere. Although we are calling for clarity on the foundations that would make this work, there is a different context today. The driver will be the economic realities, the political will and much more engagement from the public in asking for change. I agree with the previous panel that the work of voluntary sector carers is critical.

However, clear leadership, nationally and locally, is needed to make it work. It is about collaboration between staff and with service users, and treating people with respect and dignity. The processes that are in place must allow those relationships to grow. The previous panel said something that made me think about our use of the term "partnership". The language is interesting. Partnership is the new word that is being used in local government, the NHS and national Government. Although members of the previous panel said that they saw themselves as part of that, the way in which partnership is framed at the moment does not capture the voluntary sector, carers or others. Partnership is a word that is used by NHS managers and employers about the staff side. Our language will have to be clearer if we are to be—and to show that we are—inclusive. Perhaps we did not demonstrate enough of that in our submission.

We have to take enough time to get the local planning right and involve the public and staff. We have to listen and be prepared to change in response to what we have learned, and we have to assure the safety and quality of services. I can see why there might be concerns that we will get bogged down in accountability, but we must have some form of accountability and performance management to ensure that what happened seven years ago cannot happen again.

Iain Gray commented about what happened when he tried to do something, which was that people saw him coming and went off and did exactly what they wanted. We cannot let such things happen. There must be a means of holding people to account to ensure that outcomes are being delivered. Without that, we could be back here debating this in the future.

The Convener: We might come back to your ideas on that.

Dr John Gillies (Royal College of General Practitioners Scotland): I refer to the sort of thistle-shaped diagram in our submission on divisions in the provision of care. We believe that patient care should be at the centre of all care services that are provided. We developed the document to show the patient and the carer at the centre, general practice as the hub of the provision of many services and then other services surrounding it, such as social care, community health services, public health, pharmacy and the voluntary sector.

I found the diagram useful because it illustrates the complexity of the nature of the provision of health and social care. This is not just the NHS and social work. It is not just district nursing. It is not just health visiting. It is a really complex matrix. That is what the committee is grappling with, and what we sometimes grapple with in service provision in general practice in the community.

I agree with Theresa Fyffe. The important thing is to get the principles of integrated care right and decide exactly what we wish to achieve from this change in legislation. We need to have clear outcomes for those principles, against which people can be measured. If we are to achieve integrated care, some of the outcomes could be related to integration.

Dr Simpson alluded to what happened nine years ago with the establishment of community health partnerships. While there has been an astonishing degree of variation in the way in which community health partnerships have delivered services, there have been many instances in which there has been little engagement between

CHPs and general practices and the clinical community. There have been notable exceptions to that, but it is important that we do not repeat that in this iteration of legislation.

We have suggested that a useful way forward would be the establishment of general practitioner clusters to advise, suggest and interface with new organisations so that our voice—which, we feel, can reflect what patients and carers want and need—is reflected in the new organisations.

I make a plea for leadership. It sometimes seems that, whatever the problem, leadership is the answer, but we need cultural leadership that engages in the new world, which we need to engage in, and which forms relationships across clinical and professional communities and with voluntary organisations.

12:00

The Convener: Mr Lowe is offering leadership. He says that the ADSW should have a central role. Would you not naturally accept that social workers should lead the process? Is not that at the heart of the problem?

Dr Gillies: I mentioned cultural leadership. I am not sure that where the leaders come from matters that much; rather, it is important that they represent a spirit of engagement across professional organisations. That is the key to the solution, and there are examples of where that has happened across the patch.

The Convener: I am sure that there are.

Phil Gray (Chartered Society of Physiotherapy): I am delighted that the Scottish Government is taking the issue of integration so seriously. I fully recognise the truth of Dr Simpson's comments about there having been a number of goes at dealing with the matter, but that does not make the approach any less significant or important. We must find a solution.

The big difference now, of course, is that there are, to be blunt, major economic drivers as well as the population changes, with the growing numbers of older people, and the growing numbers of frail older people that there are likely to be in the future. That means that the integration of services is a vital economic necessity as well as a clinical and patient care necessity. All those things are coming together.

It is important to say that there are good experiences. The word "integration" is pretty broad; it is also to do with joined-up government. It is not just a matter of integration between whichever two groups in the system one happens to list; the issue is wider than that. For example, how do the Department for Work and Pensions, the social security systems and the housing system integrate with what we are discussing? Those things are crucial.

There is an opportunity to see ways in which we can change how we have operated. A number of those ways exist. Like most of the organisations that are giving evidence, we have no enthusiasm for structural changes; the danger with them is that everybody will be occupied for months or years with questions such as where they will get a job and where their future will be, and the energy that they should put into delivering better patient care and finding more innovative ways of delivering patient care will be dissipated. At the end of all that, sometimes we find that nothing significant has improved. We are certainly seeing that in England.

We say no to structural changes, but yes to the possibility of integration on budgets, for example. Where there is the possibility of allied health professionals, including physiotherapists, intervening by a change system that can save substantial amounts of money, it is vital that people do not spend from one budget and make savings in another budget with none of that money ever going near them. If people need to invest to save, there must be joined-up budgets that recognise the collective benefits of doing that and which can work towards a new and better system.

I will give members an example. Fall prevention systems are very important and multidisciplinary: it is not only physios and other AHPs who are involved in them, although physios play a big role. All the research—international and UK—shows that such systems can save huge amounts of money. Older people can be enabled to understand simple ways of preventing falls, such as the type of slippers that they wear or the type of carpets that they have in their houses. They can learn how to deal with a fall or to call for help when they need it, so that they do not end up in hospital or need a hip replacement, which costs a fortune. The fall prevention interventions are comparatively cheap, very effective and very well regarded by patients. They give people independence, self-confidence and a belief in themselves. However, all too often they are at the very end of the feeding chain.

It is extremely important to have a multiprofessional environment in this area—our written evidence makes that clear—but we believe that in the work that is being done by physios and allied health professionals, together with doctors and nurses, there are systems of change for rehabilitation and more integrated care elsewhere that can save substantial amounts of money. We would be happy to talk about that later.

Dr Simpson: A fairly clear pattern is emerging, in that people are against an imposed, top-down system of change. However, as I indicated earlier,

we have relied on it emerging in practice, but that has not happened.

I want to focus on terms and conditions. Highland has gone for a full, Transfer of Undertakings (Protection of Employment) Regulations-type of shift, in that people are moving from the local authority to health employment. With my background in general practice, it seems to me that that is really not necessary. GPs employ their own staff, but health visitors and nurses come in and in some cases, if they are lucky, social workers come in. They are all employed by different groups, so it is not necessary to have an integrated primary care team. Terms and conditions do not need to be shifted around.

Do we need integration at the level of the teams at the coalface? Are you arguing against the massive shifts and debates on terms and conditions of the sort that took place, with great difficulty, in Perth and Kinross on the joint futures agenda? We heard about that from Annie Gunner Logan.

Theresa Fyffe: A lot of work is done before the point of TUPE and transfer is reached. We have spent 18 months working with Highland. We are not for structural change, but we have worked with Highland to find solutions from a patient, service, professional and supervisory perspective. I was rather disappointed by the chief executive's comment that the unions were focusing only on TUPE and transfer. Having had 18 months of work, we have only now reached that point. Unfortunately, that probably reflects the quality of the relationship that has come from trying to do structural change with some staff but not with others.

We are looking to build on the success that, as our research found, came about when practitioners, working with other sectors, had a passion and drive to do things right for patients, services and the public. When they have been enabled to do that, they have done it. However, they have not been valued or built into the system.

The previous witness panel made a number of comments about capacity within the community not always being sufficient to support that work to continue. For me, the business of structural change diverts: it takes our eye off the ball and affects the quality of the relationship that might make the difference. Sadly, in Highland's case, only certain staff are being transferred and others are staying. Why is it that they can work very effectively in one sector while others have to change? That has led to a lot of misunderstanding.

Andrew Lowe: We are trying to keep our focus clearly on outcomes for older people, which is where it needs to be. When we consider a model such as the Highland partnership, we must measure whether what is proposed will help with that focus or whether it will mean two years of distraction in employment tribunals and everything else.

I have always said that Highland is a unique territory. It has supersparsity and is vast. The local partnership has determined that such an approach is the way forward, and I have never sought to stand in its way, and neither has the ADSW. However, the test remains asking how best to focus energies and efforts on outcomes for older people. What I have heard from all the witnesses this morning is that we are at our best when we work together collaboratively. We need to find our local way of doing it, and we should not be driven on that.

I find it hard to see beyond the struggle that structural change would create as a distraction. There are better and easier ways of achieving the aim that would get people on board rather than alienate them.

Dr Gillies: In a single year, a general practice will see 70 per cent of the patients who are registered with it. In five years, more than 90 per cent will be seen, whether by GPs, nurses or other clinical staff. The practice is the natural focus for integration.

I will describe the practice in Selkirk in which I have worked for 16 years. We work in a building that the health board owns, which also houses health visitors, podiatrists, physiotherapists, speech and language therapists, district nurses and health visitors. We have a visiting clinical psychologist and we have a social worker who visits once a month—that used to happen more often. The practice is a natural hub for integrating services.

Selkirk is not some rural idyll—we have our fair share of social problems and all the other problems that exist elsewhere—but that model has worked pretty well. As with everywhere else, the model is under considerable strain, because of the economic and financial pressures that we have had to deal with.

I find it hard to see how the situation that Richard Simpson talked about would advance the cause of integration on the ground, and I know that it has created a great deal of difficulty for some colleagues in Highland. If we focus on outcomes, perhaps we need to focus less on terms and conditions.

I see Richard Simpson's point. We do not want to end up where we were seven years ago, and perhaps we cannot rely on everything happening locally. Some national levers from central Government will have to push things in the right direction.

The Convener: You have hit on the nub of the issue. The hub that you describe developed through a process of incentivisation, when money was going around. GPs were incentivised to do all that; in many cases, they did not volunteer to do it. We cannot incentivise people in a similar way in other areas. When people are having to move jobs or work in another area, that sometimes makes the situation difficult. The issue is not necessarily pay and conditions, is it?

Dr Gillies: GPs were not incentivised to develop the situation that I described—the model grew up organically through the creation of health centres that had staff whom the health board employed and staff who were attached to the general practice. The arrangement grew up organically as a response to need. For integration, perhaps we need something similar on a slightly larger scale.

No particular incentives were provided to GPs to make the model that I described happen. These days, our incentives tend to be pretty contractual and focused on individuals, which can be a bit of a problem for wider engagement with the community.

12:15

Phil Gray: I will go back to the question about integrating terms and conditions of employment and integrating structures. If you think about what the solution is trying to solve, you will quickly realise that it is unlikely to solve the problem that you are looking at.

Even when you have integrated the structures and achieved common terms and conditions—with all the complexity that that involves, which I know about very well from past years—you are still left with the issue of how you get integrated professional working, and how you get teams to work together for the benefit of the older people whom they serve. When all the dust has settled, you still have the same problem.

The issue is not easy, but it has been improving in many ways. It does not matter where people are employed, but pulling them together and saying that it is essential for the people whom they are trying to help—the older people for whom they are providing care and services—that the care is integrated involves joined-up thinking. That type of leadership works and is perfectly possible, but it has still to be done.

I believe that we must look again—it has happened a little bit in the past, but not systematically—at the basic education of healthcare professionals, whether they are doctors, nurses, physiotherapists or healthcare scientists. We need to reach them at a very early stage before they become culturally locked into silos as they sometimes are. They need to think seriously about learning from other people's skills and abilities and about the ways in which those dovetail—not somewhere along the line, but from the beginning. In a sense, that involves wishing for a solution that is not here, but which could be in the future.

We must recognise that, although we are saying that structural changes will not achieve what needs to be done, leadership change and integration of teams are needed. I believe that the Government's proposal to integrate budgets will help greatly. Even if those budgets are run through different employment sectors, there will be someone with responsibility who will be accountable to the chief executives of the local authority and the local health board. In that way, you can see how money is being used in the total budget and where you can invest in order to deliver a better and more integrated service. That is enormously helpful.

Dr Simpson: I have a supplementary on the specific area of electronic records. That issue is mentioned at paragraph 1.4 of the Chartered Society of Physiotherapy's submission, and at paragraphs 7.11 and 9.12 of the submission from the Royal College of General Practitioners.

Alcohol-related brain disease, for example, is one of the more complex areas that we see, but it is nevertheless important. I did a study in West Lothian that showed that there were 12 different sets of records. We are talking about integration on the ground, which you all appear to want, rather than structural change. Why have we still got a system in which the records are based on our silos and not on the patient or the client?

That must be a starting point. We need a records and information technology system that is individually focused and not all over the place. Social work and medicine do not share records, and neither do community nurses and general practitioners. We have a totally dysfunctional system from which to achieve integration. Does anyone have any comments on that?

Theresa Fyffe: Richard Simpson is absolutely right. There is a need for an IT infrastructure that allows professionals not to keep records in silos. In some cases integration does not happen because the infrastructure is not there to support it, rather than because there is a wish not to do it.

I spoke to a GP-led model recently that has all kinds of professionals working within it, and Caldicott was one of the issues that was preventing it from going further. We are aware that Dame Caldicott's review is looking at that, so let us hope that it will move things forward. The model was almost breaking some of the rules and it was at risk of not getting things right if it did not get some guidance.

We have to find a way of sharing the information. That is where structural change becomes an issue. I remember being at an event in another part of the country at which the person who was speaking became obsessed with where the filing cabinets were. He went on and on about which room contained the filing cabinets. He wanted everybody to be in the same room with the filing cabinets. I kept saying, "You don't have a big enough building for that."

We need something different; we need the IT infrastructure and guidance that will enable the sharing of records. There are issues to be bottomed out in relation to public safety and public expectations about where records are held, and codes are required to enable professionals to understand what they need to do. However, I believe that it is the right way forward. I do not think that you will find many professionals who do not agree that it is the right way for the future.

Dr Gillies: We included in our executive summary a suggestion that there should be

"Urgent action by Government to bring forward proposals to allow the sharing of electronic patient records, supported by appropriate patient safeguards".

We recognise the issue.

All GP records in Scotland are electronic—I think that I can say that—so paper systems are a thing of the past. One of the biggest challenges in the past few years has been working out how we can share appropriate parts of our records with hospitals and vice versa. Even that sharing, which has taken place within a profession, if you like, has proved to be difficult. There are significant issues to do with data protection and confidentiality that have to be addressed. People will say many things during a consultation with their GP that they might not wish to go elsewhere. We can all think of such situations. The question is how much of the record should be shared and how appropriate safeguards can be put in so that people are not privy to information that they do not need, but other professionals get the information that they need to care for the patient.

I agree with Richard Simpson that there is an issue and that there are significant challenges, but perhaps integrated care will be one of the drivers for moving things forward.

Andrew Lowe: Having spent six years of my life as a local data-sharing chair, I am aware of some of the complexities of the issue, and I have done much to try to resolve them. I have seen a lot of money spent on electronic solutions to not very good ends, and I have come to the conclusion that we have some conflicting advice, with the Bichard principle of disclosure and the Caldicott principle of being cautious.

Often the best that we can achieve is the will to develop an effective local data-sharing protocol on a need-to-know basis. Using that approach, and not being a victim of the technology issues, we have seen a lot of progress. We have shared information with a local medical committee and been able to agree protocols with the police and the council. However, that falls short of Dr Simpson's vision of one system. Rather like Dr Gillies, I agree that there are reasons why people do not feel that it is appropriate to move to a single system, but we should have clear protocols on sharing. There is no excuse for our not developing more of those.

Dr Simpson: My personal view is that data must be client or patient controlled. They must have control of their data. We have a system in which services have control of the data. If we give the patient or client control of the data, they can say whether or not they are happy for their GP to see the psychiatrist's notes, and whether or not they are happy for the social worker, pharmacist or optometrist to see the GP's notes. In other words, the client controls things. No longer should the professionals control the data—that is what is wrong with our system at present. However, that is a personal view.

The Convener: That was a question and an answer—two for the price of one.

Bob Doris: I will stick with questions for the moment and leave the answers to the witnesses.

I do not want to talk about staffing, TUPE or whatever; instead, I want to talk about what I think we are all concerned about: the local structures that will lead to better outcomes for all our constituents. For a start, do we all agree that shared or joint budgets are the way to go and that, as we discussed in the previous evidence session, a variety of partners, including the health service, the local authority and the third sector, should sign them off?

Secondly, do we need structures that allow for very local service design and involve the RCN, GPs and AHPs as well as the health board and the local authority? I am well aware that doing things differently will result in knock-on local-level structural change that might have an impact on Ms Fyffe's union members, the professional body that is keen to progress local service provision and Mr Lowe's staff in local authorities. The final issue about structure relates to the commissioning process.

I have gone on at length so let me try to tie everything together. I hope that we all agree on the need for joint budgets and, although we must keep things focused, the need for as many people as possible to be involved at the start in service design and the commissioning process. Have your

groups been involved, or are they likely to be involved in future, in discussions about budgets at a local level and in proactive discussions about service design? What are your thoughts on commissioning?

Theresa Fyffe: There was a lot in that question, but I will attempt to follow everything through.

I absolutely agree about integrated budgets; indeed, we have said very clearly on the record that they are a way forward. However, we are waiting for the pilots to be evaluated to find out how that approach has worked. I thought that the earlier discussion about the change fund was very interesting. I do not have as much experience with local government, but the NHS has certainly had years of getting what I would term as ring-fenced money and using it for whatever fitted best. It will be interesting to see what we do with those budgets in future.

Your use of the term "sign off" is interesting. The impression that I got from the previous panel was that although their organisations were—quite rightly—among those who signed off budgets they were not present at the very beginning to discuss requirements. We should move towards integrated planning and whoever needs to be involved should be present from the very beginning. In fact, that probably takes me back to my earlier comment about what we understand by partnerships. When we talk about partnerships, we seem to refer more to two sides rather than all the individuals who should be involved in service change.

We have committed ourselves to service redesign if it improves patient outcomes. However, I am sad to say that service redesign can mean making cuts and having to make changes because of funding shortages. That is not service redesign; that is simply saying, "We have this amount of money in an envelope and we need to provide the same service for it". That leads to the dilution of services and all the risks associated with that. True service redesign concentrates on outcomes for patients, demonstrates clear engagement with patients, the public, carers and professionals and sets out what needs to be done differently and how that might be achieved.

Of course, such an approach can lead to disinvestment. One can see how, in the integration of health and social care, funding can shift from older people's care to the community and primary care. However, how can we sort out the big pots of funding for acute care? How do you change an infrastructure that is necessary to deliver all the core services that we believe should be available to the public, and how can service delivery continue while such shifts happen? We need to do a lot of unpicking to understand how we might deal with acute care and the money that is going out. It is important that we are clear about any service redesign and that there is an engagement process in that respect.

My final comment is on commissioning. I am one of the people who said to Annie Gunner Logan that the word "commissioning" sets hares running for people in the health service, because we tend to link it to procurement from our providers. That comes back to the point about language—we need to be clearer about what we mean. We need to know what we understand by "commissioning", what it involves and who should be involved in that process. It should not be the case—as happens in one board at the moment—that there is a little private meeting to deal with the issue and everyone else is meant to engage later. That is not the way to take things forward.

12:30

Phil Gray: This is a vital issue and a good illustration of how things can work best. Some time ago, the committee's predecessor was responsible for the proposal to ensure, when the community health partnership committees were set up, that allied health professionals had at least one person on them who could express a view and who had a voice. That was extremely important, because it is no exaggeration to say that physios and our AHPs are employed across numerous sectors, including the acute sector, the community sector, primary care and social care, and the different professions are integrated across those sectors in many ways, at least in the way in which they operate. In their provision of inclusive services, they are a kind of bridge. They are a glue that helps to keep together a number of services that would otherwise get fragmented.

Because the health practitioners in those groups work across sectors, they observe the things that work very well and the things that work very badly. That is the same with AHPs in hospitals, who wander around doing their jobs in different places. It was a physiotherapist, among others, who helped to alert people to the problems that existed in Staffordshire, the report on which will be published shortly. They have a significant role to play in that regard.

As the structures are changed, we hope that in the new health and social care partnerships that are proposed, it will not be lost that AHPs can play a helpful role in identifying what can be improved and developed. We would be grateful if that were included in the system.

All that is about the important process of having integrated budgets and integrated planning, but the outcome is what change that produces. There are some good examples of how, by thinking about things more carefully, significant changes

can be produced that improve care and save substantial amounts of money.

I will give two such examples. Like the rest of the UK, Scotland is struggling with the problems of delayed discharge of older people. There is a range of reasons for that. One component of that is a lack of adequate rehabilitation. I do not necessarily mean rehabilitation in the acute sector, which can be quite good. When people are discharged from the acute sector, they often disappear into what is, relatively speaking, a black hole, because there is little investment in community services for physiotherapy, occupational therapy or speech and language therapy.

Stroke services are a classic example. Over the past 10 years, stroke services in the acute sector have improved beyond recognition. It is fantastic that, if an older person has a stroke, the odds are that they will be brought in fast, they will receive emergency treatment in a specialised unit in the acute sector and they will get the blood clot-busting drugs that they need rapidly.

However, as my chair of council said when the systems were being developed, "That's great, Phil. We've really improved things for people for the first 10 days after their stroke; what about the rest of their lives?" Often, people end up out in the community without access to continued rehabilitation services. They do not need endless treatment, but one or two treatments is not going to do it; people need a continuing system of help.

The same applies to older people who get out of hospital and go back to the community. There might have been a problem with delayed discharge, so the system might not have helped them. If local authorities are to provide support in that situation, the person needs to be as independent as possible. Nursing support and rehabilitation should be part of the package, and if it is not, the person's level of dependency will increase and eventually they will end up in a nursing home—although, as a member of your previous panel said, they do not need or want to be in a nursing home and could have stayed at home if they had had the necessary rehabilitation and support to enable them to remain independent.

There is much innovation and change around. In the physiotherapy world, you in Scotland have pioneered an innovation that you might not realise has spread all round the world: patient self-referral into physiotherapy services—mainly musculoskeletal services. That innovation was developed in Dundee and rolled out across Scotland, and it is being copied in the United States of America, in Canada, in Australia and across Europe. People have realised that what has happened in Scotland is exciting and tremendous, and more and more research is showing that the approach saves money. We need to go a stage further and open up the approach to people with longer-term conditions, so that they can self-refer when they need to do so, rather than spend months in a complicated system to gain access to the service. The approach leads to shorter treatment times and saves money. Again, it is ultimately about people's independence and their lives as older people.

The Convener: I might speak to you about self-referral after the meeting. My case-load is full of people who self-referred and are having to wait. That might be an issue in my area, rather than an issue to do with the system. I will have a word with you before you go, to see whether you can help me.

Phil Gray: There needs to be the investment to do it.

Andrew Lowe: Mr Doris's question about local involvement in service design, budgets and expenditure reminded me of Annie Gunner Logan's comment about the third sector's experience of the change fund being like that of guests at a wedding. That is a vivid simile, but I hope that it is inaccurate. I prefer to think of the approach as a family reunion, because we are part of the same family—we inhabit different space but we are coming together to try to ensure that integration works.

The point about integration is that it works only if everyone plays a role. The third sector and the independent sector do things that nobody else can do. When I talk about integration I am talking not just about integration of health and local authority social care but integration of all the talents. We must begin by thinking about how we develop services locally and how we listen to what people tell us about what they want.

In my local authority, Scottish Borders Council, we have been developing a place-based approach to integration, focusing on a local area. We bring in all the players from the third sector, the independent sector, health and social care, to try to develop a model in a small area, where we have consulted local people and local stakeholders. We have developed a model and we are transforming a local hospital—the Local Government and Regeneration Committee came to see it last week.

That kind of approach, whereby there is local involvement from the beginning and people do not pay lip service to change but genuinely buy in to how it comes about, is what I think will work in Scotland. That is why I am passionate about saying, "Give us the space to create change. Give us a framework, with the principles to which you want us to adhere and the outcomes that you

expect us to achieve. Then let us go away and create, as partners, which is what we do best."

The Convener: Martin Sime mentioned the need to update information on demographic changes in order to understand the current situation, because the available information is out of date. More important, in the exercise that you are conducting, you need to know what the demographics will look like in the next few years. Have you updated your information and established current and future need?

Andrew Lowe: Yes. I was surprised by Martin Sime's comments, because there is considerable awareness of the demographic curve in Scotland. We know that it has turned upwards, and we have been able to make reasonable predictions about how much in relation to both the ageing population and inward migration. We are making plans in accordance with that information. I am not sure where Martin Sime's comments came from. I am clear in my own mind about the challenge.

The Convener: It was a national figure, and there is a lot going on locally—

Andrew Lowe: It is the comment about the national figure that I was referring to.

The Convener: The difference in opinion is interesting and it may be worth while for the committee to seek some information on the issue.

Dr Gillies: It is important that what we get for the shared budget are clear, measurable, appropriate outcomes. The outcomes of integration should be simple things that we all want to see, such as a reduction in delayed discharges and the availability of services for frail people who could be managed in the community with a little extra service that will prevent them from having to go into hospital. Outcomes for general practice are measured to the nth degree—you can look up the outcomes for every practice in Scotland on the internet. Clarity of outcomes for the shared budget is important.

I make a plea for general practice input into service redesign. GPs are clinical generalists. We are doctors of first and last resort. We are usually the clinicians whom people see first and, if a hospital cannot sort them out, we will see them when they come out. We see people of all ages and with all the diseases on the spectrum. GPs, therefore, develop a unique perspective of a community's health needs, whereas specialists, essential though they are, tend to have a much narrower perspective based on a particular disease or set of illnesses. GPs see it all.

That is not the only perspective—there are lots of other important ones—but it is important that it should inform the redesign locally. That is why we have suggested a model whereby clusters of general practices would get together to find out the issues in their communities and localities, using that information to inform the redesign of the health and social care partnership and the way in which services are set up and developed. The model would also provide a feedback loop, so when something was not going right, we would be able to say that, although it looked good on paper, it was not working on the ground.

The capacity available to a general practice to do that is an issue. Most GPs want to see patients and do not always want to contribute elsewhere. That is a support issue that will need to be addressed. There is no doubt, however, that service redesign is essential.

Two weeks ago, we looked at a Northern Ireland example involving 11 district general hospitals. After a needs assessment was conducted, it was thought that only six were needed; ideally, four or five would close, with the services moved into the community. Obviously, that would involve major issues, but it means that there would be an increase in capacity in the community, which general practice could, if not lead, at least make a contribution to.

The demographic transition means that we have a similar situation, and we need to consider that carefully. Practices should be at the heart of the redesign.

12:45

The Convener: I will introduce something that goes to the heart of the issue. As has been said, there is a lot of good practice. However, from an MSP's case-load, it seems that many people leave hospital on a Friday—the big day when the beds are emptied—but their chances of getting their own doctor during that weekend will be slight, so they depend on NHS 24, if they call it. One of the most common issues for MSPs is that the arrangements for the move from hospital to home break down, although I am sure that that does not happen in the Borders. Perhaps the home help or carer who should go in on the Saturday morning does not turn up. As a consequence, the person could be readmitted to hospital.

Is that just the world that I and other MSPs live in, or is it reality? The question for us all is about why that continues to happen when we all know that it happens. The problems in our case-load are not to do with services that are provided 9 to 5, five days a week; they are to do with the care package after 5 o'clock in the evening and at the weekends.

Dr Gillies: I recognise that world from general practice—particularly the problems that are associated with discharge from secondary care into the community. I would not say that the

Borders is faultless on that, although it is better than some other areas. In 2004, the new GP contract changed our contractual obligations. I did on-call work from 1976 to 2006, and I was glad not to do it after that, but the change has left a gap in continuity. However, the issue is not all about GPs; it is about co-ordinating care as people move from hospital to the community and back again. I cannot offer any general answers, but I believe that that is why we need an integrated system.

There are different cultures in hospitals, social work, community health services and general practice. Those services need to join forces to resolve the issues locally, but that is a challenge. Previously, attempts have been made to do that, but we now have the demographic changes and the increase in the number of people, not all of whom are old, with what we called multimorbidities, which means lots of conditions. That is a relatively new phenomenon that adds to the complexity of what we do and is a major challenge for integrated care. There should be some fairly good measurable outcomes around that.

Bob Doris: The issue is frustrating. I understand that GPs have a unique position—I absolutely get that—but so do nurses, physiotherapists, social workers, patients, carers and the third sector. The issue is how we get all those people with unique positions involved at the planning stage to deliver the most effective service. I suppose that that brings us back to the local guidelines. If service planning is to be valid and appropriate, how many of the guidelines should be recommendations, how many should be statutory and how should they be enforced? I am sorry to bring us back to structures, but the outcomes that we want will not happen unless we get the planning right, which I think is the point that Ms Fyffe was getting at.

Theresa Fyffe: Integrated planning is at the heart of the process. I am not sure that that needs to be spelled out through the legislative process. That element will be in the framework for the principles of integration across Scotland. Locally, we must have integrated planning requirements, which goes back to the question about the measurement, performance management and outcomes that are expected and who needs to be involved.

The situation that the convener described might be the experience of some people, and there are problems with provision of out-of-hours services in some areas—the position is patchy across Scotland. However, John Gillies and the RCGP have given an award to a team that provides a virtual-hospital-at-home model, which involves nurses, doctors and others working together to provide the necessary support to those people who go home on a Friday. Community nursing and other services have become 24/7 services. Previously, community nursing might not have been 24/7, with a gap after 6 o'clock in the evening.

It comes down to setting the requirements and then asking the teams—whoever needs to be involved—to find a new way of working. That must be done if they are to achieve the outcomes and meet expectations. There are lots of good examples of that happening already, but there is a block that is stopping it happening in some places, which needs to be addressed. Sometimes that is down to individuals, and sometimes it comes back to whoever is leading the service. If the leadership is clear about expectations and is not giving mixed messages, we will get somewhere. Sometimes people in authority give mixed messages to those who are trying to do the work on the ground, and that must be addressed.

The Convener: I will call Phil Gray next, but I am aware of the time and I want to round up at about 1 o'clock. If we have shorter answers, I can give people the opportunity to come in.

Phil Gray: I want to say quickly that the convener was absolutely right about there being a perennial problem with organised planning before people are discharged from hospital. It will always be the case that someone's health can deteriorate after they get back home because something happens that no one could have anticipated, but all too often systems are not set up to support people at home and rehabilitation packages are not available, with the result that individuals' conditions get worse and they end up back in hospital.

In our evidence, we mentioned a good local example: the Edinburgh community respiratory team. The team deals with people with lung conditions, including chronic obstructive pulmonary disease, and responds rapidly to help people in their homes. It saves a huge amount of money, and hospital admission is avoided for a remarkable 97 per cent of its at-risk patients. That is the kind of thing that could be done.

The Convener: Was that in your written evidence?

Phil Gray: Yes.

The Convener: That is helpful.

Jim Eadie: Earlier, Theresa Fyffe raised the issue of what is described in her organisation's evidence as

"decisive and transparent national leadership."

Why is that so important, and how do you reconcile it with the earlier panel's scepticism about a top-down approach?

I would like to hear the views of each of the panelists on that, and would then like you to answer this question: what specifically does the Scottish Government need to introduce by way of necessary joint financial arrangements to allow us to integrate budgets effectively, keeping in mind all your comments about avoiding any structural change that would divert energies from the work that is required to make this a success? I would like to hear your comments on national leadership and on joint financial arrangements, please.

Andrew Lowe: I will take the second issue first. There are a range of challenges with integrating budgets. At the moment, the budgetary cycles of local authorities and NHS boards are not aligned, and their budget-building processes happen in different temporal spaces. It strikes me that one of the first things that Government can helpfully do is in different ways to encourage an alignment of budget processes. The cabinet secretary has identified a proposal for a single accountable officer. I feel confident that if we have such a post, along with an aligned budgetary process and appropriate leadership, we can align services without there being structural integration, if there is the will to do so, which must come from the framework that you set.

I am sorry, what was your first point?

Jim Eadie: It was on national leadership. The RCN suggested that that was critical to the success of the process and talked specifically about national guidance and an integrated performance management system.

Andrew Lowe: We feel similarly about that. The greatest trick in all this is to get the appropriate alignment between local energy and determination, and national leadership and guidance. A draft set of outcomes is being developed for this work, and guidance is being developed by the various professional organisations. We need to bring that together and bring it to bear on local partnerships without stifling local initiative.

Theresa Fyffe: I want to return to the budget issue. We have come to the committee and talked about the lack of transparency in the health budget, and the difficulty in understanding it, often enough for the committee to know our view on it. That is why I referred earlier to the evaluation of the integrated resource framework, which has still to come out. We criticised Highland for racing to its position when we do not know what the evaluation will tell us. We need to know how it has worked and whether it has done the job. To be honest, I cannot really comment on the issue until we get the evaluation. We have no insight into how the framework is working, so we would like to see the evaluation.

We have called for national leadership. I think that the final speaker on the previous panel said that we should start working to get things right and have leadership so that people do not shift around. As I said, the current political context is a good driver for that, because no one will say "Well, that's a nice idea for the moment, but we will change it all again."

We want national leadership to set a direction of travel and be clear about what will be done. However, leadership works at all levels. A witness on the previous panel made a good point in that regard. We can talk about leadership from the perspective of patients, carers and teams, so when we talk about leadership, it depends on what context we mean. If it is about teamwork, those who provide the biggest bulk of the care should take the lead, but only in working with others. That model works very effectively just now. Talking about leadership and drivers across the piece would involve the third sector, but it particularly involves the drivers from patients and the public.

Dr Gillies: Budgets are not my area, but perhaps we need to think about getting shared outcomes within a quality improvement framework for the shared budgets. Perhaps we should consider a framework that would allow a quality improvement process to help develop things rather than have just static outcomes.

On leadership, as the RCN said, the tone at the top is really important. We probably need national voices saying that integrated care is an important policy for the Scottish people. However, we need the sort of leadership that allows the innovation and creativity of professionals working at the front line to come through to deliver the service. That needs a kind of subsidiarity approach. We need leadership at all levels.

13:00

Phil Gray: Leadership is incredibly important. As Theresa Fyffe said, leadership exists at all levels, and there are leaders all over the health and social care system who can be called on and who can demonstrate the contribution that they can make. Guidelines and standards are important, particularly because they save us from constantly reinventing the same darn wheel for ways of improving things. The public should be able to turn to guidelines and at least make a reasonable guess about what they can reasonably expect in terms of multiprofessional support, help and delivery.

It is about all our professions recognising the importance of working together and integrating. The sixth century monk St Benedict, when writing his rules, started with one of the most important

things, which is really about respect; he wrote one word: “Listen.” That is what we could all do.

Richard Lyle: I agree with the convener’s earlier comments about out of hours, and people coming out of hospital only to be put back in. For those who do not know, I drove for an out-of-hours service for two years, so I saw the situation at the coalface. I gave up doing that only last May, when I was elected to the Parliament.

I think that I have found a 10th point for the ADSW submission, which is regular meetings with other partners.

The Convener: We have covered a number of themes, but in case we have inadvertently omitted any, I offer panel members the opportunity for a further comment before they leave.

Theresa Fyffe: We have just completed our principles of work. That work has been done with stakeholders, the public, patient groups and our members. In fact, many of the people around this table have been involved with us in that work. We will submit that work to the committee before you have your evidence session with the Cabinet Secretary for Health, Wellbeing and Cities Strategy.

Andrew Lowe: Convener, you gently teased me about my offering ADSW leadership in the debate, but we make no apology for that offer. However, our point is about leadership with others. We are playing our part in the debate and we are keen to get behind the agenda. We want to continue to ensure that we remember the great value of social work and that, rather like general practitioners, we deal with the whole person—from the baby to the offender to the older person. We cherish that.

Dr Gillies: The virtual wards model that Maryhill practice in Elgin is using is well worth looking at. Interesting models of integrated care are developing in England, particularly in Cumbria, which is not so far away. Integrated care organisations were set up there last year, which are working and being evaluated under the Cumbria clinical commissioning group.

The Convener: I thank you all very much for your attendance and for the evidence that you have given us.

Meeting closed at 13:03.

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