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HEALTH AND SPORT COMMITTEE

Tuesday 17 September 2013

Session 4

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HEALTH AND SPORT COMMITTEE
26th Meeting 2013, Session 4

CONVENER

Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Richard Lyle (Central Scotland) (SNP)
*Mark McDonald (Aberdeen Donside) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeff Ace (NHS Dumfries and Galloway)
Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
Alan Gray (NHS Grampian)
Dr Allan Gunning (NHS Ayrshire and Arran)
Nigel Henderson (Coalition of Care and Support Providers in Scotland)
Ranald Mair (Scottish Care)
Susan Manion (Association of Community Health Partnerships)
Martin Sime (Scottish Council for Voluntary Organisations)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 17 September 2013

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

Decision on Taking Business in Private

The Deputy Convener (Bob Doris): Good morning. I welcome members of the committee and members of the public to the 26th meeting in 2013 of the Health and Sport Committee. As usual, I remind those present to switch off mobile phones, BlackBerrys and other wireless devices as they interfere with the sound system.

Members of the public might have noticed that some members and officials are using iPads and other tablet devices instead of hard copies of their papers.

This morning, we have received apologies from our convener, Duncan McNeil, and Richard Simpson. Malcolm Chisholm is with us as a Labour Party substitute.

The first item on the agenda today is for members to decide whether to take in private consideration of the committee's work programme, at today's meeting—it is item 3 today—and at future meetings. Are members agreed?

Members *indicated agreement.*

Public Bodies (Joint Working) (Scotland) Bill: Stage 1

09:45

The Deputy Convener: Under item 2, the committee will take evidence on the Public Bodies (Joint Working) (Scotland) Bill. I welcome our first panel of witnesses. We have with us Dr Allan Gunning, who is the executive director of policy, planning and performance at NHS Ayrshire and Arran; Jeff Ace, who is the chief executive of NHS Dumfries and Galloway; Susan Manion, who is the chair of the Association of Community Health Partnerships; and Alan Gray, who is the director of finance at NHS Grampian. I thank the witnesses for agreeing to go straight to questions from members. Richard Lyle has intimated a desire to ask the first question.

Richard Lyle (Central Scotland) (SNP): Thank you, convener, and good morning, lady and gentlemen. I start the question session by asking you about the models that are suggested in the bill. I understand that there are two such models: the lead agency model and the body corporate model. You might have another suggestion, and I would welcome any direction on that. What is your opinion of the models that have been suggested?

Dr Allan Gunning (NHS Ayrshire and Arran): NHS Ayrshire and Arran and the three councils carried out an options appraisal of the two options that are available to us, and decided that the balance of advantage lay with the body corporate model. In Ayrshire, therefore, we will form three partnerships that cover each of the council areas, and they will all be bodies corporate.

The body corporate model provides the greatest opportunity for close integration. The only advantage that we could see in the lead agency model was that it might make support services more straightforward to provide, but the changes are not about support services; they are about supporting the better and more seamless delivery of front-line services.

Jeff Ace (NHS Dumfries and Galloway): Similarly, NHS Dumfries and Galloway is most likely to go for the body corporate model. That is our current working assumption. Unlike NHS Ayrshire and Arran, we have not progressed to the point of making a formal decision in front of the NHS board and the council, but that is the assumption on which we will base our work going forward. As Allan Gunning said, the body corporate model seems to offer a good degree of flexibility and the ability to influence change locally, on the ground.

Susan Manion (Association of Community Health Partnerships): At the moment, what is coming back from my colleagues across Scotland is that a number of discussions are still taking place about the models. However, it appears that most areas are moving towards the body corporate model for the reasons that have just been described.

That said, the intent and purpose of both models are the same and are around developing integration. Deciding on the best delivery model depends on historical positions and local preferences.

When it comes to alternatives, I am not sure that we are considering any in any significant detail. Many of the alternatives exist under existing legislation, and there is enough flexibility in the bill to allow for local flexibility in the two models that are suggested.

Alan Gray (NHS Grampian): NHS Grampian has adopted the same position as NHS Dumfries and Galloway. We will take a decision to the board in October and we are likely to support the body corporate model. The indications are that local authority partners are likely to follow suit and support that decision in the next few months. However, that is within the remit of the councils.

Richard Lyle: I take it from what you have said that the consensus is that the body corporate model is the one that most organisations will adopt. However, do you share the concerns of some local authorities about governance and accountability in the body corporate model?

Dr Gunning: That is one of the areas that need to be clarified and nailed down. There are some uncertainties that I am sure are still being worked through. The governance and accountability arrangements will be clarified, which is important because we do not want to set up the new bodies when there are uncertainties that will dominate the agenda; instead, we want the bodies to deliver the policy changes that are envisaged in the bill. There is still some work in progress there, but I am sure that it will be sorted out in due course.

Susan Manion: A significant amount of clarification is required on governance and accountability. Both health boards and councils are concerned to ensure that the issues are clarified. Existing accountability issues cause difficulties between councils and health boards, and it will be absolutely central to get that aspect sorted.

When we deal with issues around service change, when we seek to create change and when we consider performance management, we must be absolutely clear: we must have a single performance management structure, with clarity about what we need to achieve and about accountability, so that we can achieve the organisation’s objectives. At the minute, I am not sure that the bill is clear enough on that.

Alan Gray: Our point regarding the clarity around governance is that it is very important to make a success of the integrated arrangements. The planning arrangements are very important, as is having absolute clarity around how they will work and how they will be approved. We need to set off in the right direction in that regard, and we need to have the support of all the organisations concerned as well as a clear plan, particularly as we have multiple local authorities across the health board area.

Richard Lyle: You said that there needs to be clarity. What further clarity would you suggest? I am sure that you have looked through the bill. Perhaps I am taking away questions from other members, but what other suggestions or concerns do you have?

The Deputy Convener: Before the witnesses start to answer, I should point out that, although we did not take any evidence from you there, Mr Ace, all four of you should not feel obliged to answer the same question if you are going to make the same comments.

Does anyone wish to talk about specific examples regarding more clarity?

Dr Gunning: The issue applies to areas such as the chief officer’s accountability, both to the integrated joint board and to the statutory agencies. There are a number of things that flow from that in relation to the financial governance of the integrated budget.

The bill is not particularly explicit in areas such as clinical and care governance. Staff governance is a statutory responsibility for us in the NHS. That is another area that needs to be thought through in a wee bit more detail.

I hope that those examples are helpful.

Jeff Ace: We have a beautifully simple system in health in Scotland at the moment, and when we look at the new models, there is some nervousness that they are more complex. The key thing is that we should not establish a governance structure that gets in the way of the change that we want to make. I am reasonably confident that, certainly in a simple system such as that in my health board, which is coterminous with the local authority, we can work through a governance structure that does not get in the way of people undertaking the radical service changes that are needed.

Nonetheless, as a chief executive who has signed the accountability letter that singles me out as the accountable officer, it is clear to me that our beautiful simplicity of line, from cabinet secretary

through the board and the chief executive, will become slightly cloudier as we go lower than that if we have a body corporate model or a lead agency model—it does not make a lot of difference which we choose.

We just have to be careful that, in creating this vehicle for more interagency change and perhaps more dispersed decision making than we have at the moment, we do not lose some of the current system's simplicity and clarity.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I mainly want to ask about the acute side of things but, following up Richard Lyle's comments, I think that all your submissions agree that structural change in itself is not going to deliver the changes that you want. However, we end up talking about the issue a lot because that is what is in the bill. I find it interesting that most of the questions are about the body corporate model and that that is the model that most people seem to want. As a result, that is the issue about which we will probably ask you and others quite a lot of questions.

Some—albeit not many—people have argued that, in a way, we do not need legislation because a lot of this can be done without it; indeed, a lot of what is proposed is already happening. I know that many of you have already gone down the route of closer working relations, if not integration, with local authorities but, from a health point of view, what changes or further steps will you have to take as a result of the bill that you have not already taken?

Susan Manion: The changes represent a significant step up from the current local arrangements across Scotland. Integrated financial and service planning will be absolutely crucial. The bill gives us the opportunity to take that approach through integration and strategic plans. However, the major issue is how we bring the financial resource together, which will require a system to support operational delivery, and how we plan to deliver significant service change and ensure that resources are shifted around the system to do that effectively. You can do a lot of that with pooled or aligned budgets, but the bill takes things to a whole new level and it is crucial that we have the right infrastructure in place to support that.

Dr Gunning: I highlight some points of principle, the first of which relates to joint and equal responsibility and accountability between the statutory authorities. That is important because targets for health-specific issues such as delayed discharge and emergency admissions to acute hospitals have been very much seen as health targets. Although we have worked very well with local authorities and other partners, statutory provision will help to clarify and strengthen things.

The second point of principle is the more formalised role of the third and independent sectors and of users and carers in local communities, which will build very well on the good work that has been done through reshaping care for older people.

Finally, the third point of principle relates to the statutory underpinning for locality planning, which I think will be particularly important for health. Planning for place has not always been deeply embedded in the NHS planning process—we tend to look at disease classification, age or whatever. As we know, however, many of the challenges that face us relate to people with co-morbidities and complex needs who do not fall into the neat planning categories that we might have used in the past. I see a powerful model for locality planning that will build up a picture of and assess local needs and which will create the opportunity for a different type of relationship between public services, the other partners that I have mentioned and the communities that they serve. That will in turn flow into a coherent strategic plan that will spell out the intended changes and a performance regime that will monitor whether those changes are actually being delivered.

10:00

Jeff Ace: To follow up on Allan Gunning's point, the key advantage for my local system concerns locality planning and the local delivery of change.

In health, we have centralised our decision making a little bit over the past five years or so, and integration gives us a critical mass back at the locality and community level so that we can start to reverse some of that decision-making power and bring our general practitioner community in particular strongly into the process. Suddenly, in my system, we will get four natural localities across the region and a critical mass of devolved decision making that we are optimistic will be a game changer for us.

Although there has rightly been a lot of focus on the top end of corporate governance and the body corporate model, we need to flip that on its head to see the impact of the bill. It is about localism, and we need a far greater critical mass of decision making at a community level if it is to work. That is the bit about which we can get our clinicians and partners excited in a way that they are not excited by the machinations of the body corporate.

Malcolm Chisholm: That is really interesting. That was the intention of community health partnerships, but it has not happened to the extent that it should have done.

As I said, I will mainly ask about the acute sector. The worry that people have about any integration is that it will reinforce horizontal

integration but weaken vertical integration within the health service. I am interested in how the acute sector relates to that.

One health board has expressed concerns that integration may lead to the separation of the body corporate from the acute sector and almost lead to a purchaser-provider or commissioner-provider relationship between the two. I would be worried about that. How do you see the acute sector relating to the proposed model? The key question is: how do you envisage the financial power of the acute sector relating to it?

Jeff Ace: I am in a lucky position because I have one council, which is coterminous with my boundaries, and a relatively small acute service—I have one district general hospital and one large community hospital that provide acute care. My plan is to bring the whole thing into the body corporate model so that we do not lose the integration between primary, community and acute care. We will put the whole £250 million-worth of health services we have into that partnership.

It is a function of luck—the size of my system—that I am able to do that. It is a great solution locally, but I am not sure that it transposes across Scotland, given the far greater complexity and size of organisations in the rest of the country.

Susan Manion: My response is linked to the point that Mr Chisholm made about CHPs and localities. The intention of the original CHP legislation was to improve the quality of what was provided locally. It was about engaging with patients and service users as well as communities.

There are significant areas in which CHPs have been successful and I am anxious that the integrated partnerships build on those successes. CHPs were less successful in leading change across the system. Although that is a fair criticism, they perhaps had a lack of leverage to do that. The bill allows us to consider the partnership's commissioning responsibilities, which will allow us to create change.

The argument—it is sometimes an argument—about what is in and what is out when it comes to acute services has sometimes detracted from the reality of what we are trying to create.

It is essential that we get the links right between acute, community and primary care services, so that we engage clinicians at the local level as well as specialist clinicians. However, the argument about acute services has become a distraction that has impeded progress on many of the issues that we face across the country in the context of organisational change. Some clarity on that might help.

Dr Gunning: Mr Chisholm asked an important question. I think that it is useful to clarify the situation. Joint strategic commissioning—the strategic plan—has echoes of a return to the internal market for the NHS. People ask whether we will have the purchaser-provider split and something equivalent to NHS trusts, with all the bureaucracy that goes with them. However, joint strategic commissioning is really designed to bring about improvement by assessing needs, determining the best way to meet them and ensuring that the required services are delivered.

In Ayrshire we have two district hospitals, each of which provides services to residents in all three partnerships areas in Ayrshire. As Jeff Ace said, in some places the Dumfries and Galloway model is not supported. The important issue is the patient's pathway, which is what binds the partnerships and acute services together. There needs to be a seamless flow for patients, users and carers between the community setting, primary care, hospital—when that is appropriate—and then discharge, re-enablement and rehabilitation.

I think that everyone knows that, but maybe what is missing is a process that binds everything together, which, for me, is about being clear about the changes that we want to make to shift the balance of care. The strategic planning process should make that transparent and spell out what the partners are committed to doing to bring about change, and the resources should follow.

In the context of shifting the balance of care, the change agenda in acute services should not, in principle, be any different from other major service change that has occurred in the NHS over the past 20 years. For example, in mental health services there was a clear policy of no longer having continuing care beds in the NHS for people with a learning disability. Partners then got on with bringing about the changes that would support that policy outcome. Partnerships and acute services will have to work through the same process.

In principle, the relationship between partnerships and acute services should not be any different from the relationship between partnerships and the many major local authority services that are extremely relevant to the partnership agenda but which are unlikely to be managed within it. Education is probably the best example of that.

The Deputy Convener: Does Malcolm Chisholm want to come back in at this point?

Malcolm Chisholm: No, I think that the responses were helpful. I just wonder whether things will be different in the large health boards. I was quite interested in a comment at the end of NHS Ayrshire and Arran's submission, where you asked how the arrangements will work if non-executive directors in health boards have to sit on lots of local authority partnerships. That might be a

slight problem for Ayrshire; it will be a much bigger problem for local authorities in the old NHS Argyll and Clyde area. I am interested in how that will work in practice.

The current process is not really analogous with the changes in mental health and learning disability services, because the acute sector cannot be run down in any comparable way, not least because of the demographics. I suppose that is why I am still struggling to understand how the budgets will work. Indeed, one of the witnesses on the next panel will argue that the budget should be centrally determined because there will be such difficulty in deciding, first, how much goes in and, secondly, what services are covered.

Alan Gray: That is one thing that we must tackle up front, so that we do not get too focused on the money. How we move resources is clearly an issue that we must resolve. I echo what Allan Gunning and Jeff Ace said about the importance of spending time on getting the planning right. It is about integration of services, not just in the partnerships but between the partnerships and the acute sector.

It will take time to work through. The plan is strategic and it will have to have a horizon of five to 10 years. The important thing is that we do not rush into making short-term decisions but, instead, take the time to work out how to redesign our current healthcare system to meet the future demands that we are all facing. We need to change the way in which hospital services are organised.

The most important decision that we will make is about spending time up front in the early years of the partnerships on building confidence in one another and building the strategic plans that will allow us to see how we can move resources over time. It takes time to move resources that are currently invested in staff and services, but we need vision in the strategic plan along with the leadership that will allow us to make the changes that we need to make to build a sustainable healthcare system in Scotland for the foreseeable future.

Dr Gunning: I agree with Mr Chisholm that the detail of the analogy does not always hold. The point that I was getting at is that, essentially, we are shifting the balance of care in learning disability and mental health services. One of the policy objectives is to provide seamless services in the home or in as homely a setting as possible. In principle, the same proposition is before us and all the partners will have to be very clear about how that will be delivered. That is really the point that I was trying to make.

Secondly, there is a distinction between total resource and the operational management of budgets. I would certainly not be in favour of splitting up the operational management of budgets within district general hospitals. From my experience, I do not think that that would work; it would become tremendously confusing.

We have to bear in mind the fact that the majority of resources that are consumed by acute services are the consequence of decisions that are made by colleagues in primary care. We have to strengthen the link, and I think that we have the opportunity to do that.

Rhoda Grant (Highlands and Islands) (Lab): In listening to what you are saying, it occurs to me that the body corporate model means setting up a whole new bureaucracy in times of tight restrictions on spending. I can see how savings can be made by better incorporation and sharing at ground level, but setting up a whole new bureaucracy must have a cost associated with it. Is that the case?

Dr Gunning: I would not describe it as a whole new bureaucracy but support for a new way of working. We have to look at the bigger picture and find opportunities to share services.

I can show how structural change can support changes without organisational change, and I will step outside the current discussion to talk about procurement as a function within the NHS. All the NHS boards in the west of Scotland have got together to procure things as a single body, so instead of doing something five times we do it once. We have been able to make substantial savings as a consequence, but there has been no structural change in line management reporting. That model can be transported and the body corporate model can support real change and improvement without leading to a big increase in bureaucracy. The bureaucracy does not automatically follow.

Clearly, the setting up of the integration joint boards and the non-executive input will all have to be thought through. My view is that we should keep those things that need to be put in place to the absolute minimum that is required to support the change on the ground. That is where all the things that we have been talking about in relation to locality planning become important.

Jeff Ace: The challenge is a powerful one. We need to demonstrate to our local communities that the structures that we put in place do not create a bureaucratic cost. It would be a very hard sell if we had to say to our population that the services that we were providing separately will now be provided together and that that will cost us more in bureaucracy. I would not like to have that conversation, so the onus is on us to make the systems work within our existing financial, management and leadership resources. It is a

strong challenge because, on paper, the set-up is now more complex than it was. We have to find a simple way through the potential complexity that does not cost us more suits on seats.

10:15

Rhoda Grant: That is certainly a concern.

I will move on. We had evidence last week from councils that are concerned about the breadth of the bill, because it does not focus only on health and social care but includes any services that are offered. Is it right for the bill to have that wider scope? Alternatively, do you agree with the councils that it should be amended to focus only on health and social care?

Susan Manion: That is a good point, because you can read quite a lot into the bill in its existing form about the shape of the organisational arrangements and about what is in and what is out.

Briefly, we would seek clarity—it will come either centrally or locally—about what is meant by the proposal on acute services, what is meant by the inclusion of unscheduled care, and whether that is part of a commissioning budget or a provision budget, because the proposals broaden it out.

The discussion about the body corporate model indicates that it is very difficult to draw lines around older people's services as such. The bill therefore has to be broader because, from an NHS point of view, when it comes to primary care and community services it is very difficult to separate out different chunks of how we deliver. We have to think about how we work together locally around GP practices to link into patient pathways of care. It is a crucial issue.

Dr Gunning: There are some specifics towards the end of the bill on the role of agencies that currently provide services only to the NHS but under the provisions in the bill can provide services to wider stakeholders. The spirit of the bill is to ensure that any potential barriers to integrated working are removed, and its provisions are designed to support integration. The important point is that there is an appropriate balance between providing the necessary statutory framework and allowing enough flexibility for local partnerships to operate in the way that best suits local circumstances. That is always a difficult balance to strike.

As was said previously, when you look at some aspects of the bill in isolation, you see that it contains residual powers that could be quite considerable if enacted. Those are the important issues that are before us.

Rhoda Grant: Do you have concerns about that? Or, from a health perspective, is that okay? Local government covers a spectrum of services including not just social care but transport, housing and education—the whole lot. In your role, do you have a concern about the breadth of the bill?

Dr Gunning: I do not think that we have such a concern in Ayrshire. We feel that, on the health side, the bill gives enough flexibility for us to organise in a way that we think is appropriate to support service delivery. For example, it is welcome that services beyond services for adults can be included if local partnerships feel that they would benefit.

We would clearly like to see clarification about the services that must be included, those that might be included and those that will not be included. To be fair, some further detail that has still to come out—probably in regulations—will give us more information about the position.

Susan Manion: Active participation from integrated partnerships with local community planning arrangements and strategic community planning arrangements will be absolutely crucial. The bill does not touch enough on health inequalities and how we are going to look at the whole shift towards prevention and dealing with inequalities. There is a real opportunity for partnerships to be key to part of that work.

Through the commissioning arrangements or through the existing planning arrangements, we need to be able to work much more closely with colleagues outside social work and across the council because we need to be able to influence our colleagues in transport, housing and the environment because those issues all impact on inequalities. The fact that the bill has a broader look at where the partnership would sit in relation to its planning partners is crucial.

Nanette Milne (North East Scotland) (Con): I want to follow up what has already been said about stakeholder involvement. Concerns have been expressed to us, particularly by the third and independent sectors, that there is limited detail in the bill about the involvement of stakeholders. What are the panel's thoughts on that?

Also, last week we had some discussion about the role of GPs. It is crucial that they are involved. I well remember when CHPs were set up because my husband was a GP at the time and there was disillusionment because they had lost their local area. Suddenly, instead of looking after a small area, the whole of Aberdeen as it was became a CHP. The profession is fairly disillusioned, so how will the bill enthuse them and help you to get their involvement? Without that, it is not going to work.

The Deputy Convener: How will the bill motivate GPs? Who wants to come in on that?

Jeff Ace: GPs do disillusion very well. It goes back to an earlier argument about localities and communities, and I think that I can wrap in all stakeholders as well as GPs.

Clinical professionals and a lot of third sector bodies find it difficult to engage with us on a regional basis. Their ability to act and to mobilise resources does not work in that way. They can put different solutions in place in different areas.

The focus of our integration locally is on a decentralising integration in which we achieve critical mass in a locality area that is far smaller than a traditional CHP area. That allows us to bring in GPs—we will have a GP clinical lead for each of the localities—and to bring in the third sector and other organisations that are active in that locality. They might not be the same organisations in other localities. The flexibility to create solutions that are tailored to a relatively small area and a small number of communities is a real strength. That seems to be raising enthusiasm among clinicians and other partners.

Dr Gunning: I support Jeff Ace's comments about locality planning. If we go back far enough to local healthcare co-operatives, there is almost a nostalgic look in the rear-view mirror at how they worked.

I have a practical example that I heard one GP talk about. The agendas need to be locally relevant to practice populations. For example, this particular GP said that they know that there is necessary bureaucracy in the running of public services, and all of that can go on. However, what they want to see on the agenda is a debate about issues such as the quality of the incontinence service. That GP said that such things are real to them and that, if they can spend their time shaping that agenda, it will be worth engaging.

One of the successes in the community health partnerships has been the role of the public partnership forums, not only in CHP-related service change but in the wider landscape of service change. This is another point of clarification, which goes back to the point that Susan Manion made. We want to build on what has worked well in CHPs, through such mechanisms. In Ayrshire, some of the forums that support the CHP committees have wider stakeholder engagement and have worked well.

We have a model for engagement of the third and independent sectors, in the joint strategic commissioning process for services for older people, which seems to have worked well. I think that those sectors want to build on such strategic input. We can build on what is already working.

Susan Manion: The discussion about the whole clinical and care pathway for individual patients is crucial, because GPs and clinicians are most interested in what they can do to make life better for the patients who are in front of them. Much of that is about having some influence over how to change things, whether we are talking about incontinence services or patterns of referral to more specialist services.

That is what GPs are interested in. Links with other clinicians locally, through the models that are starting to emerge, are helpful and will, I hope, help GPs to become more engaged in what we are trying to do.

Nanette Milne: Do the witnesses think that there should be more detail in the bill, particularly about the third and independent sectors? The sectors have provided a significant amount of evidence to argue that they should be in the bill.

Jeff Ace: I would not want there to be a requirement for third and independent sector bodies to be represented on committee X, Y or Z or board A, B or C. That could require a lot of commitment from the sectors, for relatively little advantage. Where we need the sectors to work with us is on actual service provision and the local solutions that we can put in place—that would be preferable to their having what might be a tokenistic presence at a region-wide committee, which would not play to their strengths.

The Deputy Convener: We will put that point to the third sector in the next part of the meeting.

Dr Gunning: It is important that there is positive engagement with the sector and, as I said, we have a model in that regard. However, the arrangements must follow the governance and accountability arrangements. We must be very clear about the distinction between strategic involvement and where the responsibility lies at the end of the day, which will be with the statutory partners. It is important that we draw that distinction, to be fair to colleagues in the third and independent sectors.

Gil Paterson (Clydebank and Milngavie) (SNP): It is clear that there is a status issue. The bringing together of health boards and local authorities and their budgets gives status to the two big organisations. However, the third sector delivers a lot on the ground. How do we give the third sector status and a voice, so that we get the best out of it?

We will hear from the third sector, as the convener said, so my question might be more appropriately put to those witnesses. I am sure that they will have something to say about the matter.

The Deputy Convener: I think that our next witnesses are in the public seats, just behind the current panel. Their ears are probably burning. [*Laughter*.]

Alan Gray: Mr Paterson's question takes us back to the point that Jeff Ace made at the start of the meeting. We are turning the issue on its head by putting locality planning at the forefront, supported by strategic frameworks.

We have to make that approach a success and we need to engage with the third sector. We also need to engage with the public on looking after their own health. We need to empower communities to be involved in decisions that affect them. There are assets dotted all over our health board areas, which could be better used by communities. It is for us, as leaders of the health service, to ensure that we engage meaningfully at locality level.

GPs' biggest frustrations are about making connections, even within the health system. We must make it easier for them to make connections with the public and ensure that when they want people to be admitted to acute services they have a known point of contact—a face, a person. A range of work has been done around trying to integrate GPs into the whole health system and integrated health and care partnerships.

10:30

The Deputy Convener: With our witnesses' indulgence, because of time constraints, we will move on to the next question from members.

Mark McDonald (Aberdeen Donside) (SNP): I will be shamelessly parochial, but I think that it will nonetheless be relevant to the bill. Mr Gray possibly knows where I am going to go.

Concerns have been expressed about Aberdeen City Council's decision to establish an arm's-length company—a local authority trading company—for the delivery of some of its social care services. The chief executive of NHS Grampian is on the record as saying that, although that does not prevent integration, it could restrict the range and nature of the partnership that is established in the Aberdeen area. Given that things have moved on and the council has established such a company, what discussions have taken place? Are you confident that the partnership will be able to provide the maximum benefit?

Alan Gray: Without going into the details, we have to recognise that the local trading company has been set up. I view it as a service delivery vehicle, as it will deliver services and will be commissioned by the integrated authority. It will not make things any more difficult. It is different from what we have in the other two local authority areas with which we work but, if we take a sensible approach with the city council, the vehicle will not be an inhibiter to progress on the integration agenda. We just have to understand what the vehicle is there to do. It is there to achieve a range of objectives for the council, but it will not necessarily get in the way of effective partnership working in the city of Aberdeen.

The discussion has moved on from when correspondence was exchanged on the issue, and we now recognise what the vehicle is there to do. There has been positive engagement between health board and council officials. We now have to spend time on strategic plans, and the trading company will be part of that, because it will deliver part of the service that we commission, in the same way that some of our operational services in the community health partnership currently provide services. I do not see the trading company as an inhibiter and I do not think that the bill needs to address the issue specifically. It is for us to work through the detail of that as part of the joint commissioning arrangements.

The Deputy Convener: Mr McDonald, it is valid to follow up on that specific issue, but, if you want to do so, could you be brief, because there is a wider issue about structures?

Mark McDonald: That is the point that I am coming to. Previous legislation has often been found not to capture local authorities' arm's length organisations. Is that approach captured by the framework in the bill?

Alan Gray: The governance remains with the integrated authority. That is where the responsibility lies for governance and for the decisions on the planning and provision of services. It will be for that group of individuals, when they come together, to determine how the trading company forms part of that and what services will be commissioned through it. That decision is still to be worked through, but it should not prevent that approach.

Mark McDonald: Obviously, we are focused on the governance and accountability issues in the bill, but the driver behind the bill is to improve service delivery to individuals in receipt of care. I am aware that there are long-standing issues in some areas, in relation to the recruitment of carers, for example. Do you envisage that the closer working and the potential to look at issues such as workforce will have a positive impact on the situation in areas where there is a difficulty in recruiting appropriate care professionals?

The Deputy Convener: I do not think that that is specifically directed at Mr Gray, although he is welcome to answer it. I will come back to the other witnesses.

Alan Gray: That comes back to the point that I made earlier about looking ahead. We now have to design a health system that can be delivered within the constraints of various local markets. Each of us faces different difficulties. It is for us to

design a system that recognises where the challenges are and then to work together to find a way forward. There will be challenges on issues such as recruitment, but we need to find a way of working through them to come up with a system that is sustainable and attractive for people to work in and that recognises the challenges in local areas.

Dr Gunning: From the perspective of carers, one potential advantage of workforce change is fewer handoffs between services, because health and social care staff will be working as part of a single team. People talk about conversations over the kettle, but the fact is that co-locating those teams in a single area enhances teamwork, outcomes and the involvement of carers. There is a big human resources and organisational development strategic agenda here, but we must build on things that have already been successful, such as joint training in child protection, to ensure that we are developing the workforce in a coherent, consistent and appropriate way.

Susan Manion: Dr Gunning has highlighted a point that I think was missed earlier in response to the question about the potential added value of the new legislation. Workforce planning must be linked to the resource change that needs to happen because under the current arrangements we still have different care workers—care home and healthcare workers, for example—going into people's homes and there are sometimes still gaps and overlaps in provision. Planning and delivering that service more effectively while taking HR issues into account will provide significant added value. Indeed, that is what excites us about the new legislation.

Jeff Ace: Linking back to a previous question, I think that it is important to realise that the bulk of carers come not from the statutory agencies but from families and third sector organisations. That is the sort of area where each system has to demonstrate its effective working with other partners at a very low—say, community or family—level. That quality of engagement with the third sector and other partners is what will determine whether this bill makes any improvement.

Carers provide a really useful example of how not all of the solution lies with the statutory agencies. In fact, most of the solution might not lie with those agencies; it might well be that a lot of our success will be driven by the quality of our engagement with our non-statutory partners.

Dr Gunning: I think that there is a wider strategic agenda that links back to the Christie commission and particularly to the question of how public services reshape their relationships with local communities. That is a central issue for us all; indeed, in East Ayrshire, a vibrant and very structured communities programme has been set up through community councils to address that very matter.

If we in Ayrshire have a concern, it is about some of the links between this bill, the community empowerment and renewal bill and the Children and Young People (Scotland) Bill that is currently going through the Parliament. There is a responsibility to ensure that those specific examples are consistent with each other and lead to the same outcome that we all want. There will be quite legitimate overlaps, but we must ensure that they are positive and that we are not duplicating things or, worse still, pulling things in different directions.

Aileen McLeod (South Scotland) (SNP): The only questions that I had been hoping to ask have been asked and indeed answered, particularly on the issue of encouraging the meaningful involvement of our third and independent sectors or users and carers in the design, development and implementation of our services. However, if you wish to put anything that you have not already said on the record, feel free to do so. For example, I am aware that the community health and social care partnership board in Dumfries and Galloway includes representatives from the third and independent sectors and there is also, of course, the putting you first programme.

My safety net question was going to be about workforce planning and training to build capacity in the community but that, too, has been asked and answered.

The question that I will ask, coming back to the bill, concerns complaints and patients' rights. I understand that, at present, our health boards and local authorities operate entirely separate complaints procedures. In addition, health boards have to comply with the Patient Rights (Scotland) Act 2011, which sets out the rights and responsibilities of patients who use NHS services.

How do you envisage the complaints systems and the 2011 act working with integrated services that are meant to appear seamless from the perspective of the users?

The Deputy Convener: For the moment, the witnesses thought that they were getting a blank sheet of paper and could say whatever they liked. However, we now have a very focused question. Any takers?

Jeff Ace: For the bulk of the pathways, the means by which a patient's complaint will be dealt with will be clear. In perhaps four or five years' time, there will be a blurring in community care at the home level between what is health provision and what is social care provision. At that point, the question of which of the discrete processes we will use will become difficult to answer, and we may

need to come up with some sort of different landscape around complaints management.

Dr Gunning: I think that that is right. Already, some complaints cross boundaries between agencies, just because of the nature of things, and the agencies have to work together to address those issues. There may be a need to formalise those arrangements a wee bit more.

I would like to use the question to cover another point that we have not dealt with yet. The issue of complaints leads to the issue of ombudsmen and so on. It is important that the scrutiny agencies go with the grain in terms of the policy objectives of the bill. I know that thought has been given to joint scrutiny arrangements, but the last thing that we want—going back to the earlier point about bureaucracy—is for scrutiny to take place individually and then collectively, because, before we know where we are, the burden of bureaucracy on frontline services will increase, which is the last thing that we would want.

Aileen McLeod: At the moment, the 2011 act is primarily aimed at patients using NHS services. Should that be extended to cover social care services also?

Jeff Ace: A client in the social care framework and a patient in the NHS framework both have a framework of rights-guaranteeing legislation, so I do not think that there is a gap at the moment. I think that you are asking whether we should blur the line between the two frameworks and make one the dominant structure, as it were. I do not think that there is an urgency around that. At the moment, I think that people understand clearly where the Care Inspectorate’s responsibilities lie and where the responsibilities of Healthcare Improvement Scotland lie. I think that we have clarity at the moment. It might be an issue that needs to be dealt with in the future, but I do not think that there is an urgent problem there.

Dr Gunning: The focus of some of the provisions in the current patients’ rights legislation is very much on treatment times in acute services, such as the 12-week treatment time guarantee. Whether there will need to be a statutory underpinning around access times in future is a major policy issue. Certainly, however, I see many of the challenges within the current legislation being to do with the issue of guaranteed access times, which is really important.

10:45

Gil Paterson: Most of the questions that I wanted to raise have already been covered. Dr Gunning said that he likes conversations over a kettle. I was born and raised in Springburn where we used to try to have conversations over a barrow. I think that his way is much better than the way I was brought up.

The Deputy Convener: Can I just say, as a representative of Springburn, that things have moved on a lot there?

Gil Paterson: That is right. I no longer live there.

Ms McLeod raised the idea of two different systems for people to make complaints, which is a serious question. I suspect that you are saying that it should change organically and that in the future they will come together, and that putting in effort and resources now may make it fail. A comment on that point would be fine.

Jeff Ace: We will always be able to answer a complaint. Between us and the council we will find a mechanism, as we do now, when an individual crosses our organisations, so there is no urgent necessity for legislation on the complaints mechanism.

The Deputy Convener: Do any other witnesses want to comment on that point? Mr Paterson, do you want to comment?

Gil Paterson: No thank you. That is fine. I have heard enough.

The Deputy Convener: It is not often that members have no comment to make at this stage.

May I take the opportunity to say briefly, because time is starting to get ahead of us, that if other witnesses want to put something on the record that you have not been asked about, now is your opportunity to do so. Is there anything that you would like to add?

Susan Manion: Speaking for the CHP association—saying this might seem like turkeys voting for Christmas—we are delighted with the opportunities that integrated partnership presents. When one is called to give evidence one considers the issues that are missing or the bits that we want to emphasise.

We appreciate the thrust of the change. We recognise that it is coming off the requirement for us to be bold and to use the opportunities. Locally, we are keen to be bold and to use the opportunities. We need to make sure that we make some step changes now to build on what has been successful, because there is so much more that we can do together, but we need the legislation to help us to be able to do that, otherwise we would have done a lot of it before now.

Jeff Ace: I will pick up on the point about the third sector that was raised earlier. It is important to re-emphasise that every system will need to make its engagement with the local third sector work in a way that is dramatically different from the

way in which it has worked so far. We need to be assessed on the quality of how well that works.

I and some of my health service colleagues are thinking about how to legislate effectively for that engagement in a way that works for Glasgow or for rural Dumfries and Galloway. That is the bit we are thinking about, not the realisation that we will have to change radically the level and quality of our engagement with third sector and other partners.

The Deputy Convener: Thank you Mr Ace. Does Dr Gunning or Mr Gray want to add anything to that comment?

Dr Gunning: I will make two brief points. Although we are talking about structures, governance and accountability, integration is not an end in itself, it is just a mechanism for improving outcomes for the people and the local communities that we serve. Integration cannot be achieved by legislation alone. There are big leadership challenges at all levels, national and local, within and outwith the statutory agencies. We need to be aware of the organisational development and wider change agenda, and the leadership that will be required at all levels to make integration a success.

Alan Gray: It is important to understand the relationships between the strategic plans that the councils and the health boards will undertake and the integrated plans that each of the partnerships produced and how they will work together. Our board serves more than one council area and it must be recognised that a lot of our services are organised across a region, indeed, across the north of Scotland.

It is important to get the right balance between planning decisions at a strategic level across a board area and the strategic planning decisions taken at an integrated authority level. If the legislation can simplify that, as Mr Ace said, in terms of governance and accountability, that would be ever so helpful to ensure that we achieve the right outcomes and deliver what we are required to deliver under the new arrangements.

The Deputy Convener: Thank you very much. I remind witnesses that our scrutiny of this bill will be on-going and if there is anything that you want to add in writing please do so, as the committee continues to take evidence. We would find that helpful and welcome it. All that remains is to thank all four of you for giving us your time.

The meeting will suspend for five minutes while the next set of witnesses comes in.

10:50

Meeting suspended.

10:55

On resuming—

The Deputy Convener: We continue with agenda item 2, which is to hear evidence on the Public Bodies (Joint Working) (Scotland) Bill. I welcome our second panel: Ranald Mair is the chief executive of Scottish Care, Nigel Henderson is convener of the Coalition of Care and Support Providers in Scotland and Martin Sime is the chief executive of the Scottish Council for Voluntary Organisations.

As we did with the first group of witnesses, we will go straight to questions to allow more time. Gil Paterson has indicated that he would like to ask the first question.

Gil Paterson: Thank you very much. It is good to see the panellists here. I would like to start almost where I finished, when I followed my colleague, Nanette Milne, speaking on stakeholder involvement.

It is evident that the voluntary sector wants to be involved in the new structures. I think I used a phrase like the "two big beasts" that have automatic status. I wonder how the panellists see their sector engaging in the structure. What would you like to see in the bill? What is your input? How do we get your status to the same level as the two big sectors, if that is at all possible, without money coming into the frame?

The Deputy Convener: I did say to the previous panel that every witness does not have to answer every question, but I have a feeling that all three of you will wish to answer this question. Can we start with you, Mr Sime?

Martin Sime (Scottish Council for Voluntary Organisations): Thank you very much. This goes to the heart of one set of concerns that we have about the bill, which clearly sees the third sector in a secondary role, both in its institutional aspects and in terms of the evidence that we just heard.

There is still a widespread view that we are here to deliver other people's priorities. That is a misunderstanding and misrepresentation of the crucial role the sector has to play, and of its many different interests in this field. We understand that the bill is structured as it is, providing for an equal number of representatives from the two big public service "beasts" for the balance of power. We recognise that if the third sector had a voting seat at that table it would, in effect, hold the balance of power.

I think that the Cabinet Secretary for Finance, Employment and Sustainable Growth said at a recent briefing with the third sector that if things get to the point where you have to vote then people have missed the point altogether. That is a fair reflection of the problem that is associated with

third sector representation. We would like to see the third sector represented at all levels in the new structures. If we are going to have the new structures, it is important that the third sector have a seat at the strategic tables because it has a strategic contribution to make to the bill, and not just to its objectives.

If only the statutory agencies are to vote—based on the rather odd reasoning that we have heard so far, which is that they are statutorily responsible for public money—the third sector and other interests should have some power of veto over the plans and how they are developed. It should certainly have a right to contribute to those plans.

I know that Mr Paterson said that it is not a question of money, but there needs to be a modest investment in the third sector's capacity to engage with all the structures, otherwise you are simply asking hard-pressed volunteers in voluntary organisations to stop doing something else in order that they can engage in statutory planning. There needs to be investment.

Most of all we argue that it is not a question of structures; it is about building stronger communities, which will take the strain and the pressure away from all the focus on delivery of care services to people. If we do not do things that reduce demand on formal services, we are kind of missing the point.

11:00

Ranald Mair (Scottish Care): I was not sure whether the reference to "two big beasts" was a reference to Mr Sime and Mr Henderson. [*Laughter*.] As you know from the written evidence that we have submitted, Scottish Care is clear that it will be a missed opportunity if the third and independent sectors are not fully included in the governance arrangements in the future. That is the position that we have to date enjoyed and discharged responsibly within the work of the change fund and the reshaping care for older people programme. Those are four-way partnerships within which the third and independent sectors have sign-off responsibilities, and which have created a sense of joint ownership of delivery of care and of development of new models of care.

Rather than capture the progress that has been made, the bill sets us back dangerously to a point where the third and independent sectors become "consultees", and not full partners in a process. Despite the optimism that was expressed by Dr. Gunning and others, there is a real danger of our losing ground rather than gaining it. The evidence that we submitted makes it clear that the third and independent sectors deliver more social care than the statutory sector delivers. One has only to look at care homes and care at home, in which the bulk of services are delivered by third and independent sector organisations.

How can there be integration of services? In a sense, and in an honest way, the title of the bill states that it concerns the "Joint Working" of statutory bodies. That is it. We have given up on "integration".

As you know from our written evidence, we would have preferred that this was a public services bill in which everybody who is part of the delivery of public care was brought together, and that the focus was on that level of integration. We feel very strongly that the third and independent sectors have to be represented at all levels of governance and planning in order that we are not just at the commissioned end of service delivery but are wholly part of the process from the outset.

Nigel Henderson (Coalition of Care and Support Providers in Scotland): I echo much of what has been said. It is particularly interesting to note where we are today and the part the third sector has played in achieving that. An awful lot of what is delivered across the country was pioneered, innovated and created by third sector organisations and is now part of the mainstream.

It is also interesting to see the push within the health service now to move to a person-centred way of working; the health service is playing catch-up with the voluntary sector, which has been person-centred for the past 20 years. We have a significant contribution to make—not just as providers, but as equal partners. It is interesting to reflect that we are trusted to provide care and support to some of the most vulnerable people in Scotland but are not trusted or respected as equal partners.

I absolutely echo what Mr Sime and Mr Mair have said: we need to be involved at all levels. We can deal with the mechanics and how we sort it out later, but the basic premise has to be involvement. The third sector does not always speak with one voice; it includes a diverse range of organisations. We have diverse interests, but our range of interests crosses the whole community in Scotland, at different levels. It is very important that we do not leave the two big statutory authorities to do this by themselves. They need people like us to help to shape, to create and to innovate for the desired outcomes.

Gil Paterson: I hear what you are saying and how you are delivering your message. Are there any practical items that you can bring to the table that encapsulate what you are trying to achieve, bearing it in mind that you have just said that the range of voluntary and third sector organisations and where and how they deliver is very wide? How

do you bring all that together before you can impart power to act to maybe one individual?

Ranald Mair: I have an example that relates to Nanette Milne's questions in the earlier evidence session, about the decisions that GPs make and why people end up in hospital. The GP can pick up the phone and get access to a hospital place if they are worried about Mrs Smith, but they cannot get immediate access to an intensive care-at-home package or to a care home place. The purpose of integration is to bring all the options to the fore so that when GPs are making such decisions they have immediate access to all the options.

If we leave the provider sector in a situation in which commissioning must be through the social work department, there is not immediate access, not all the options are brought to bear and the systems are not redesigned. It seems to me that there are practical ways in which the provider sector—private and voluntary—must be part of the planning and the bringing together of options at the front line.

Martin Sime: There is a track record in this. The Government makes a significant investment in what is called the third sector interface—none of us likes the name very much, but the intent is very clear—which consists of local umbrella bodies that are designed to provide a framework through which the third sector can co-operate. In health and care, we have heard examples of the different roles that the third sector can play as a vehicle for user, carer and community groups, as an advocate for special interests and people with disabilities, and as a service provider.

It is clearly quite difficult for any one organisation to represent in a traditional sense all that diversity in statutory planning processes. However, we are working towards that in the community planning world and we are making real progress with the TSIs. The representative role is to enable messages from the diversity of interests in the sector to be represented at the table and reflected in the discussions. However, it is just as important for the messages from the community planning table to come back to the diverse constituency in the community. In other words, the role is not to represent a bloc of interest, but to act as an interlocutor and take messages back and forth from what are really quite diverse sets of interests.

We could undertake that role in health and care, but we cannot do it from a standing start with no resources. That is my message to the committee. Also required is a very clear message to the statutory partners that this is not an optional extra or something that should be left to local decision making. We know what happens when such things are left to local decision making: in large parts of the country, they do not happen.

Nigel Henderson: I think that the question was specifically about how we do integration. I do not have a snappy answer, but I would reflect what Martin Sime said. We already have community planning structures, although getting involvement is sometimes difficult. Certainly, as a service provider, I sometimes find engagement difficult; equally, though, I understand that we have third sector representation.

However, there must be discussion of how integration and community planning link up. We could set up lots of committees, structures and all the rest of it, but I would then worry about how we as a sector would ensure that we were represented. We think that we are entitled to be represented and to be part of things, but as Martin Sime said, the question is about how we would resource that. There are already frameworks in community planning that could feed into health and social care integration so that there is awareness of what is happening from the ground up.

Gil Paterson: So, to make integration happen, must there be a reference to it on the face of the bill, or would it work through guidance?

Nigel Henderson: I think that it is a strongly held principle within the policy memorandum, so I do not see why it should not be on the face of the bill.

Ranald Mair: To strengthen that point, anyone reading the bill as it stands would not know that the third and independent sectors existed or contributed anything. There is a disconnect between the policy memorandum and the bill in that regard. We are already core partners and need to continue to be. Reference to that in the bill would mean that the matter cannot be left to any local opt-out or whatever; our inclusion would become a formal requirement.

There are partnerships in which that would happen anyway, as was reflected by Dr Gunning earlier in the meeting. He said, "In Ayrshire, we would do that." That is fine, but there might be other parts of the country where the choice would be not to do it, or not to do it well enough. Therefore, it has to be in the bill.

The Deputy Convener: I have a supplementary question, if members will indulge me. Mr Sime, I think that you said to challenge our views that, if it is about equal partners, we have local authorities, health boards and the voluntary sector, which could hold the balance in a strategic board. What should be the balance of influence in voting rights and input for the third sector on a strategic board? More important, if you believe that there should be something on that in the bill, the bill has a great

deal of flexibility on what the body corporate may look like, for example. I do not mean this glibly at all, but do you seek to have a nod to the third and independent sectors, or would you like the bill to micromanage their role? I do not mean that in a pejorative way. I am interested in getting a bit more clarity around that.

Martin Sime: I would not start from there. The bill is primarily an object lesson in 14 public bodies coming together with 32 other public bodies to create 32 new public bodies. That is what it is, in effect, and the third sector's interest in that kind of institutional arrangement is necessarily limited.

As my colleagues have reiterated, the third sector's engagement in delivery of health and care services and the promotion of initiatives in the community, which might obviate the need to use those services, is absolutely central. If we do not get our heads around a set of priorities that put that second domain above the first domain, we will have lost the plot.

It seems to me that we started on this journey because Scotland faces significant demographic challenges. I worry that the conversation is no longer about the significant demographic challenges and how to meet them, but about the institutional arrangements and a piece of public sector infrastructure. If the message is that you can have all this public sector infrastructure without the engagement of the third sector, I would of course have to say, that you cannot.

My argument is that the third sector needs to be seen as an established partner, not as a downstream deliverer of public sector priorities. If we are not an established partner and are outside the tent, the tent will become very uncomfortable to be in altogether, because the third sector will make its voices and interests known in other ways.

I do not have an answer to the dilemma that the committee faces. I understand why local government and the health service are equally unwilling to cede a voting seat at the table: it is because of the power that that would give the third sector. The third sector would be ill advised to simply grab such a seat.

My message is a bit mixed. I would like to see in the bill recognition of the absolutely pivotal role that the third sector plays in supporting people and communities, and the need for all public authorities to engage with the third sector at every level on an equal footing.

The Deputy Convener: I note that we are trying, with the structures that underpin the bill, to ensure that the third and independent sectors are part of strategic planning at the earliest phase. That is about meeting outcomes for individuals in our communities. I hope that you appreciate that we are looking at the nuts and bolts of the bill. Mr Mair, how would you like the bill to be amended?

Ranald Mair: I accept that there are aspects of governance and accountability for which the statutory agencies are specifically responsible. There is the accountability back to local elected members and health boards' accountability back to ministers.

I accept that the third and independent sectors are not in exactly the same position. That does not, however, mean that we cannot be full strategic partners and have a kind of non-exec role in local boards. It is not possible effectively to do a strategic needs assessment in an area, to develop a locality plan and to appraise the options for how services can best be delivered without the inclusion of the third and independent sectors. It is not beyond us to come up with a governance model that would allow that strategic inclusion, while accepting that the statutory agencies have particular lines of accountability in relation to public moneys and so on.

11:15

The Deputy Convener: That is helpful.

Nigel Henderson: There are three potential levels of involvement. One is at the health and social care board level, one is at the level of the strategic commissioning process and one is at the locality planning level. We should be involved at all levels. Being involved early in any strategic planning is crucial. We would like the bill to be changed to reflect that and say that the third and independent sectors must be involved at those points.

In an ideal world, it might be useful for us to have voting rights at board level. However, as Martin Sime said, hopefully we have a process that allows for consensus to arise and in which we do not have to wave votes around because people share the same vision and agenda on integrating health and social care.

The Deputy Convener: There are two supplementary questions on that, from Aileen McLeod and Richard Lyle.

Aileen McLeod: Martin Sime said earlier that the issue was not about the structures but about building stronger communities. In his written submission, he mentioned the capacity implications for the third and independent sectors and the fact that

"the operating environment for the third sector remains challenging".

A key challenge within that for the way forward is how we rebuild capacity in communities to deliver health and social care services effectively. How should that be done?

Martin Sime: You put that question in an interesting way. I am not sure that the top priority in my book is to build capacity to deliver services. The top priority is to build capacity to reduce the demand for services. The third sector does a range of things, or is a vehicle for them, in communities, such as befriending, lunch clubs, care-and-repair initiatives and the Food Train. There is a raft of third sector interventions that enable people to sustain themselves in communities and be independent. Community transport is a classic example of that.

Those are not commissioned care services; they are voluntary organisations doing things with communities that enable older people to be independent. We need much more of that, but it is precisely those services that are most under threat from the reductions in public expenditure. As budgets tighten, the statutory or formal services retain an element of priority and anything else is seen as marginal. That is exactly the wrong way round. An investment in services that enable older people to sustain their independence and good health in the community would be genuine prevention.

My worry is that we all run after this word "prevention", but it is interpreted in much the same way as the change fund was interpreted, which is to mean that new ways of intervening in people's lives and providing services have priority over ways in which people can make decisions for themselves.

I want to open up one area that has not had enough priority. We are having conversations about the bill and the delivery of services without sufficient reference to the Social Care (Self-directed Support) (Scotland) Bill. It seems to me that the two bills are ships passing in the night. Self-directed support ought to enable people to make decisions for themselves about the kind of support and infrastructure that they need to meet their needs. That is fundamental to the canvas of services going forward.

The Deputy Convener: Mr Mair wishes to speak, but I ask him to hold on to his thought for a second. If he and Mr Henderson want to answer Aileen McLeod's question, they can do so, but two members want to ask supplementaries. We will take Richard Lyle's supplementary now, so that the witnesses can reflect on both questions. That will allow us to get through questions more speedily.

Richard Lyle: In some ways, your submissions are quite critical. I agree when you say:

> "this sector provides 85% of the care home places in Scotland and over 50% of care at home. There are more older people in care homes any night of the week than in hospitals, and more ... care workers employed in the private and voluntary sectors than in the public sector".

I love the bit from Ranald Mair that says:

> "The mundane title of the Bill might also tend to obscure the fact"

of

> "its impact".

A number of critical points are made.

I come from a local authority background and I have been involved with many local organisations and many sectors. In a partnership, who will speak for all those involved? Who will be at the table? If you were included, would you really need a vote?

The Deputy Convener: I think that some committee members have jumped the queue for asking questions. A very patient Rhoda Grant was meant to be next.

Aileen McLeod asked about building capacity; Mr Lyle asked who would represent the third and independent sectors should a vote ever have to be taken.

Ranald Mair: I will try to respond to both points. We have good experience to draw on from the change fund and reshaping care partnerships. We have tested the ground on some of the issues. We have representation—we have worked out how to do that. There are representative bodies. I sit on the Glasgow reshaping care partnership steering group, on which the third sector is represented through the Glasgow Council for the Voluntary Sector and the independent sector is represented through Scottish Care. We have worked out who will represent us, which has been important.

One of my disappointments with the bill is that it does not seem to say what is working. Some of that ground has been painfully gained over the past period; that did not happen automatically. Initially, the involvement of the third and independent sectors in some aspects felt tokenistic, but that has improved as we have demonstrated that we bring something to the table.

On capacity, we have had a dual model to enable our sectors to be full partners. Money has been channelled from the Government to support the sectors and their engagement, and local partnerships have invested money because they recognise that, if we want the third and independent sectors to be full partners and deliver new models of care, they have to put resource into that.

We have good experience that we could draw on, but we are not doing that. We do not have to say how the sectors will be represented, how to create joint structures and how to develop capacity, because we have done that for the past two or three years—we have been on that journey with reshaping care. We should capture and build

on that, rather than start again, but the bill has the danger of pushing us in that direction.

Nigel Henderson: The bill refers to the third sector—the voluntary sector—as well as the for-profit independent sector and the not-for-profit service-providing sector. Those distinctions are important. No one single body will represent the totality of third sector views. Service providers, which I represent, have a view about the contribution that we can make, which might differ from the view of community and volunteering groups. It should not be beyond the imagination of partnerships to look at how such voices are heard and at how to enable them to be heard.

In the past, a lot of change has been miscommunicated. For example, when a hospital is to be closed, we hear only the headline that the hospital is to close, and we do not hear the headline that better services will sometimes be developed in the community. Why are we not communicating and engaging with communities? There might be capacity issues, but there is a willingness, a creativeness and an inventiveness in the sector and we will find ways in which to participate. It will be much better if we are invited to be there as equal partners instead of having to barge the door down.

There needs to be something in the bill that says that the third sector must be involved, although how that happens could be left to local discretion. We already have the model of third sector interfaces in community planning, so it will then become our job to ensure that our views are being represented through those third sector interfaces. I do not think that there is a one-size-fits-all solution whereby we can simply say, “That will be the body.”

Rhoda Grant: Let me reel back the discussion a little to the plea to be involved in governance and commissioning. How would you deal with that, given the rules and regulations about governance and financial interests in the public sector? There is strict guidance about how people can use their influence in decision making. If you were on the board, you would be commissioning services in which your organisations, as contractors, would have a financial interest. That would be a huge conflict of interests that would be difficult to manage because there is no statutory control of your organisations. How would that work?

Nigel Henderson: If we have a conflict of interests, that will be shared by the other partners, as they, too, provide services.

Rhoda Grant: But that is their role—they have been set up as public organisations to provide those services.

Nigel Henderson: In terms of statutory control, the scrutiny to which we are subjected is as intense as, if not more intense than, the scrutiny of some areas of the national health service. We must be registered providers and must go through all sorts of processes. We are inspected regularly and we are held accountable. We are also, in the main, charities and we are held accountable by the Office of the Scottish Charity Regulator. What we can do is very much subject to controls and limits.

Your starting point is to jump to the point at which we might get into arguments about who does what and all the rest of it. If the bill is about fundamentally shifting the landscape of health and social care—if it is about considering the Christie commission principles, moving things upstream and beginning to think about prevention—we need to be involved in the discussion to ensure that we help to shift the agenda. As I said, we have a long history of being creative and innovative and finding different solutions, and all the people who contribute to what happens in health and social care must be involved on an equal basis. The governance issues are important, but we should not lose sight of what we are trying to achieve.

Ranald Mair: It is an important issue that we must address. Scottish Care is not a service delivery organisation; it is a not-for-profit representative body. Therefore, I think that we can represent the potential contribution of the sector as a whole without feeling compromised or having a conflict of interests—possibly better than local authorities, which may want to protect in-house services while supposedly adopting an open options-appraisal process. I do not necessarily agree that the conflict of interests would apply to us and not to the statutory partners.

The important point, which is one that I have made to the committee in previous discussions, concerns the regulation of commissioning processes. We need clear national standards. The process needs to be regulated to ensure transparency and to ensure that our involvement at a strategic level in commissioning focuses on the volume and range of services that we require and how we shape the models of care to deliver what is needed in the future.

11:30

If we are not at the table, time will be wasted. I am in discussion with one health board and local authority at the moment about the development of intermediate care to prevent people from going into hospital. Traditionally, the local authority commissioning staff went into a darkened room and came out with a spec of what they wanted but, when that was presented to providers, it became clear that it could not be delivered in the way that was wanted. In other words, we must be involved

at an earlier stage to shape the models of care that will deliver what is needed.

I do not think that there is a conflict of interests that cannot be overcome. If we are involved in the commissioning process from the outset, the gains will far outweigh the concerns that we might be partisan in how we go about the process.

Martin Sime: Having read the evidence that was given by local government representatives last week, it is difficult not to conclude that here was the promotion of self-interest on a grand scale, so to be accused of somehow promoting our interests in the commissioning and governance arrangements seems rather rich. For our sins, Ranald Mair and I sit on the national delivery group for health and care, and we have had two special meetings over the summer to consider the bill and its implications. Those discussions—although that is a polite word for them—have been absolutely dominated by the pursuit of the institutional self-interest of health services and local government to the point where the purpose of the bill and the interest of people who might need access to services was almost completely absent.

One thing that the third sector might bring to the top tables is a continual focus on those needs, on the purpose or object of the exercise and on what we are trying to achieve. If one takes a top-down approach to public authorities delivering things to people, either directly or indirectly, one gets into the business of thinking about conflicts of interest.

If the bill was somehow turned on its head and we thought about how to build a system of health and care support from the bottom up, based on the needs and interests of communities and underpinned by the rights of individuals to make choices about the services that they felt were appropriate to their needs, one would come to a completely different set of conclusions whereby health and care institutions are the servants rather than the masters of those processes. The problem is that the bill, in a traditional Scottish public service top-down way, is paternalistic at its heart and is the exact antithesis of the recipe as set out in the report of the Christie commission on the future delivery of public services for building services around communities and their needs. In the bill, we are building structures around institutional interests.

Rhoda Grant: There is nothing to prevent other organisations from being involved in community planning.

None of you has answered my question about how to set up governance structures that are not only fair but seen to be fair, and that ensure that Joe Public does not think that private contractors and third sector organisations who will make a profit are involved in making decisions about how the care is delivered. How do you prove to him that you are not doing it out of self-interest for your organisation and that his interest is at the heart of it?

People in health boards do not have a financial interest and neither does local government. Local government has a democratic interest in serving its public, because its members are elected on and off to do that—they are public representatives. How do you square that circle and ensure that you are seen to be making that decision not only properly but transparently and in a way that fits with standards in public life?

Martin Sime: Voluntary organisations that deliver care are almost universally charitable. They do not distribute profit and there is no personal gain or private advantage. Any resources that they generate go straight back into their cause or mission. They are a public good, so if a charity sits at a top table articulating a view on behalf of the community that it seeks to represent, I am not sure that the public would have much of a problem with that. The public seem to support the idea that charities can play a bigger role in the community and have significant confidence in them.

Of course, charities are subject to adequate and proper regulatory frameworks, thanks to the sterling work of the Parliament to pass Scottish charities legislation for the first time and to establish OSCR to ensure that charities keep to their bona fides. It seems to me, however, that we are kind of missing the point. Not all charities have a service delivery interest; some have a representational interest. The third sector interfaces, for example, do not deliver health and care; they deliver support to the third sector organisations that deliver health and care. It is therefore perfectly reasonable for us to be represented at the top table without any conflict of interest.

We see the problem manifested in adult care services. Local government thinks that the best way of getting the best value—a term that local government does not apply to itself, incidentally—from working with the third sector is through competitive commissioning processes and offering contracts to what is usually the cheapest provider of services. There is lots of evidence, particularly from some pretty innovative work that the Scottish Government health department is doing with the third sector, that that does not get the best out of the third sector, because all that the buyer gets is what is written in the contract. They do not get the third sector using its development expertise or volunteers engaged in the service or a developmental approach that might find other resources to bring to the table. There is none of that if the service is on a commissioned and

contracted basis. That is not the way forward for health and care services being delivered by the third sector. We need to find new ways to generate proper partnerships between the third sector and the state to get the best of both worlds.

The Deputy Convener: Mr Mair, how do you address the conflict that Rhoda Grant suggests?

Ranald Mair: I have a couple of things to add. As has been said by others, I do not necessarily think that we are caught in that trap. We have the evidence base from the reshaping care programme and the change fund that we have discharged that involvement in an even-handed and non-partisan way, but that has to be open to scrutiny. People should have the option to withdraw from certain decisions and they can declare their interest if there is a perceived conflict.

Within commissioning, we can separate off the strategic planning element and the broad options-appraisal element from procurement. I do not expect to be involved in any decisions about how services are procured. The procurement process should be transparent, whether it uses a tendering model or another model. We can separate the planning function and the options-appraisal function from the mechanics that are involved in procuring services. It would be inappropriate for sector representatives to be involved at that level.

Again, I do not think that the one cancels out the other. We need to be clear about the level of involvement and the range of decision making in which we are engaged. Processes need to be clear and transparent so that there is no conflict of interest when it comes to the procurement of services. However, as I said, I would equally apply that rigour to local authorities. They should not be able to allocate contracts to in-house public bodies while insisting on tendering and retendering processes for the third and independent sectors. Let us have one set of rules for everybody, as well as transparency for everyone.

The Deputy Convener: Would you like to add anything, Mr Henderson?

Nigel Henderson: I just reiterate that we are a not-for-profit sector. We are charities, so there is no profit motive and, as Martin Sime said, everything goes back into the work that we do. Within CCPS there are about 73 organisations, which are all social care providers. About 75 per cent of our income comes from public bodies through contracts, service-level agreements and grants, and we generate the other 25 per cent ourselves from individuals, charitable trusts and other pots of money. That money goes back into the public good as well, so we already add considerable benefit. We are not in it to build empires and deliver simply for the organisations; we are there because we believe passionately in delivering better outcomes for people in the community. As Martin Sime said, the public can have confidence in charities through some of the structures that already exist.

I echo the point about commissioning and contracting. Local authorities now put out tenders in which they cap the rate at about £14 or £15 and say that no one will get more than that. However, we know that their in-house services cost at least £10 an hour more than that. It is therefore not a level playing field. There is already a lot of self-interest evident in the public sector. We need to be able to get to grips with that. If we simply move the structure but have the same behaviour, we will not achieve the bill’s goal.

The Deputy Convener: Would you like to add anything, Rhoda?

Rhoda Grant: No. I have not really had an answer to my question, but I do not think that I will get one, so I will just leave it there.

Mark McDonald: I understand entirely the need for the third sector to be confident that the bill will not exclude some of the good work that is currently being done. However, do the witnesses believe that the issue of third sector engagement needs to be on the face of the bill? Could guidance be developed to ensure that the role of the third sector is taken into consideration, which might give some comfort to you?

Martin Sime: We seem to be going over the same ground. Let us see whether we can look at the issue in a slightly different way. I am a bit of a sceptic about whether the bill will achieve its intended purposes. I am not sure that all the discussions that we are having about the role of the third sector should be solely in relation to the bill; they ought to be more in relation to how the third sector engages with public authorities more generally and how the third sector engages locally.

I believe that the third sector’s engagement in the delivery of health and care services and the support of communities is critical for the future, because there is no plan B that involves not using or working with the third sector, or not building strong communities. It therefore seems incredibly unfortunate to have a bill such as this that completely marginalises the third sector to some kind of downstream deliverer of public sector priorities—that simply does not work.

I think that a lot of the bill is totemic anyway, so let us have the totemic engagement of the third sector recognised on the front page of the bill to send a very clear message to public authorities. The previous panel of witnesses reflected the view that they did not need the third sector at the strategic level but just needed it for delivery. That sort of message is incredibly damaging in the long

run to the interests of people who use health and care services. We need more third sector engagement at the strategic level, but the bill does not get there in its current form.

The Deputy Convener: Mr Henderson, do you want to add anything?

Nigel Henderson: It feels like we are going over this issue in great detail. The Parliament has a history of putting principles right up front in bills, but with this legislation, many of the principles and aims are in the policy memorandum. We would like more of those to appear in the text of the bill, particularly in respect of the inclusion and equal status of the third sector. That is a principled argument, to some extent. Martin Sime is right to say that there are some areas of tokenism, but it is an important token to ensure that we are an accepted and credible part of what happens in the public service world in Scotland.

11:45

The Deputy Convener: I assume that Mr Mair agrees with that.

Ranald Mair: No, I am going to disagree wildly. [*Laughter*.]

I listened to the cabinet secretary last week as he emphasised once more that the move towards integration was not about structures but about culture and vision. I agree with that in one sense, but the structures that we develop must reflect the culture and vision that we want to have, and if that is about partnership, the structures must embody that partnership.

The text of the bill does not need to go into huge detail about the involvement of the third and independent sector, but it should contain the requirement for the sector to be fully included. The detail can be in the guidance, and it will be for local partners to work out some of the mechanics that we have discussed this morning and come up with the working answers. If we have not managed to provide those answers now, we can—I hope—find them at local level as we try to move things forward.

The issue is the absence of any reference to us. We do not need a lot of comfort built into the text of the bill, but some acknowledgement that we exist would be marginally helpful.

Mark McDonald: That comes back to a particular difficulty with the sector. In a local authority or a health board, it is easy to define who is responsible or accountable. However, it is difficult to define who is accountable or responsible in the third sector, given that it ranges from prominent national organisations to local organisations that are often much less prominent. How do you ensure that, rather than having 100 different voices at the table, you have one voice that will represent adequately that range of interests?

Martin Sime: In a sense, we have covered that. In reshaping care for older people, it was agreed at national level that the third sector interfaces would take on the responsibility of enabling the third sector to be represented. Those third sector interfaces had, written into their funding agreement with the Scottish Government, a responsibility to engage with all parts of the third sector and to enable the sector to represent itself to public authorities.

You will not get a corporate view, because we do not have a single view on these matters—you will get a lot of different views, and that diversity is a critical strength of the third sector. We therefore need an enabling mechanism, which must be the interfaces, as there is no other mechanism. It is their core business, and they must reconcile the needs of small local and community organisations with the needs of big national care providers, housing associations and many other interests in the third sector, including those organisations—on which we do not seem to be spending enough time—that give voice to particular needs and interests in communities. Carers groups, for example, must be represented and have a role to play in integration. Where will the voice of people with disabilities be heard amid all these structures and infrastructures?

The third sector interfaces are the starting point for that consideration. The interfaces receive modest central funding to enable them to be independent from local government, the health service and other public authorities. The third sector already plays that role in community planning in every part of the country and there is no reason why, with a modest investment, it cannot play that role in the arrangements in future, as it has done with the change fund for older people. My preference would be for that to be recognised in the bill.

The Deputy Convener: Mr Mair, I am not sure whether you want to answer that but, because of time constraints, if you could let it pass, I would be grateful.

Ranald Mair: I am happy to leave it. The focus should be on what has worked within the change fund arrangements, because we are already doing that, so we do not need to reinvent it.

The Deputy Convener: I have three colleagues who still wish to ask questions.

Mark McDonald: I have one further question, convener, if you will allow me.

The Deputy Convener: Of course, but it will be brief, I hope.

Mark McDonald: It was on Mr Mair's response to Rhoda Grant. I do not want the panel to think that I am in any way trying to downplay the importance of third sector partners, but we have to look carefully at how the interaction will work under the bill. Mr Mair suggested that there could be third sector involvement in things such as strategic planning but that the involvement would be removed at the point of commissioning and procurement. Could the system be disaggregated to that level, given that strategic planning will by definition inform the commissioning and procurement approach?

Ranald Mair: I see it all as part of strategic joint commissioning, the principles of which are being shaped. Within an overarching commissioning approach, one could separate off the strategic planning and options appraisal aspect from the procurement aspect. I am saying that third sector representatives would not need to be—and arguably should not be—involved at the procurement end. I would not want to be involved in evaluating tender bids that come in from provider organisations, as that would be wholly inappropriate. However, as a sector representative, I should be involved in the design stage, the strategic planning stage and the weighing up of how we best secure the provision going forward. In all those areas, we can add value to the discussions. Indeed, we can make the procurement exercise more productive when it happens and ensure that it achieves its purpose.

If we use the principles of strategic joint commissioning and allow third and independent sector representatives to be involved at that level but leave the procurement to the statutory agencies, there will be separation and an avoidance of conflict.

Nigel Henderson: Again, the issue goes back to the diversity of the sector. I hope that people who use services and people who care for those who use services will be heavily involved in the decisions about what services are procured. They have their own structures and representative groups and bodies. Are we talking about third sector representatives or third sector advocates? It might be a clearer role if people are given a voice at local level to contribute not just to the big picture but to the local picture. It will be different horses for different courses within what is a diverse sector.

Mark McDonald: Could the issue be dealt with through, for example, a requirement to have meaningful consultation with the third sector, rather than the third sector being involved? The issues of lines of accountability and conflicts of interest that have been raised would thereby perhaps be removed.

Martin Sime: Personally, I would not recommend that way forward. It seems to me that we are talking about a paradigm in which the public sector does things such as procurement to us in the third sector. That is already a move away from the policy intention of the bill, which is to create partnerships to enable us all to play to our strengths. With the bill as it stands and the intentions as you describe them, as well as the discussion about conflicts of interest applying solely to the third sector rather than equally across the public sector, we are already in a hierarchical relationship in which the third sector is seen as the deliverer of public sector priorities. That is not the way to get the best out of us, and it is certainly not the way to create a partnership. It would not go down well among organisations working at the front line if public authorities told us what to do. Why is procurement a process that is applied only externally and not something that is applied to public authority delivery of services, too? We need to move on from that.

The Deputy Convener: I hate to say this, Mr Mair, but please be brief, as we have two further questions to ask before we close.

Ranald Mair: Okay. The model that we are advocating is the one that Audit Scotland advocated last year in its report on social care commissioning, which said that providers need to be involved at a much earlier stage in the process and not just at the procurement end, because that leads to poorer results. The argument is not about some sort of empire building on our part but about how we get better outcomes for people. The drive on self-directed support will mean that individuals are increasingly empowered to make choices about the services that they get, so we will have to change the emphasis on local authorities controlling the commissioning process.

The Deputy Convener: Thank you. We have to move on. I call Nanette Milne, who has been very patient.

Nanette Milne: I am pleased that Mr Sime mentioned the SDS bill, which is now the Social Care (Self-directed Support) (Scotland) Act 2013. I have long felt—and I think that I am on the record as saying—that it will not work properly until we achieve the cultural shift that the integration of adult health and social care should bring us. Do you believe that the bill will facilitate the implementation of SDS in the integrated arrangements? How could it best do that?

Martin Sime: I would like to say that it will but, unfortunately, my view is that there is not strong enough evidence that the bill will lead to the changes that we need in order to make self-directed support the norm. We need a bit of history. We need to look back over the past 10 years to successive failures to drive integration

and join up services, budgets and processes, and we need to ask ourselves whether the bill will somehow overcome all those difficulties. I have not seen the evidence, so I am not convinced.

The best example that I can give on the potential for self-directed support and the work of the third sector to change people's lives for the better is around Alzheimer's. The Government has made a welcome commitment that individuals who are diagnosed with Alzheimer's have a right—that word is important—to a year of post-diagnostic support. That is a huge advance, and people around Europe are looking at how it could be implemented elsewhere. It is a great credit to the Parliament and the Government that that is being instituted.

I understand that there are voluntary organisations that feel that, at the end of that year, they will be able to go in and work with people and their families to deliver a package of care that is based on what they want, using the right to self-directed support. Over the next few years, we are going to see a huge change in the quality of services and their relevance to individuals, and all the evidence suggests that that will reduce demand on formal public services in the long term, that it will be cost effective and that it will deliver for families.

Those changes are possible because of the self-directed support legislation, but they have nothing to do with the bill that we are discussing. The bill is irrelevant to those changes. We are able to change things on the ground because of self-directed support and the work of the third sector in a way that was unimaginable in the past. We need to pause and reflect on that experience and think about how we can get more of the benefits of the self-directed support legislation and the engagement of the third sector with individuals, carers and their families to drive new models of care. That is the way forward, rather than all this commissioning stuff.

The Deputy Convener: Mr Mair and then Mr Henderson—do you see a link to self-directed support?

12:00

Ranald Mair: Certainly, I do not think that the bill ties up. There is a lack of connectedness between the different policy agendas. We have the national dementia strategy and we have self-directed support. However, it seems to me that the bill does not do quite enough to show—to evidence—the connectedness of the different strands.

The bill in itself does not say enough about choice, empowerment and control being with service users. It does not even do enough to emphasise that the quality of care outcomes are what should drive commissioning, for instance. This is not about how to get services at the lowest possible cost; it is about how to deliver improved outcomes.

There is a tension between what is in the bill and what we are trying to achieve with self-directed support. It is to be hoped that there is a point at which the two have to come together—on the ground, if not in terms of legislation. However, I do not think that the bill does enough to capture the connectedness between the different strands.

Nigel Henderson: There are a number of issues. The bill does not capture the self-directed support stuff at all. Also, the Social Care (Self-directed Support) (Scotland) Act 2013 is largely about local authority spend, not about health spend. Our concern about the new integrated budgets is that, if money loses its identity—if there is no longer a health pound or a social care pound, just a pound for health and social care—what are the implications for charging and eligibility? How does the health authority view the money being used for social care purposes? A lot of things need to be bottomed out there.

The culture that we want at the core of this is reflected in the self-directed support act. It is a culture in which citizens are empowered, in which they have choice and control and are no longer simply passive recipients but active participants in their care pathway or in their care journey. It would be interesting to see much more about how SDS can help to shape the future of health and social care integration rather than it simply being seen as a subset of what already exists.

Nanette Milne: I find that very interesting. I was concerned during the evidence taking for the self-directed support bill that there seemed to be a sort of disconnect between the statutory bodies. How to get the culture change—to properly bring them together, hearts as well as minds—concerned me and that is why I thought that the 2013 SDS act would not really work properly unless what we are discussing now was effective in bringing about that culture change. That is why I was interested to hear what you said.

The Deputy Convener: We want answers to this question, of course we do, but we have one further question and time is almost upon us, so brevity would be good. I know that it is an important question.

Nigel Henderson: I will just throw in a word: trust. Part of it is about trust. We have talked a lot about whether the third sector can be trusted as partners. That has been a major theme of the discussion this morning.

Do we trust citizens to make the right choices and decisions for themselves? It seems to me that

the secret of the SDS act will be whether we actually trust and empower people to make choices and take control. At the moment, I have to say that there is a bit of foot dragging on some of that. The SDS act becomes law next April. I think that it will take a few years to bed in, but trust is at the heart of a lot of what we are talking about here.

Ranald Mair: There is a parallel bit within the bill that I think is relevant—there is some emphasis on locality and local planning and there is a similar point to make about what we are prepared to devolve to localities. Will we give them control of budgets? Will we empower localities in the same way as we are talking about empowering people in relation to self-directed support? Will we trust individuals? Will we trust local communities? That, for me, would be the strongest potential connection—if we get the locality planning aspect of things right in the bill.

Martin Sime: I will simply add that this is a debate about institutions and I am not convinced that rearranging the institutional furniture will get us to the point that we need to be at. We should be having a debate about how to face the demographics. If we do not have that debate—if it is postponed because we are all busy shuffling the deckchairs—the ship will sink.

The Deputy Convener: I will move to our last question shortly. If I did not make a brief comment on self-directed support, carers and adults with learning disabilities in Glasgow would think that I was not adequately representing them. I think that there is a feeling that in Glasgow self-directed support has been used—this may link in to other decisions—to mask budget decisions by a local authority rather than in the spirit of the Social Care (Self-directed Support) (Scotland) Act 2013 and that it has been used to pursue a local authority agenda rather than to ask individuals what they really want.

I will leave that comment sitting there. Constituents have written to me and asked why I did not mention that when self-directed support was mentioned, so I felt that I had an obligation to do so.

Martin Sime: I will respond briefly, because we are having a debate in the third sector about our attitude to self-directed support being influenced by its inappropriate application as a means of rationing by local government. We stand by the principle of self-directed support and the empowerment and user choice that it offers, but it asks a much more fundamental question of us all: why is the application or delivery of self-directed support a responsibility of local government and therefore subject to variability? Why can the Parliament not just say, "Everybody has a right to this," and establish what that right involves in terms of resources. After all, we are talking about a population of only 5 million people.

It seems to me that we could cut the resources a different way and that to have 32 separate discussions about what self-directed supported means for people with Alzheimer's does not do justice to the interests of those people.

The Deputy Convener: We will have to leave both my comment and Mr Sime's comment sitting on the public record. Malcolm Chisholm has the final question.

Malcolm Chisholm: I will try to move us on to one final new area, although I have enjoyed the discussion and we could say a lot more about connecting the bill with other areas of policy. I agree with what you have said about the gap that there is, in several ways, between the policy memorandum and the bill—the third sector is one of those issues; quality is another that some of you mentioned in your submissions. We do not have time to talk about that, but clearly it is also very important.

I will talk about budgets—the issue is not unrelated to Martin Sime's comments about demography. Nigel Henderson's comment about budgets in his submission was extremely interesting. Although I have not read all the submissions, I think that it was quite an unusual comment. A lot of the direction of travel is towards more local flexibility but, as I understand it, Nigel Henderson's group is saying, "Look, particularly around the acute budgets, you will have so much trouble working out how much money will come in, how much will come from health in general and how much will come from local authorities." In a sense, that organisation's view is that budgets should be centrally set. Given that budgets are such a key aspect of all this, it is important to ask Nigel Henderson what the thinking behind that suggestion is, but it would obviously also be interesting to hear the views of the other witnesses.

Since I am asking only one question, my final comment is that, although I am quite attracted to Nigel Henderson's idea, it probably means that there would be a greater degree of prescription around the services that are attached to that budget.

Nigel Henderson: Absolutely. Martin Sime has described this as a very institution-focused discussion. One of our concerns after the bill was launched was that we already sensed that local authorities and health boards were looking to minimise what they might have to put into the integrated pot. We worry that we could create this whole new infrastructure and it might have very little control over very little money. We think that there needs to be more prescription about what

money should be allocated to the joint health and social care partnership fund.

Somewhat tongue in cheek, we put forward the notion that the Government should surely practice what it preaches. It currently has an NHS budget and a local government budget. Should it not start out with an integrated budget? You therefore do an element of top-slicing and say, “This is the budget for health and social care partnerships. This is the budget for the health service. This is the budget for local authorities.” You therefore have a new budget line in the Scottish Parliament budget.

I understand that that could be very controversial, as it would be seen to take away local control and accountability and perhaps to go back to the days of ring fencing. There are dangers, because we know that if money is ring fenced that is as much as will be spent. However, to start the process off in the way that it needs to continue, it might be a possibility to start for a period of time with an integrated budget right at the centre.

Ranald Mair: I agree with Nigel Henderson that, interestingly, in the past months there has been a retreat from the enthusiasm for pooled budgets. Both local authorities and health boards seem to be looking to hold on to more resource within each of their separate areas rather than put money into a shared pot. There are some issues about what is put into the budget and what decisions are made about it.

Two other difficulties should also be touched on. We talk a lot about the shift in the balance of care, but through the three years of the change fund to date we have seen very limited shift in the balance of resource. Keeping Mrs Smith out of hospital saves money on paper, but there is no corresponding shift of resource—the money does not follow Mrs Smith. That creates a difficulty because there is an increased spending requirement to maintain Mrs Smith in the community, while the spend within the hospital sector is also maintained. We have not actually seen the big shift that was to be one of the things that would create sustainability going forward. I think that we have yet to come up with a workable model on that.

A final budgeting issue is that the overall requirement for a realistic budget for delivering older people’s care continues to be, as the delivery group suggested, the elephant in the room. There will be a shortfall. Between now and 2020, we will run into difficulties. As a society, we will need to find ways of spending more money on that. We need to spend the existing pot better and more effectively and, yes, we need to seek to control and reduce demand, but even if we do all that and become more efficient, there will still be a shortfall.

Martin Sime: Welfare changes, demography and public expenditure cuts are all heading us down a really difficult route. There was an expectation that integrating health and care would help us to get all our ducks in a row so that we could create efficiencies. For those of us who have been engaged in this process for many years, it is a huge disappointment to discover right at the last minute that there is no prospect of significant agreement between health and local government on how much money goes into the pot. Without that agreement, the purpose of the bill simply defeats me.

We are at a critical point. It could be that a whole lot of backstairs arm twisting will get some level of agreement. As I understand it, the latest is that the stand-off position that is acceptable for health is that how much health money goes into the budget should be a matter for local agreement. That could mean a lot or it could mean a little. It could mean that local variation wins out—so the Convention of Scottish Local Authorities will be happy—but it will not drive any of the changes that are necessary in order for us to meet these challenges.

I think that we need to ask ourselves some pretty uncomfortable questions. Is the current standard of anonymous 15-minute hurried care visits the kind of future that we want for our care services? Is having a voluntary sector workforce on minimum-wage zero-hours contracts and without pensions the kind of future that we want for our care workers? What is the case against national rates for care and self-directed support?

If any of those things were done and if the centre said, “This is how much money is going into our future health”, that would take a lot of the heat out of the institutional battles about power and responsibility. The third sector has no interest in taking sides in that institutional battle. It is a very unedifying sight that is not getting us to the point that we need to get to, where we are all perfectly aligned so that we can use our limited resources to meet what are quite substantial and growing demands in our communities.

The Deputy Convener: Does Malcolm Chisholm want to pick up on any of those points?

Malcolm Chisholm: No.

The Deputy Convener: Due to time constraints, I will not ask, as I did with the first panel, whether you wish to make any additional comments, but I am sure that you are vocal enough that you will write to us and follow up matters very closely, as you have done already. Please do that, as it helps us to form an opinion as we continue to scrutinise the bill.

I thank the three witnesses who have appeared before us in this second evidence session as well as those who appeared in the first panel. As previously agreed, we will now move into private session.

12:15

Meeting continued in private until 12:44.

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