The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

FINANCE COMMITTEE

Wednesday 28 November 2012

Session 4

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FINANCE COMMITTEE
31st Meeting 2012, Session 4

CONVENER

*Kenneth Gibson (Cunninghame North) (SNP)

DEPUTY CONVENER

*John Mason (Glasgow Shettleston) (SNP)

COMMITTEE MEMBERS

*Gavin Brown (Lothian) (Con)
Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)
*Michael McMahon (Uddingston and Bellshill) (Lab)
*Elaine Murray (Dumfriesshire) (Lab)
*Jean Urquhart (Highlands and Islands) (Ind)

COMMITTEE SUBSTITUTES

*Dave Thompson (Skye, Lochaber and Badenoch) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Bob McDougall (Trust Housing Association)
Marlene McMillan (NHS Ayrshire and Arran)
Catriona Renfrew (NHS Greater Glasgow and Clyde)
Soumen Sengupta (West Dunbartonshire Community Health and Care Partnership)
Michael Thain (City of Edinburgh Council)

CLERK TO THE COMMITTEE

James Johnston

LOCATION

Committee Room 2

Scottish Parliament

Finance Committee

Wednesday 28 November 2012

[The Convener *opened the meeting at 09:45*]

Decision on Taking Business in Private

The Convener (Kenneth Gibson): Good morning and welcome to the 31st meeting in 2012 of the Finance Committee of the Scottish Parliament. Could everyone present please turn off their mobile phones, tablets, BlackBerrys and other electronic devices. We have received apologies from Jamie Hepburn, who is unwell. However, I am pleased to see that David Thompson is here again as a substitute. How many times is that now, Dave?

Dave Thompson (Skye, Lochaber and Badenoch) (SNP): I think that it is the second or third.

The Convener: I am sure that it must be more than that, but you are certainly a welcome addition to the committee when you are here.

Agenda item 1 is to decide whether to take in private item 3 and further consideration of our draft budget report at future meetings. Is that agreed?

Members *indicated agreement.*

The Convener: I ask members' indulgence, because I would like them to—

John Mason (Glasgow Shettleston) (SNP): Switch off their phones.

The Convener: Indeed, Mr Mason. I would like members to agree to take the employability report first in our private session. We did a lot of work on that last week and all we have to do is go through some paragraphs that we did not fully agree on. Taking it first would give us much more time to go through the budget report in detail. Are members okay with that?

Members *indicated agreement.*

Demographic Change and Ageing Population Inquiry

09:46

The Convener: Item 2 is to take further evidence for our demographic change and ageing population inquiry. We will take evidence in round-table format. I welcome to the meeting Mr Bob McDougall, from Trust Housing Association; Soumen Sengupta—I hope that I have pronounced that name correctly—from West Dunbartonshire community health and care partnership; and Michael Thain, from the City of Edinburgh Council. We still await two guests who have unfortunately not arrived yet.

I said this last week but, for those present and for the record, I point out that the purpose of the inquiry is to identify the impacts that demographic change and an ageing population will have primarily on the public finances in respect of the provision of health and social care, housing, pensions and the labour force; and on the planning being undertaken by the Scottish Government and key public bodies to mitigate such impacts.

In its call for evidence, the committee asked to what extent the pressures on health and social care are a consequence of an ageing population as opposed to other health challenges such as obesity. For example, in relation to factors such as sight loss, thinking skills, diet and nutrition, and fragility fractures, there can be long-term, substantial costs for health and social care, as well as for housing—for example, they may affect the ability of a person to continue to live in their own home and whether adaptations are required.

Like last week's session, this session will therefore focus on the health, social care and housing aspects of the inquiry. I will allow up to 75 minutes for the session. I will ask Michael Thain to start us off. He made an excellent submission on behalf of the City of Edinburgh Council. However, before I go to him, I remind everyone that anyone can contribute to any part of the debate or discussion; the only queueing system is when I see you. If you have spoken, feel free to chip in two or three minutes later, because we are not taking people in sequence. You can contribute as frequently as you wish.

Michael, in your detailed and interesting submission, you highlight the long-term financial planning model that has been adopted by the City of Edinburgh Council to identify the costs of delivering services and to calculate what savings could be achieved. The context for that is a predicted 43 per cent growth in the number of

households in Edinburgh. Can you talk to us about that 10-year plan just to kick us off?

Michael Thain (City of Edinburgh Council): The 10-year plan was introduced in 2009 and is designed to give the council a longer-term, more strategic context in which to make budget decisions, given that local government has become very focused on what needs to happen next year. The purpose of the long-term plan is to ensure that members, officers and the public are aware of longer-term risks when making decisions for the year ahead. The long-term plan is revised annually and it takes account of demographic issues and tries to take account of other policy and public contexts in which decisions are made. Issues such as rising energy costs for households and the impact of welfare reform are increasingly part of the long-term financial plan in trying to assess the impact of the wider policy context on households and what the council has to do to respond and to prioritise within that.

The Convener: It was interesting that in your submission, Mr Sengupta, you said that West Dunbartonshire Council does not use

"demographic projections beyond the three year budgeting cycle."

You also state:

"However, if it is fundamental for local government to project spending needs, there is also a requirement for central government to provide a certain level of information on same basis – i.e. funding plans over a longer period of time than 3 years."

Will you comment on that?

Soumen Sengupta (West Dunbartonshire Community Health and Care Partnership): Thank you. I think that we have started to learn from the experience of areas such as Edinburgh in what we have been doing. There are two elements to it, one of which is, as our colleague has just highlighted, that the plans end up being revised annually anyway, however long term the plan is; and the further out you go from the medium to the long term, the more uncertainties or assumptions—however they are defined—there are.

We have taken a prudent approach until now. We could set out something much more long term, but the reality is that, for years 6, 7, 8 and 9, there would be so many uncertainties that we would have to do something quite radical after four or five years. The plan would be a 10-year plan on paper as opposed to a 10-year plan in practice. That said, we have had the advantage of seeing what areas such as Edinburgh have done and how they have firmed up their work.

Since we made our submission, our authority has put in place five-year strategic and financial plans, rather than three-year plans. In addition, we are going through the process of developing a 10-year capital plan for the authority for the investment decisions that we need to make. In doing that, we are thinking about the needs of the population, particularly the impact of demographic change and the increase in the volume and proportion of the older population: both the 65-plus age group and the 85-plus age group. We are also thinking about the challenges that that presents for other cohorts of the population that previously would have been of a higher proportion or higher number. Obvious areas to think about in that regard include the number of schools and investment in the school estate "versus" the investment that we will need to make in supported housing accommodation, care homes, aids and adaptations and so on.

The Convener: Mr Thain, you said in your submission that

"some £52 million of additional demographic change-related expenditure has been identified within"

the long-term financial plan. Is that a direct result of having produced the plan? Will that help the council to direct its spending more effectively in years to come?

Michael Thain: Knowing that £52 million of additional funding is required over the next 10 years will inform our decision making when we are considering efficiencies in budgets or areas that require additional resources. It makes it easier to make longer-term policy decisions when we know that there is that additional requirement and it allows us to see the risks. For example, if there are proposals for efficiencies in an area, we can see what the risks may be if we make savings.

We also have plans that go beyond 10 years—for example, in the housing revenue account, we have a 30-year business plan that allows us to do longer-term financial planning around debt management and so on.

The Convener: I am interested in the comment in your submission that

"the impact of demography ... is not restricted to older people"

and that in five years you

"expect to have to spend £13.4 million more on social care for adults with learning disabilities, compared to £10.5 million more on older people".

Do you expect that trend to continue, or is that a medium-term expectation?

Michael Thain: As our submission makes clear, a greater proportion of people with learning difficulties are being identified to council services through our assessment processes, and that proportion is increasing year on year. Our projection is for that existing trend in the area of learning difficulties and physical disabilities to

increase. The methodology in that respect is mostly about predicting continued growth in those areas on the basis of previous trends. As my colleague Mr Sengupta has said, none of this is an exact science but, if you regularly review these matters, you will at least have some context in which you can make year-to-year budget decisions. In short, as far as disabilities are concerned, there have been year-on-year increases in demand for services from households and we expect that situation to continue. However, if that demand drops off, the discipline of our long-term financial planning will allow us to be aware of that when we make decisions.

The Convener: I should say that everyone else is allowed to contribute to this discussion; it is not a dialogue between me and a couple of our guests.

Gavin Brown (Lothian) (Con): I have a question for all our panellists. We have heard about various timelines, from a year-on-year approach to three-year plans, five-year plans, 10-year plans and even a 30-year plan in relation to some business aspects. Obviously, the longer term the view that you take, the more strategic you are but the less accurate the figures on which you have based your plan might turn out to be. What is the optimum length of time that it is worth modelling and projecting for?

The Convener: Is that an open question, Gavin?

Gavin Brown: I am throwing it open to everyone.

The Convener: Michael Thain talked about an additional £52 million being needed over the next 10 years, and I wonder whether he can set that in context and tell us what proportion that is of Edinburgh's budget. I know that the City of Edinburgh Council's grant was increased yesterday from £709 million to £711 million, but I do not know what its total budget is.

Michael Thain: I think that the budget is just over £1 billion overall, so—if my arithmetic is right—it would be in the region of 4 or 5 per cent. Is that right?

The Convener: Is it not 0.4 or 0.5 per cent?

Michael Thain: Yes. As for the optimum length of time that we should model for, it all depends on what we are looking at. I mentioned our 30-year business plan for council housing, and the reason why we have projected rental income, debt and investment over such a long timescale relates to the nature of the housing life cycle. Over the past 10 years, the discipline of business planning has become much more common with regard to council housing and in housing associations, and having an awareness of what you need over the longer term to maintain and improve properties, build new homes and so on gives you some context in which you can make decisions for the next four or five years. Indeed, that kind of long-term business planning is carried out quite widely in the private and commercial sectors and is particularly relevant with regard to housing.

10:00

The key thing is to be aware of the risks in the information that you include in your planning. Mr Brown is absolutely right to point out that the longer you plan forward, the greater the risk that things will change. After all, things in the outside world will themselves change. Projections on household growth are probably more vulnerable to change than projections on population growth, because a lot more depends on people's behaviour. Welfare reform and the changes to housing benefit—for example, the move to reduce benefits for social housing tenants with one or more unoccupied bedrooms—might well lead to significant changes in how people compose their households. Such things are difficult to predict until we see how major policy changes are impacting on people. The longer term your plan, the more strategic you are being, but the other aspect of being strategic is an awareness of the risks in predicting these kinds of things. It is certainly a sensible discipline to be aware of them and to review such matters accurately.

John Mason: Continuing on the issue of data and projections, I noted in paragraph 5 on page 2 of the NHS Greater Glasgow and Clyde submission a very interesting table on life expectancy and healthy life expectancy, which is an issue that the committee has discussed before. I am interested in the fact that the table refers to men—and in the fact that at this table all the men are at one end and all the women are at the other; I do not know how that happened.

Catriona Renfrew (NHS Greater Glasgow and Clyde): We do not want to run the risk of having our lives shortened by sitting near you. It is much safer at this end. [*Laughter*.]

John Mason: Absolutely. Is the information in that table quite robust? Secondly, can you tell us a bit more about the idea of healthy and not-healthy life expectancy? The committee has heard that people need most intervention and help in the last year or 18 months of their lives. Does that mean that if someone lives 10 years longer, they will not need help for an extra 10 years or is the process more gradual? How does it work?

Catriona Renfrew: Coming back to the earlier discussion about planning, I think that that is the sort of thing that is very difficult to predict. Optimists might argue that, as people's lives

lengthen, the period in which they are healthy will also lengthen. However, that brings into play a series of behavioural issues such as the rise in obesity and alcohol consumption and the increasing number of people with long-term conditions and other disabilities. As you become more pessimistic, you can easily find yourself arguing that, although people will live longer, an equivalent percentage period of their lives will be spent in ill health. That is a huge issue for the health service.

The expectation is that looking after older people better in the community and being more innovative in dealing with them will take pressure off the health service and potentially allow a shift in resources. That is partly true, because a number of older people who are stuck in hospital do not need to be there. However, on the demand side, a population that lives longer but has made unhealthy lifestyle choices will put massive demands not just on the traditional older people's care that we provide but on a whole range of health services, whether they be cancer services, surgical services or whatever.

If we put all those things into the mix, it becomes incredibly difficult to plan beyond a relatively limited horizon. Nevertheless, it allows us to begin to calculate some of the risks and issues and calibrate our planning more neatly as we move forward.

John Mason: So if people start living longer, we might well find very big differences emerging between 75-year-olds in one area and 75-year-olds in another.

Catriona Renfrew: Those differences already exist. I have to say that there are not many 75-year-olds in the most deprived parts of our health board area; actually, the situation is the other way round. The 45-year-olds in some of our most deprived populations are the equivalent of 75-year-olds in our other populations. Poverty and people's lifestyles have a huge impact on their physiological condition rather than their age, and it is their physiological condition, not their raw age, that determines how much they use the service. An 80-year-old in Perth, for example, will probably use the health service significantly less than a 50-year-old in the east end of Glasgow.

Jean Urquhart (Highlands and Islands) (Ind): I want to ask Michael Thain about integrated services and budgets. How does that work? Who is involved in the writing of this report, for example? Do you have any integrated budgets with the health service to deliver services for older people and younger people?

Michael Thain: There are various examples of integration. Seven or eight years ago, the council established a partnership with the health board on community health and other aspects of social care services and appointed a joint director of health and social care services, who reports to the chief executives of the council and the health board.

I could come back to you with a detailed submission about where the integration takes place on budgets and decision making. However, there are also examples of projects that have been quite innovative in bringing forward that integrated service provision, such as the longer-term facilities and flexible care facilities, which involve officials from different disciplines. Granton flexible care, now known as Elizabeth Maginnis court, was developed by a housing association with grant funding from the council on the capital side and funding from the health board and the council's health and social services on the revenue side, which provides the money to keep the development viable. It is a state-of-the-art facility, but it was possible only because of the joint working and integration between different parts of the local authority and the health board and other agencies, such as the housing association.

Bob McDougall (Trust Housing Association): I have some general comments about some of the points that have been raised in relation to the planning cycle.

Housing associations are duty bound to prepare 30-year planning proposals. However, I have to say that our expectations of what the situation will be like in 30 years' time are based on holding up a finger in the air. A more realistic planning cycle is a five-year one. The three organisations on whose behalf I am speaking represent probably around 10,000 to 11,000 units across the breadth of Scotland, from north to south and east to west. We work in all 32 local authority areas and, with regard to the debate that we have had thus far about the strategic approach of local authorities in the planning cycle, what we find to be absolutely consistent is the lack of consistency. Inconsistency exists everywhere, and not everyone takes a strategic view. Part of the difficulty for us is how to feed into those services in a way that is meaningful.

Edinburgh has taken a strategic approach, and we have fitted in with that. However, we find it difficult to fit housing into the integration agenda. One of the key issues for us is the fact that, in the debate around social care and health, housing is not at the table. You might say that we are going up to the big boys and saying, "It's your ball, but give us a game," but it is more than that. Our consistent argument is that the way to keep people out of the healthcare system who should not be there is to do much more in the community to meet their needs, and the way to do that is to co-ordinate services better.

There is an argument that says that housing is in the third sector and that, therefore, that is the route into the change fund, but our fundamental premise is that housing is fundamental to people's wellbeing and health and that, if you do not get it right, that is where the problems start. If you get housing right, you put in place the building blocks of a fairer and more just society, and it helps the health and social care services.

Jean Urquhart: Everyone has at least paid lip service to integrated services, and I am anxious to know what people's experiences are of making those work. There is always resistance to either giving up budget or sharing it. In the Highlands, people have even had to change which organisation they work for in order to make the integration agenda work—for example, health service employees have had to become council employees. I am grateful to Mr McDougall for his response on housing, but I would like to hear from the other witnesses with regard to other areas. Each of the submissions highlights that housing, social care, the third sector, local authorities and the national health service should all be involved. I would like to get a feel for how that works.

Soumen Sengupta: West Dunbartonshire community health and care partnership is an established integrated arrangement, so it might be helpful with regard to some of your questions.

Earlier, you mentioned integrated budgets. Like other areas, we do not have a pooled arrangement—the money does not all go into one pot and lose its identity at that point, although that is what the Scottish Government proposes as part of the forthcoming legislation. We have aligned budgets. The director of the CHCP is accountable to the chief executives of the council and the health board. He is responsible for the totality of resource that is allocated for social work and social care in the council and the community healthcare services that are provided by the NHS board. All the heads of service, me included, have responsibility for two sets of budgets in parallel, as well as for staff who are on different employment contracts.

We make it work. We ensure that everyone knows that people are clear that our common purpose is to deliver for our clients—our patients and residents—and emphasise a common set of values around quality provision and improvement. That enables people to work together. Fundamentally, what is required is a willingness on the part of the partners—at a corporate level among the agencies and the elected members, who create the body within which that can work, and at the level of management, who work with clinical staff, professional groups, social workers and so on—to make it work.

From a financial perspective, although it is irritating having to constantly manage two ledgers in your head, in parallel, the key point is that it is the same head of service who is responsible for both budgets, which means that people do not shunt costs between the council and the NHS, because all that that would do is move a headache from the left side of your brain to the right side. It also enables people to plan and develop comprehensively. Indeed, many of our service managers—at the next level down—are also integrated into joint teams and joint posts.

We have done that across our older people services, the rest of our adult services—learning disability, addiction, mental health services and so on—and our children's services. Not least because of the policy context, children's services are at a different point in the process but, from our perspective—as we said to the Scottish Government in our response to the consultation on integrated partnerships—we are strongly of the view that integrated partnerships should exist across all care groups.

That ties into the earlier points about the need to think about the population as a whole and communities as a whole. If you are planning for children and families, you must remember that families, by definition, include adults. Similarly, people who care for elderly relatives are often parents themselves. You should not make artificial distinctions in the population, as there is a dynamic set of needs in the community.

On the housing component, Bob McDougall makes a valid point, from a practical perspective. We are talking about partnership not in a vague sense of people coming together to chat about an issue but in terms of people delivering, investing in and making hard choices about the services.

Integrating responsibilities for governance is tricky stuff, as we have seen across Scotland. It is ambitious work. It has been talked about across the United Kingdom as being the model to go for, but it is hard. From our perspective, the primary links for us, over and above the health and social care crucible, are the relationships in the council, particularly with regard to education services, which link to the children and young people's agenda, and housing services. The guidance around older people's commissioning strategies will increasingly become joint documents across the NHS, social care services and housing departments.

We work closely with third sector housing colleagues. They might take a slightly different view on how successful we are in that, but we understand the role of the third sector and other voices with an interest in housing. However, we seek to work on that through our housing

department colleagues instead of creating parallel lines of engagement.

The change fund can be perceived to be a magic bullet but, if you think about the number of stakeholders who are around the table in the average local change fund implementation meeting, trying to have their interests represented, you are talking about a much bigger meeting than the one that we are having today.

In terms of strategic decision making, in the short, medium or long term—indeed, many of the challenges around our older population and demographic change are short to medium-term challenges; they are about what we do in 2015-16 as much as what we do in 2025 and onwards—we are dealing with huge tables of people, which presents us with a challenge about how to get strong, robust and clear decisions when we have such a multitude of voices.

10:15

Elaine Murray (Dumfriesshire) (Lab): As Bob McDougall has touched on, one issue is where housing lies within all of this. We know that investment in housing adaptations and in appropriate housing for older people can keep people independent and save money both for social services departments, because they do not need to put in as much care, and for the health service, because fewer people present as emergency admissions. The joint submission from Bield Housing Association, Hanover (Scotland) Housing Association and Trust Housing Association points out that it is crucial to address

"who pays for what, how and when",

so the issue is not just about ensuring that people talk to one another but about how the budgets are set up. Do housing associations have sufficient access to change funds in order to be able to make such changes? I note that the submission also makes the point that we have become a bit fixated—this may be true of all of us in this place—on the number of units being produced rather than whether the types of properties being provided or brought back into use are suitable for older and disabled people.

Bob McDougall: In our submission, we are saying that there is a need for a better shared understanding of what we can do. As Jean Urquhart rightly pointed out earlier, there is no new money so the trick is how we can use the existing resources better to provide a better result.

Our argument is that we should look at the mix of resources and how they might be distributed differently. For example, there is a natural tendency to say that we need to build new houses—and that is a need—but our argument is that a lot of the existing housing stock is not being used properly. Although there are huge pressures and challenges out there, there are also huge opportunities to use the existing stock better.

An interesting example is that the use of sheltered housing in the broadest sense is reducing in Scotland because of funding pressures. As Michael Thain alluded to, we are seeing the use of more specialised types of housing with care models—which we also provide—so my consistent argument over the last wee while has been that the middle ground, if you like, is being squeezed. People are moving out of the traditional sheltered housing sector and moving more towards a retirement model where they pay for their own support, but they are also moving to more intensive care. The middle ground is being left. If we can get the funding better balanced, there is an opportunity to engage with social and health care colleagues on using the existing resources better by investing in that middle ground: we could use the existing stock better, refurbish it and provide additional services to people in the community to try to prevent lots of people from ending up in the care system because of age rather than because of infirmity.

I wish that I had £1 for the number of times that people in the health service have come to me and said, "Mrs Smith is coming home from hospital next week. Is that okay?", to which I have to say, "Wait a minute, it will take three months to sort out her housing problems." That means bedblocking for three months until we do something. The issue is so basic.

Nationally, we had an age and adaptations budget of £10 million, but that has been cut to £8 million. It was proposed to cut that again to £6 million, but we produced evidence that the social return on investment—the SROI—from adaptations produced such value for money that the budget should be expanded rather than cut. Now, I give full praise to the Government for agreeing to keep the budget at £8 million rather than cut it, but there is a strong argument for expanding that budget. That is very basic, simple and straightforward stuff, but it is very cost effective. There is huge potential to help people to stay in their own homes and save the public services vast amounts of money. Most people want to stay at home; the problem is that many people, when they get old and infirm, need help to have their home adapted to allow them to remain there.

The Convener: I am sorry that Catriona Renfrew was not here for the start of the session, because I had intended to start off with her submission. The submission states:

"the immediate pressures of demographic change will make it difficult to fund and support other priority areas with

longer term benefit ... by extending current models of health care to more older people with long term conditions it is unlikely we can realise aspirations to shift resource to preventive spend and early years. ... The annual budget process should also give due regard to other policy priorities, including early years and preventative spend, which may have more significant long term benefits and are essential to the future sustainability and affordability of services."

All of us around the table would agree with that, but how do we strike that balance in the current economic climate? How do we address demographic change while investing in preventative spend?

Catriona Renfrew: If only I knew the answer to that. That is the challenge.

First, let me pick up on the housing issue, which I think is one of our most fundamental failures of planning around the care of older and disabled people. Over the 15 years that I have been working in planning health and community care, we have never cracked the proper planning of housing with housing providers, given the housing finances that councils hold, in a way that matches the predictable needs. Many people end up in care homes or hospital because we cannot deliver innovative housing solutions that bring together a housing solution with a care solution. I am not sure that it is viable to go down the avenue of always ensuring that people stay in their own homes; the issue is more that, as people need more care, they need to be able to make incremental choices for different models of housing with some care before they end up in a nursing home.

I say that because I think that it is important not to be distracted by the integration of services when thinking about the planning of housing. The integration of planning is different from the integration of health and social care service delivery. To me, the issue that we need to crack is how we can ensure that across Scotland planning for housing is integrated in a consistent way that allows us to build on the best examples. I do not think that it matters whether housing is in the partnerships in that sense, but I think that it is really important that the planning of housing is part of the responsibility of health and social care partnerships. I am not trying to duck your question; I just wanted to endorse those points.

The challenge for us is that the health service faces a series of pressures. A whole series of new treatments come in every year, which Governments are always keen to see delivered because there is public demand for them. I could come up with 10 or 15 innovations that have been introduced over the past five years that have had significant extra costs, so nothing stands still. People also want shorter waiting times, which is quite rightly a Government priority and has transformed the way in which healthcare is delivered. When I started in the health service, people routinely waited five, six or seven years to get a hip replaced, which is not acceptable. There are also the pressures of demographics, with more older people.

Another issue is the quality of care provided to older people. We cannot just do more of the same, because the demands that people of our age will make when we are older will be different from the standard that is accepted by older people now. Very often, what is provided is relatively cheap institutional care, because it is actually relatively cheap to put people in nursing or care homes rather than provide them with better and more extensive community packages or provide high-quality residential care of different types.

In our submission, we make the point that that whole series of demands is difficult to manage. It is dangerous to accept a simplistic answer about one part of demand that says, "If older people use the health service less, there will be a wodge of cash that we could take out of the health service to fund different services in the community such as different forms of housing." If we take that easy route out, we will be in real difficulty in the next three to five to 10 years because that answer ignores a whole series of other demands on the health service, which are also becoming ever more difficult for us to deal with given the current state of public finances.

Like Soumen Sengupta, I think that it is also important to mention children's services. If we did more right for children aged zero to three, over time we would reduce demand for healthcare and social care and, indeed, for interventions from the police and criminal justice system. There is a lot of talk about early years collaboration and a quantum shift to prevention, but it is actually extraordinarily difficult to deliver that because there is a 10 or 15-year period when that preventative spending does not yet have an effect on other costs.

The complexity of all those planning and demand issues means that it is really difficult to come up with a simple answer. The real answer is that there is no simple answer. The complexity needs to be acknowledged and become a focus for all public bodies to try to work their way through in a collective planning sense.

The Convener: I find it interesting that your submission states:

"Recent evidence from the telehealth projects in England do not yet provide definitive evidence of cost-effectiveness"

in relation to, for example, reducing demand on older people's services.

Interestingly, according to Ayrshire and Arran, telecare and telehealth are now being seen as essential elements in the equation of supporting

people in their homes, with the emergence of more sophisticated technologies and telecare services that reduce the cost of unplanned hospital admissions and delayed discharges. I will let Marlene McMillan respond in a wee minute, but will Catriona Renfrew comment on that intriguing difference of opinion between Greater Glasgow and Clyde, and Ayrshire and Arran?

Catriona Renfrew: It comes back to my earlier point that these problems are not going to be solved by simple banner-headline solutions. Telehealth works for certain people with certain chronic diseases—for example, it has been really effective in dealing with chronic obstructive pulmonary disease, and social care-type telecare facilities can allow people with certain forms of dementia to continue to live at home safely—but it is not the big answer to the set of problems that we are discussing.

As a health board with an urban population, our perspective on telehealth is different from that of people in more rural areas, where telehealth might play a larger part, but we feel that it is not a solution to dealing with the pressure on the health service, particularly as people are becoming frailer and more of them are living on their own. If those people need care—if, for example, someone needs help to go to the toilet at midnight—telehealth is not going to help them. They will need someone—a physical person—to come and help them, and that is where we bridge back to the issue of housing and having disaggregated forms of housing that are not care homes but where care is delivered to people. That care might be triggered by a telecom solution, but you will still need a body to help someone who needs a body.

Bob McDougall: Convener—

The Convener: Hold on a second, Bob. I was going to ask Marlene McMillan to comment on that contrast between the views of the two health boards. Over the past couple of years, the committee has taken considerable evidence that about £1.5 billion is spent on unplanned admissions and if I am reading it correctly the submission from Ayrshire and Arran—which is, of course, my own area, although many of my constituents will go to Glasgow—seems to be suggesting that telecare can make a very positive contribution.

Marlene McMillan (NHS Ayrshire and Arran): NHS Ayrshire and Arran has a mix of rural and urban populations and given the costs of providing care to those who live in rural areas, where the housing might not be appropriate, where there is a lot of poverty and where there are transport issues and other such difficulties, I think that telehealth and telecare work for the peripheral population. There are additional costs in caring for people with, say, high dependency needs who live away from the centres of population. Moreover, as I think NHS Highland will agree, a higher proportion of older people live in rural areas in Scotland and there are fewer young people.

The Convener: Bob, did you want to comment on this issue?

Bob McDougall: I was only going to say that telecare is a vital and increasingly important aspect of the services that we provide. However, I should sound a note of caution. It is very attractive to organisations because it allows them to reduce staff resources—for example, with that kind of a warning system, you might not need overnight cover—but the customer base will say that reducing personal input in that way represents a diminution of services. Telecare is cost effective—no one has to be on standby any more—gives greater coverage, provides immediacy and allows people to be called out, but all of that comes at a cost and the bottom line is that it reduces the amount of human contact in the services that are provided.

The Convener: I know that from the withdrawal of warden services in recent years.

Bob McDougall: It is the same sort of thing.

The Convener: It was not just that people had to wait for someone to come out, but that they did not know the person who turned up. They used to know the warden and there was a kind of trust in the relationship.

Bob McDougall: That is certainly an important aspect. After all, a large part of what we are discussing is not only about using money differently—which is, of course, key—but about making a fundamental cultural shift in attitudes. We need to get the message out to the customer base about how things are changing, because people have certain expectations about what can be provided and there is a job to be done in providing information and advice and getting the message out about what we can afford. We cannot do everything that people want us to do.

The Convener: Indeed.

10:30

John Mason: On the interaction between housing and health, I have been impressed by the great facilities that Trust Housing Association and Bield Housing Association have in my constituency. Of course, nothing is appropriate for everyone, but it strikes me that those facilities are appropriate for certain people. As a result, I was a wee bit surprised to read in paragraph 9 of the Bield, Hanover and Trust submission that, with regard to older people remaining in their own homes,

"Where possible this should be through adapting their current home rather than downsizing or seeking specialist housing".

Actually, I think that it would be better for some people living in their own homes to downsize—after all, they might not be able to heat their house because it is too big—or to move into specialist housing.

Further down that paragraph, the submission says that

"funding streams should be identified".

That is a good phrase; everyone wants more money, but no one wants to suggest where it should come from. Is there a link with health in that respect? If preventative spending is successful we might well end up closing hospitals; however, when the health service suggests closing a hospital, all the politicians jump up and down and say that they do not want that to happen. How do we cross that bridge?

Finally, I was interested in Catriona Renfrew's comments that there is no one-size-fits-all solution and on the notion of people staying at home. This week, I saw a French film called "Amour", which I believe Jean Urquhart, too, has seen. It is about an older couple who are desperately trying to cope at home. Without giving away the whole film—

The Convener: —because we will all be rushing out to see it. [*Laughter*.]

John Mason: I highly recommend it, because it touches on many of these issues. The couple make a commitment that the wife will not go into care but, as the film progressed, I became increasingly convinced that coping at home was not the best solution for them. How do we bridge the gap and ensure that we give people the best rather than what is just the norm, the fashion or whatever?

Catriona Renfrew: As I am no housing expert, I will defer to others if I get this wrong but I think that there is a gap, not in relation to hugely adapted or particularly fancy housing but in relation to the kind of core-and-cluster model that we have used for mental health. In such a model, a pool of staff not only looks after people with high care needs but supports people who live around that core service in a range of other accommodation that is much closer to being their own home than a care home would be. Older people resist going into care homes partly because it is an extreme institutional solution to their situation; after all, although they might need care at short notice, they might not necessarily need a huge amount of it. It is very difficult to provide in an unplanned way seven-days-a-week out-of-hours care to someone living in their own home who might need care within 15 or 20 minutes and, because people do not have a full range of options in the middle, they can end up in an extreme situation with 24/7 on-site care.

In any case, a lot of older people simply resist going into nursing homes. It is not seen as a high-quality environment—indeed, it is often not a high-quality environment—and across the public sector the price of nursing home care has been squeezed through national negotiations. Indeed, it could be argued that it is not well enough funded to give people the quality of care that they need, particularly those with dementia who not only have physical needs but need more time spent with them and high levels of human interaction to manage their condition.

Bob McDougall: In response to John Mason's question, I would advocate a multiplicity of choice. The bland statement that we should aim to support people in their own home at all costs is simply wrong. As he rightly pointed out, not everyone can be supported in their own home—nor, indeed, should they be because that might condemn them to isolation and loneliness. They will just not get the support that they need.

Instead, we need a variety of choice. I think that in that respect there is a disconnect between the housing profession and healthcare colleagues. Very often when we discuss the detail with healthcare people the light bulb goes on and they say, "I didn't realise that that could happen. That could be a solution." Our models include what we call housing with care, in which a person is provided with not only accommodation but a meals service, which is hugely important. We also have staff on site who give medication, provide low-level care and support and deal with minor nursing issues.

Different models, including the core-and-cluster model that has been mentioned, in which other services are provided from the same source, are being developed all the time. It is not beyond our wit to further develop those services in a more meaningful way and on a more local basis.

To my mind, it is about looking at how existing resources are used, asking whether we can do that differently and looking for evidence of cost effectiveness. John Mason asked about what we said in our submission about the use of existing housing stock. The SROI study that we did on adaptations in very sheltered housing produced evidence that that approach was cost effective. If we take something out of existing health budgets, for example, something else must stop. The question is whether we can spend that money differently and quickly get evidence back, before we spend any more, that doing so is effective. We must ensure that we get value for money, because we do not have additional money. It is therefore about using existing resources differently.

I think that the key to that is for people to understand what is available, but at the moment we do not do that very effectively. Professionals do not share with one another information about what is available in the best way for the best use of public resources overall. I will hold my hand up and say that we, too, are not good at that. I will shut up, but first let me say that next year the big challenge for us is to engage with health professionals and get our message out to them, which is what we aim to do.

Michael Thain: I want to add to the debate about what we do with existing homes, how we help people move when their home is no longer suitable—whether to a care home or a better home—and how we plan for growth in the number of households, the majority of which will be among the elderly population.

Fundamentally, we need new homes. To go back to Catriona Renfrew's point about what we spend on adaptations to existing homes, I think that there is a limit to what we can do with existing homes, because they were never designed to deal with the growth in the older population. Looking back and forward over the long term is valuable in that context. Most homes, certainly in Edinburgh, were built before the second world war, and 70 per cent are flats. They are old and were not designed for the energy cost increases that we are seeing or the older, more frail population.

As well as considering the adaptation of existing stock, we need to think about the impact of rising energy costs over the next 10 to 20 years. Growth in the number of households is mainly due to growth in the population of older people; if we assume that their incomes will reduce, we can see that energy costs will have a big impact on them. As energy costs increase, there is a limit to what we can do with existing homes to improve energy efficiency and put in new heating systems. Some of the solution comes down to having new housing, which tends to be more energy efficient, and better heating systems, and being much more flexible when it comes to dealing with people's changing needs in their own homes.

Part of the fundamental challenge in dealing with new housing, both for the market and for social housing providers, is how we fund it. The level of capital subsidy to fund new social housing has been decreasing for a while now and will continue to decrease. The capital subsidy is just not there, unless we take it away from building schools and hospitals, for example. We therefore need to find other ways of funding new housing, including new rented housing—the market is not supporting home ownership either, and mortgages and so on are just not there.

There is therefore an issue about providing and finding ways of investing in new housing to help people move and to cater for the growth in the number of households that consist of older people over the next 20 to 30 years. The issue is not just adaptations but fuel poverty.

Michael McMahon (Uddingston and Bellshill) (Lab): I bang on about the same point every time we discuss this issue, but John Mason has already touched on it and Mr McDougall also commented on it. He said that what we need is a fundamental cultural shift—I think that that is absolutely right. Everyone who has spoken has talked about long-term planning and trying to envisage what will be required. However, when it comes to implementation, we are not allowing the space and time for a cultural shift to develop, for the ideas to percolate through and for people to deliver in the longer term; the next day's newspaper headline becomes much more important or the cost of implementing something becomes the immediate issue, although it needs to be considered in the longer term.

We can talk about integration and get health officials, housing officials and social work officials together to look at the available statistics and data in order to make projections but, when it comes to rolling out the programmes and going forward, there are interventions from politicians and others, who say, "We like that bit of it but not that bit" and start to pick it apart. We therefore never get to the point of sitting down and asking how things are going to be in 10 years. As a result, within a year a plan can start to collapse because certain bits of it have not been implemented or because they have not been taken forward at the same pace.

I have been trying to focus on the idea of a cultural shift throughout all our discussions. We need to get away from short-termism and plan for the longer term in such a way that people buy into it and support it. There will be discussions and deliberations about how to implement plans, but if we agree that the longer-term picture is what is most important, we at least have a starting point to go forward from.

The Convener: It is interesting that both John Mason and Michael McMahon have talked about politicians as if they are not politicians—but that is us!

Soumen Sengupta: I want to pick up on a number of points. Elaine Murray and John Mason touched on something that was in Michael Thain's submission but which I think applies to all of us, which is that funding streams must be identified. It is appropriate to say to the Finance Committee that, for a range of reasons, including the overall financial climate, there is less money in the kitty than there was before. The issue, therefore, is where the money is to come from. If we spend more on X, what do we not spend money on? As Catriona Renfrew said, we want to receive

benefits from our preventative agenda, which we must push forward, particularly for the zero to three age group. However, we will not see any benefits from that until we are further down the road, so the question is what we sacrifice and who will lose out right now, given all the demands and pressures that we have.

Mr McMahon referred to the demands to deliver. Even with the change fund or any number of other medium to long-term initiatives, we have demands such as, "In six months, you will have achieved X change, and if you haven't achieved that improvement in six months, you will be under a lot more intense scrutiny." I have been a public servant for more years than I care to remember, so I understand the deal in that regard and the effect of the social contract on how we operate, but it makes things quite difficult. In that context, Catriona Renfrew referred to complexity and uncertainties, for which there are no magic bullets. It is about how we get the required space.

Catriona Renfrew and Bob McDougall both made the point about leadership of the debate. I think that Bob would agree that we need to recognise that the demands and expectations that people have in 10 years will be different from those that people have now, because people will have a different view of the world—the view of the world that I will have when I am 65 will be different from the view that my dad has at 65, for example. The issue is how we engage in responsible discussion with people about how their world is changing, what opportunities there will be and what they think might be better. However, there are also challenges around the fact that it is no longer about people comparing what they will get with what their parents or grandparents got. For me, that is the big challenge.

With regard to housing changes and their costing models, for example, even if we work out who will pay for that and how we will design it, people still have to want to buy into it. Choice costs: the more diversity of choice that we have on the table, the more we have to invest in providing the options for people exercising choice. However, people also have to want to move on from what they have had before, which may be unsustainable, into something new. That point appeared to be the crux of the film to which John Mason referred: people like and are used to what they have—they are comforted by it and it fits in with their world view and sense of self-identity—but the bottom line is that they need to make a shift. Even if it is not about making a shift into a care home but about making a shift into another type of housing because they are downsizing, that is a big psychological leap for lots of people. The question is how we engender a cultural shift so that such changes are just part of what we do and how we live.

The Convener: I think that we all know the challenges; it is really the solutions that we are looking for. I want to touch on some of Bob McDougall's submission. He said in his submission:

> "Scotland currently spends around four times more on emergency admissions to hospitals for the over 70s than on the entire free personal nursing care budget ... and we believe that the Government can do much more to increase resilience at community level to avoid unnecessary hospitalisation and relieving bed blocking ... In this respect, housing needs to be given a more prominent role in the development and delivery of local Change Fund Plans."

You have given us some details on that but, for the record, will you say more about how you think we can go forward on the issue?

10:45

Bob McDougall: That goes back to the point that Catriona Renfrew touched on about whether the housing sector needs to be at the table at the planning stage. I advocate that it does. That is not just about banging the table; it is about being effective. Michael McMahon touched on the cultural challenge that exists. This will sound hugely simplistic but, from my perspective, the best use of resources is a matter of power and control. We need people to be willing to look at budgets and say, "That's my budget, but I'm willing to put it in the pot and allow someone else to control it and to give that power away."

That might seem simple and fundamental and a bit idealistic, but that is the essence of the issue. The housing sector needs to bring its expertise and budget to the table, along with the health and social care sectors. The people round the table then need to forget their former professional loyalties and tribalism, deal with the issues in an entirely independent way and use the resource to get a different outcome for the citizens of this country.

We have a discipline-led approach, with housing, social care and health perspectives. I advocate that, at some point, those must come into a funnel so that we get an outcome that ignores those professional barriers. The customer's argument would be that they do not care who chaps on the door. Whether it is someone from the general practitioner service or someone from the health, social care or housing services, the customer just wants their needs to be met. They care less about the label and more about the solution. For us as professionals, the challenge is to match that aspiration. We need to forget the tribalism and professionalism, although perhaps people will say that it ain't gonnae work, because there is too much politics involved. That is the real challenge. It is about taking what we have and mixing it up differently.

No matter how good a system is, it will not work unless people are committed to it. Conversely, the worst systems in the world will operate well if the right people are involved. If we get the right people engaged and give them the freedom to operate and to get the best results—and they forget what has gone before—there is a chance to do things differently.

Catriona Renfrew: For me, the integration of health and social care changes the whole dynamic. For example, the failure to plan housing properly has a massive impact on the health service but, without integration, the health service does not have a direct relationship with or role in the planning of housing. When health and social care are brought together, that brings together the need to deal with the consequences of poor housing planning through an integrated budget. That is a huge change, and people sometimes underestimate its scale. A committee of councillors and non-executives or a director of a partnership that is responsible for costs in health and social care, including some of the costs in the acute sector, will have a massive incentive that does not exist at present to plan housing properly.

When housing is not well planned, the consequences generally fall on the health service, through delayed discharges and unnecessary admissions, but the health service does not have accountability for or a role in housing planning. Therefore, the integration of health and social care and the focus of the new partnerships on the way in which the people for whom they are responsible use acute care is a game-changing dynamic that will make a big difference if it is done properly and in the way that has been set out. Whether in the Christie commission report, Labour policy or Government policy, the direction is the same, and it involves a fundamental shift in the way in which we do business. That will not solve all the problems that we are talking about, but it will solve some of them.

Michael McMahon's point about short-termism is interesting. One reason why housing planning is so problematic is that it is the only real long-term planning that we do. Long-term service plans can be changed year on year, but when we build houses, commit capital and borrow it from the banks, we really have to get it right. That is one challenge that we have not been able to meet, because it involves real decisions about bricks and mortar. The kind of planning that I and councils do for services does not tie us in for the same length of time, so we can take more risks and plan on a short-term basis.

Bob McDougall: Interestingly, I guess that, when we talk about housing input, most people would have in mind a public sector housing input, but I am talking about housing in the broadest sense, which includes the private sector, and that is a different animal. Trying to engage the private sector in the housing solution that we are talking about and in integrating services is different, because people in that sector will ask where the profit margin is. If we want to build housing in a better way and have better space standards, people in the private sector will want to know whether they will be able to sell those houses on the market.

There is a disconnect in social public policy because, as Michael Thain said, we have a drive towards providing better housing, perhaps with better space standards and more rooms, but at the same time the benefits system is changing to drive down costs, and people will be penalised if they have too much excess space. There are competing social policy drivers.

I return to my fundamental point. It has been said continually that housing is a fundamental aspect of good healthcare and social policy for the future. Therefore, housing professionals need to be part of the process, so that they can offer their expertise and influence the planning model.

The Convener: The NHS Ayrshire and Arran submission points out that, in North Ayrshire, of which my constituency is a part, two thirds of older people are in private housing. Therefore, the issue is not just about local authorities and other social providers. Older people in private housing must be considered, too. That brings us neatly on to Marlene McMillan.

Marlene McMillan: The reason why a high number of older people in North Ayrshire are owner-occupiers might be because the social rented sector has been bought up. That can leave people asset rich but cash poor. When we studied fuel poverty in Ayrshire and Arran, it was clear that over-65s are almost twice as likely to be in fuel poverty as families with young children. The utility issue—the heat or eat question—limits people's ability to remain independent, healthy and in their own home. There are issues around that, particularly in the 15 per cent most deprived areas in Ayrshire and Arran.

I return to Mr McMahon's point about short-termism and the need for a culture change. I did not get an opportunity to make a point about the demography right across the life course. In North Ayrshire, for example, the biggest group who are migrating are the 16 to 29-year-olds. The young population in North, South and East Ayrshire is projected to shrink in the short term, which is the next 10 years. That raises issues about the dependency ratio and informal care. Informal care should be considered, as it prevents rising costs of long-term care for older people. A big study by the Organisation for Economic Co-operation and Development found that informal or family care

accounts for the equivalent of 20 to 36 per cent of European gross domestic product.

There are other policy issues. If we can get young people to stay in Ayrshire and Arran, we will have a more balanced population, not an ageing one. If we have an ageing population, it will stagnate and the dependency ratio will be huge. We have modelled some dependency ratios. We arbitrarily took all 50 to 60-year-olds and projected to 2035 and found that, in South Ayrshire, we ran out of young people to look after the over-75s, because South Ayrshire has the highest proportion of such people. In Ayrshire and Arran, between 2010 and 2035, the number of over-85s will increase by 110 per cent, and they will account for 10 per cent of the population.

We must try things to keep the population balanced, such as graduate recruitment programmes and offering easily accessible housing to young people for their first home or for family start-up. We need multiple policies to deal with the ageing population and to maintain a balanced population in the more rural areas.

The Convener: Employment is a key issue as well, of course, because if there are fewer job opportunities in North Ayrshire, or indeed other parts of Scotland, and people move to where there are opportunities, that creates an imbalance of its own.

If anyone wants to make any final points, now is your chance to grab my attention.

Michael Thain: I have two very quick points. First, on Catriona Renfrew's point about joined-up working between housing and health, my experience in Edinburgh is that it works relatively well when dealing with people coming out of hospital. The allocations process gives top priority to people who have medical or health needs. We have a joint housing register, which gives people access to housing association and council homes. It works pretty well, in that what stock we have in the social housing sector is prioritised for people coming via that route. The fundamental problem is the lack of new stock coming through.

Secondly, there is always a danger in these debates that we focus on there not being enough money. It is incumbent on public servants and officials to look at new ways of funding things. Our experience in pushing the boat out on new housing development in the past couple of years, by adopting other forms of tenure and through more private sector funding, has led us to increase our approvals from about 500 new homes to 1,500 new homes—both council and housing association homes. However, it has meant the council putting in prudential borrowing, it has meant more private sector funding and it has meant moving to mid-market rent and a slightly higher-rent model. However, it works and it creates a significant strategic impact in delivering new homes, cheaper-to-heat homes and more flexible needs homes. It is about the new funding models and the risks that we have to take in using them.

Jean Urquhart: This is kind of a whole new topic—

The Convener: That is really helpful at this stage.

Jean Urquhart: It seems that there are a number of academic studies. I do not think that the public sector or the Government has cracked how we best use university and academic research. Across Scotland, there are two or three examples of pilots—there is also the New Economics Foundation—on how we best use money and how we take things to a much more local level. Sometimes the solution lies at the level of the street or fairly small communities. There is more and more research, but we have not cracked how we use it, and a lot of great research sits gathering dust on shelves. We need to find a way of bringing local authorities, health boards and so on into that integrated approach on housing. Some extraordinary solutions have been found and are actively happening in some places. What that represents is a kind of hope at the end of all this.

Soumen Sengupta: I have two points, one of which I hope ties into that. After all the points that have been made, I want to try to add something a little bit positive as well.

First, there has been a lot of commonality here today. It is not as if we have compared notes before we walked in the room. It is emblematic of the fact that a lot of work and thinking is going on. It is not just reflected in the work of this committee. In NHS boards, councils, integrated partnerships and housing—whether it is third sector or private sector—there is a lot of debate and discussion, and a lot of richness around. People are trying to tap into what is going on and trying to do different things. There is a whole series of demands on that, but we are trying to get into it. It is difficult. It is not a thing that is unique to Scotland—it is going on throughout the United Kingdom and western Europe. Taking on your point about solutions, I think that this is difficult stuff and it is clear that there are no magic bullets, but we are all working on it.

Secondly, I want to pick up on something that Catriona Renfrew said. The integrated health and care partnerships have the potential to be a game changer. I want to underline what we say in our submission, which is that, from West Dunbartonshire's perspective, the most effective vehicle for doing that is to ensure that all health and social care services in the community—from cradle to grave—are within the purview of those

partnerships. They should not just be older people or adult partnerships; they should cover children as well.

Bob McDougall: Jean Urquhart is right. Interestingly, when we did the SROI study on adaptations in very sheltered housing we asked David Bell to validate it. He looked at it in quite some detail and worked with us on it. We routinely try to validate the work that we are doing and see whether there is a bigger picture there.

It is clear from what has been said this morning that a lot of good and collaborative work is going on. However, having spent most of my career in local government, I would perhaps part company a little bit in that I have the view that there is still too much navel gazing and that the public agencies perhaps speak to themselves more than they do to the customer base. The challenge for all of us to is to focus more on what the customer's needs are and feed that back. If that happened, would that change how we deliver services?

You may say, "You would say that, wouldn't you?" but I would still say that housing is fundamental to a caring and safe society. It should be at the planning table. I say that not just with a public sector hat on but with a private sector hat on as well. A big part of the housing solution going forward has to involve the private sector, and the private sector is not round the table at the moment. When I say housing, I mean housing in its broadest sense. It has to be part of that debate. The challenge for us as a society is to use the resource that we have in a different way and to change the attitude and culture, and the perception of how we do it.

The Convener: Thank you, Bob. I thank all the witnesses and committee members for their contributions.

11:01

Meeting continued in private until 12:36.

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