The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 10 September 2013

Session 4

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HEALTH AND SPORT COMMITTEE
25th 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)
*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:

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
Ron Culley (Convention of Scottish Local Authorities)
Andrew Eccles (Glasgow School of Social Work)
Peter Gabbitas (City of Edinburgh Council)
Susanne Harrison (City of Edinburgh Council)
Ritchie Johnson (Aberdeenshire Council)
Councillor Peter Johnston (Convention of Scottish Local Authorities)
Duncan Mackay (North Lanarkshire Council)
Alison Petch (Institute for Research and Innovation in Social Services)
Soumen Sengupta (West Dunbartonshire Community Health and Care Partnership)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 10 September 2013

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

Interests

The Convener (Duncan McNeil): Good morning. I welcome members and the public to the 25th meeting of the Health and Sport Committee in 2013. As usual, I remind those present to switch off mobile phones, BlackBerrys and other wireless devices, which can often interfere with the sound system. Members of the public may have noticed that some members and officials are using tablet devices. That is instead of having hard copies of their papers.

We have received apologies from Richard Simpson. I welcome Malcolm Chisholm to the committee, as the Labour Party substitute. I also welcome Rhoda Grant, who joins the committee, replacing Drew Smith.

The first item on the agenda today is to give new members and substitutes an opportunity to declare any interests that are relevant to the work of the committee. I will invite them to do so in turn, starting with Rhoda Grant.

Rhoda Grant (Highlands and Islands) (Lab): I do not think that I have any relevant interests to declare, but I make a voluntary declaration of my Unison membership.

Mark McDonald (Aberdeen Donside): I direct members to my entry in the register of members' interests, but I do not believe that I have anything relevant to the committee to declare.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I would state what is in the written register of interests: I am a member of Unison and of the Educational Institute of Scotland.

Subordinate Legislation

Public Health etc (Scotland) Act 2008 (Sunbed) Amendment Regulations 2013 (SSI 2013/201)

09:46

The Convener: Under agenda item 2, we will consider three negative Scottish statutory instruments.

There has been no motion to annul SSI 2013/201, and the Delegated Powers and Law Reform Committee has not drawn the regulations to the attention of the Parliament.

There are no comments from members, so are members content with the statutory instrument?

Members *indicated agreement.*

Sale of Tobacco (Prescribed Documents) (Scotland) Regulations 2013 (SSI 2013/202)

The Convener: There has been no motion to annul the next set of regulations, and the Delegated Powers and Law Reform Committee has not drawn the instrument to the attention of the Parliament.

There are no comments from members, so are members content with the regulations?

Members *indicated agreement.*

Contaminants in Food (Scotland) Regulations 2013 (SSI 2013/217)

The Convener: There has been no motion to annul this third set of regulations, and the Delegated Powers and Law Reform Committee has not drawn the attention of the Parliament to the instrument.

There are no comments from members, so are members content with the regulations?

Members *indicated agreement.*

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

09:48

The Convener: Agenda item 3 is on the Public Bodies (Joint Working) (Scotland) Bill. We continue our evidence taking at stage 1. Our first panel today consists of academic experts. I welcome Andrew Eccles from the Glasgow school of social work and Professor Alison Petch, who is director of the Institute for Research and Innovation in Social Services. Do you wish to make any introductory remarks or comments?

Andrew Eccles (Glasgow School of Social Work): No.

Alison Petch (Institute for Research and Innovation in Social Services): I am happy to move to questions.

The Convener: Fine—that is good. Nanette Milne has the committee's first question.

Nanette Milne (North East Scotland) (Con): My question is initially for Mr Eccles, but if Professor Petch wants to say anything later, that is fine. You have had an interest in the role of interprofessional working in health and social care. I wonder if you would wish to make any comment on how important you view that to be with regard to securing the proposed legislation.

Andrew Eccles: First, it is very important to have interprofessional working. A lot of it goes on already, in a variety of forms. I have a concern about using a sledgehammer to crack a nut as regards organisational and major structural reform, and we should recognise that interprofessional working takes place in a variety of ways in different localities. It is absolutely crucial, and I do not think that anyone in the room would think otherwise. It is a question of how best to do things and how to learn from the experience of what has been attempted over the past decade or so.

Nanette Milne: I, too, am interested. I have a health background myself, and I am well aware that there can be issues between health professionals and social work professionals. For integration to work properly as far as the culture is concerned, they have to amalgamate.

Andrew Eccles: I agree with you. It is worth bearing in mind that there are also historical tensions between different health professionals: between acute and primary, and between allied health professionals and other practitioners. My experience, having done quite a bit of research on the front line with practitioners, indicates that the process is complex and uneven. I have worked with teams where the relationship between health and social work was, frankly, excellent but there were real tensions between different aspects of health on the same team. We could try to reduce the issue to divisions across different professions, but it can sometimes be a good deal more complex.

Nanette Milne: Has your research revealed any particular reasons for that? Is it down to personalities and local circumstances?

Andrew Eccles: It can be down to personalities. Some reasons that emerge involve other agendas that exist at the same time. When I was doing research some years ago, there was the whole agenda for change within the healthcare system, which preoccupied a lot of people. There was a sense in which people were being pulled in different directions at the same time with regard to where they might put their energies. That would be a long-standing issue with any form of organisational, structural or whatever change in interprofessional working. The context and the other agendas that might be around are pretty important for getting proposals to work.

There is a classic issue around value bases between social work and health. The British Medical Association's submission to your committee last year raised a point about value bases, medical models and social models. Those are old arguments and it is not an insurmountable issue. One of the key issues is people being able to belong to organisations that are genuinely learning organisations, as opposed to training organisations.

When I look at the proposed legislation and consider organisational issues or issues of procedure, I think that the key issue, again, will be one of working cultures. It will be about spending time and effort getting people to understand where one another is coming from and developing trust, which is key. That will be more important than organisational or procedural shifts.

Nanette Milne: Are you saying that that cannot be legislated for, or do you think that the bill will be effective in bringing it about?

Andrew Eccles: A recognition of the fact that the process is not easy is required—it requires time and space. If I mention resources, I mean not necessarily just money. For example, quite a bit of the teaching that I do is with social work managers and health managers. One of the things that becomes very apparent with their organisations is the lack of space. With the best will in the world, front-line practice takes up most of people's time. The space to be a learning organisation is often at something of a premium.

Nanette Milne: Even with new legislation, presumably you foresee the process as being an evolutionary one.

Andrew Eccles: Yes. I do not think that the bill will guarantee; it would be folly to imagine that. More subtle and complex engagement with some of the issues is required, as is well rehearsed in the literature.

Alison Petch: I endorse a lot of what Andrew Eccles has said. There are some very good examples of the traditional barriers melting away when teams work together at the front line. However, we should not underestimate the large amount of ignorance among different professional groups about what their future partners do.

Increasing people's knowledge and understanding will address some of that, but we also have a challenge because, in times of uncertainty and change, people tend to scuttle back to their tribes, as it were. We need to ensure that people look in the other direction and see that, through working together, they will better support the people whom all this is for.

The Convener: We have focused on the transition a lot, as do the submissions. If the new workforce is to develop and if more and more care is to be delivered in the community, what do we need to do in the long term to ensure that the new workforce grows, works and learns in the community rather than in acute or other traditional settings? A big shift is being made. What do we need to do now to make that permanent and to go beyond the transition?

Alison Petch: It is important to separate out each group's unique skills and to determine where much more flexible overlap can occur at the boundaries. We have tended to have distinct professions.

We have talked for years about avoiding having four, five or six different professionals moving into someone's home. To focus on the individual and the support that they need, we need to be clear about when more overlapping and more development of generic working can occur and when a distinct professional identity is needed, as for some distinct procedures.

We need to reshape the workforce and to ensure commonality in the workforce in focusing on the individual. We tend to have all sorts of disjunctures between the hospital, the community and professional groups in the community. That often gets in the way of the delivery that is needed.

Nanette Milne: Does the bill do enough to bring together all the relevant groups, particularly locally? How do you see the leadership that will be needed to make the bill work?

Alison Petch: You have put your finger on it. The bill per se will not make any of what is proposed happen. I hope that the fact that the bill is here will raise the profile and that the requirements will ensure a focus on trying to get the approach right, but it is not the bill that will deliver—that will come from leadership and having a vision of why on earth we are doing this. We are not moving chess pieces round the board; we are trying to facilitate the best delivery mechanisms.

I am absolutely certain that we must not get bogged down in the architecture and mechanisms. Although it is challenging, we must try to infect everyone with the enthusiasm for and vision of what the approach can do to give people a decent quality of life. We must identify the shared, communal leadership that I hope will move that forward.

Andrew Eccles: I agree entirely with Alison Petch about leadership, which has been inconsistent in the past decade. It is clear from doing research that some people have bought into the approach much more than others; some people regarded it as a process that they had to follow, whereas others were much more enthusiastic. The evidence of that is clear in different areas.

I agree with Alison Petch about generic working, but there are substantial areas in which social workers and people in the health service, for example, do fundamentally different things. People need to feel that their professional skills will not be impinged on. It was interesting that some people regarded even quite small shifts in their working patterns in respect of assessment, for example, as deskilling, whereas other people saw that as reskilling. There was no common denominator; it was a pretty sensitive issue.

It is probably more a question of not having people thinking that they are going to end up as generic workers. However, there is a gap or space in which we can do things in a more generic way while holding together what I think are quite important value bases that exist in health and social care.

10:00

Rhoda Grant: Both of you seem to be telling us that, although the bill will not hamper the process, it will not make it happen.

Andrew Eccles: I do not think that, axiomatically, the bill will make it happen. Some of that view is based on what I see as the merits of the bill, which suggests that there be—to use an overused phrase—some local ownership. Such an approach is useful and welcome, because people do things in different ways and there might be particular circumstances in different areas of Scotland where people want to do things differently.

However, although that is perfectly commendable and although the bill puts down a marker, the proposals with regard to structures, organisations, procedures and the ultimate outcomes will not in themselves shift the situation. Instead, leadership must buy into the process to a much larger extent.

Rhoda Grant: Will anything in the bill as drafted prevent the process from happening? For example, I believe that you said that things were a bit too top-down.

Andrew Eccles: I would advise caution about outcome measures. A wealth of literature and some very fine work on this matter—Toby Lowe from the University of Newcastle is particularly good on it—suggest that the use of such measures can be counterproductive, because people will seek to meet the outcomes and, if you like, measure the measurable, with the possibility that some interesting experimental work or different ways of working at a local level might start to get stifled. That has the potential to be problematic unless there is greater clarity about or better specification of the outcomes.

Alison Petch: The word "outcomes" has very much become the buzzword of the moment, but we need to be clear about what we mean by it and whether we are talking about outcomes for the individual or for communities, or of a particular policy. As far as integration is concerned, we must remember that, as well as the proposed national health and social care integration outcomes, which I think are pretty much going in the right direction with their emphasis on the individual, we have organisational outcomes such as the health improvement, efficiency, access and treatment, or HEAT, targets and single outcome agreements, along with the most important outcomes of all—the outcomes for the individual.

Over the past five or 10 years, there have been real developments in attempts to focus on outcome-based assessment and delivery with the introduction of self-directed support. Indeed, going back to the previous question about the workforce, we need to remember that that major initiative will overlay all of this.

As a result, when we talk about outcomes, we have to be clear about what we mean. If we are not, the danger is that we start to live in a land where everyone speaks the words without necessarily meaning the same thing.

Rhoda Grant: The challenge is that we know that there is an issue, because constituents and front-line workers, who are more often told what they cannot do rather than what they can do, have said so. If the outcome—or, if you like, the desired effect—is that people can live at home, healthier and more supported, and do not come to complain to us, how do we deliver what will amount to a cultural change? After all, we have been talking about the issue for years, but it seems that little has changed. How do we as politicians effect that change and make it happen?

Alison Petch: Perhaps I am just an eternal optimist, but I think that there has been quite a lot of movement on that over the past five or 10 years as a result of the joint improvement team's work around personal outcomes and the talking points approach. I have to declare an interest, as some of my colleagues were involved in that work. At IRISS, we do quite a lot of work with local partnerships on the delivery of outcomes. The change will not happen overnight—none of these things will happen overnight—but there has been a shift from 20 years ago, when outcomes were never the focus. It is just about the pace of change.

To go back to your initial question about what the bill can do, for me, the most important aspect of the bill is that it states the integration principles, because those are good principles. The danger is that they get lost in all the discussion about different arrangements, the production of plans and who will be the chief officer. I do not know whether there is an opportunity to strengthen those principles, because I know that what can be done in legislation is limited. However, it is important to get across to people that it is not only about the mechanics but about trying to deliver on the key principles that are outlined in the bill.

Andrew Eccles: It strikes me that in this area language is pretty important. It might be interesting to think about what we understand by integration, because there are different models of integration and there is the move from collaboration to integration. I remember that ,10 years ago, when I did some work on collaborative working, I was slightly chided by someone who said, "We are now integrated." However, that was clearly not the case on the ground, because they were not integrated. It would be useful, when we use such phrases, to explain to front-line workers what their application in practice might mean for their jobs and what they might be expected to do. Integration is quite a heavy phase of people working together or of joint working or collaboration—it is often regarded as one end of a scale or continuum.

Alison Petch says that she is perhaps an optimist. I am not a pessimist, but I am certainly a realist when it comes to the overambition or overoptimism in the past. The overoptimism has probably been about the ability of structural and organisational change to deliver results. One problem is that there has been some linear thinking that, if we do X, Y will follow. In fact, the interface between health and social care is often a complex area, so we cannot have linear thinking

whereby we take the approach that, if we do something organisationally or procedurally, something else will follow from it. The issues are too complex for that. Alison Petch and I have talked previously about the idea of wicked issues. Such issues are not always easily solvable, there are no standardised patterns for dealing with them and outcomes will often be variable. We have to allow space for such complexity.

We must be realistic about what is achievable. We should certainly have a greater degree of working between health and social care, where that is possible. The lesson that we can learn from the past is that there were big ideas that were highly optimistic and in relation to which a good deal more spade work probably had to be done to research what was likely to happen in practice. It is important to keep people on side so that they buy into the approach.

Alison Petch and I are both aware of good research that shows what it takes to get front-line workers to buy in to such changes. There is not much point in simply saying, "You will do this," because the changes might not make sense to them and they have to see why they should buy into the new approach. Workers have to see that there will be a better outcome as a result of the changes and not view them as just another set of procedural changes whereby they are told, "This is how we will now do things." That cultural shift is important.

Rhoda Grant: I almost disagree with you, because the people who are coming to me saying that we need change and better integration are the front-line workers who go into somebody's home and cannot, for example, give them a bath, because that is somebody else's job, despite the fact that that is what they should be doing for the good of the person concerned.

That happens all the time to front-line workers, who must follow rules and regulations that tell them what they cannot do. They see where the need lies at first hand, but they do not have the scope to do anything about it. The bill aims to achieve a change in approach through integration, but how do we get that to happen at management level? To an extent, the issue might be that people are empire building and keeping their own responsibilities close to them. How do we free up people on the front line who want to work in such a way so that they can do so?

Andrew Eccles: Thinking back to the previous attempts, one of the problems for me was the outcome measures that were used. The JPIAF—or joint performance information and assessment framework—outcome measures were essentially around processes. That is the problem. Moreover, organisations might start to meet the organisational targets or objectives first, certainly in times of fiscal pressure. We have to get beyond that particular problem.

The early work that was done by Wilkinson and others back at the turn of the century on work in England involved interviewing chief executives in primary care trusts, who said that their primary concern was to meet the immediate targets of the organisation effectively and that, after that, they might start to look at other areas in which they could work. That is problematic in a target culture in which organisations might be inclined to meet their immediate targets rather than something that might be slightly more ambitious and involve thinking outside the box.

Alison Petch: That is critically dependent on having individuals who see a vision. I am sure that members have heard about the getting it right for Mrs Smith mantra, which led one of the developments south of the border. It permeated throughout the professional groups in the area. I lived down there at the time, and it was on signposts all over the place. It became a collective vision that we were all in this together to make a decent life for Mrs Smith. We could all be the Mrs Smiths of the future. We must have that transformation from delivering on particular targets and having boundaries around who can do what. There has to be a belief that things can be different and can be driven, and we must have leaders who can drive them. I sometimes wonder whether those leaders can be made or whether they are just born and are innate leaders. People must have belief and commitment. It is not just about working through processes.

Andrew Eccles: I agree. To go back to one issue, there will be some work to do to establish that sense of good will among front-line practitioners to make things work, given some of the experiences. I am thinking of the community healthcare partnership in Glasgow, which lasted for four and a half years, in effect. I did work with some of the CHPs in the early stages of setting them up. Enthusiasm certainly existed, but the tensions were clear. We need not rehearse them all here, but they were pretty apparent at the time. That has left front-line practitioners who are probably sceptical and who are likely to say, "Here we go again with another round. We're going to start to have those structures and procedures." There is good will, but it has been dented over the past decade. The way that we attempted things perhaps 10 years ago was probably too driven by organisational change and procedures.

Malcolm Chisholm: I read about getting it right for Mrs Smith, which Professor Petch talked about, and was impressed with it. It is not the only example of good practice, but what can we learn from the evidence of where there have been big improvements? I think that there was evidence on

fewer emergency admissions and delayed discharges, for example. We have got the message that it is not about structural change in itself. Leadership was mentioned; perhaps you can mention some other things.

I have a related question. Although structural change will not cause what is required, is it a necessary precondition? For example, with getting it right for Mrs Smith, there was a big organisational change to a care trust. That is not available in Scotland, but is organisational change part of what is required or is it totally irrelevant? If it is totally irrelevant, I suppose that we might ask whether we need the bill at all.

Alison Petch: My personal opinion is that the jury is still out on whether elements of structural change are needed. Knowsley is an example of where good outcomes for people were achieved without major structural change. In a sense, we have to look beyond structural change, given that it looks as though elements of it will happen, to focus on the things that are necessary.

It is also important to know that the process is not instant. The getting it right for Mrs Smith approach evolved over 10 years. I fear that the thinking is almost, "Right—the problem's been around for so long that, this time, we'll get it right and have it sorted 12 months down the road." We must appreciate that it will take time.

10:15

We must focus on the individual and think about all aspects of their life. People need housing, which is a critical element that tends to be forgotten, and they need training, health support and social care support. If we start by thinking about the individual and all the bits around them, some of the boundaries fall away. I know that the word "holistic" is much misused, but the approach must really consider what is necessary to deliver what people need.

Experience provides key elements that can make the approach work. Boundary spanners—that is a dreadful expression—are leaders who facilitate working across organisations' boundaries. A lot of attention must be paid to the local context. It is good that the bill refers to localities, but it is essential that people understand communities' strengths as well as their needs.

What works in Orkney or the Highlands will not necessarily work in the middle of Glasgow. That makes the situation more difficult, because it puts the onus on local leaders to understand the position, engage with their communities and build on local good will, facilities and opportunities in order to deliver. That is more complex than saying simply that we will sort out the situation by rejigging boundaries and ordaining this, that and the other.

There is a pretty strong evidence base from 10 to 20 years' experience of what can facilitate such working, almost regardless of the structures. That is why the energy should not go into the structures.

Andrew Eccles: When we hit problems, we tend to reorganise—that is an old phrase, which I think is wrongly attributed to Petronius. We take that approach because we are quite good at reorganising and we tend to play to our strengths.

Some of the skills that have developed in health and local authority management in the past 10 or 15 years relate to organisation, structures and meeting targets. People might fall back on that skill set when we ask them to integrate health and social care more. They will start to think about how to organise that and the procedures that they could use. We need fundamentally different thinking, which will be difficult, because the way in which we have organised public policy in the past couple of decades has not hugely encouraged thinking out of the box.

Alison Petch was absolutely right about leadership. The last time that such an approach was taken, many people viewed it instrumentally and as something that had to be done, but we are talking much more about purposely working back from a vision of what could be achieved. Doing that will take time.

Malcolm Chisholm: To be fair to Scotland, far less organisational change has been imposed here than in England. A lot of the changes that have taken place have involved local authorities and health boards working out their own arrangements. Another view might be that the bill will not make much difference, because it respects and builds on what has developed.

I hear everything that the witnesses are saying about not relying on structural change. I suppose that there are two questions to ask about the bill. First, is anything in it harmful? Let us do no harm. Secondly, can we introduce in legislation some of the more fundamental points that you made about leadership, culture and so on, or is all that not really the stuff of legislation?

Andrew Eccles: As I read the bill, I see that a large proportion of space is given to the options for structures and what structures might look like, compared with the proportion that is given to issues to do with training. Actually, the issue is not just about training, as I have been involved in training sessions that did not seem encouraging in the context of the need to think outside the box. I would like there to be more emphasis on the idea that people in organisations need the space to be able to engage in the integration agenda.

There are lots of interesting ways of doing that. Health workers, social care workers and people from other health professions could look at vignettes of patients, in an attempt to understand what a particular patient might need—that can be quite a long process. The approach might enable people to understand why others think differently. It might be that we need a little strengthening somewhere, so that rather than just say that there will be training we say what the training might look like and why it might not simply be done in the way that it was done in the past—it might be a good deal more innovative. There needs to be space for that to happen. That is crucial.

Alison Petch: I take Malcolm Chisholm's point. We have been fairly modest about structural change in Scotland. When the proposals came out, I was pleased that earlier talk about wholesale structural change had been put aside. However, after a few months of optimism I became a little more despondent because, as far as I could see, people were getting bogged down in discussions about who would be the chief officer and how we would do this or that. Some of my initial enthusiasm faded away.

I would like us to recapture some of the vision of the original proposals. An area in which I wonder whether the bill could be much stronger is budgets, because budget pooling will be critical to much of what we are talking about. With the best will in the world, we know that budget pooling is what sends people back to their little territories to try to protect their boundaries. I noted that some of the submissions to the committee express concern about protecting health budgets.

Unless we are dedicated to cracking the issues of shifting the balance of care and pooling the support that is needed to prevent unnecessary admissions to hospital, much of what we do will just be frills around the edges. If anything can be done to overcome some of the rather permissive and vague elements of the bill, particularly in relation to what comes from the acute health budget, that would strengthen the bill.

I would also like specific reference to be made to the housing function. I was always taught that delivery depended on equal inputs from health, social care and housing. We used to talk about the three-legged stool, which I fear is in dire danger of becoming a two-legged stool.

Those are the two elements that I think would strengthen the bill.

Malcolm Chisholm: I think that your final point will feature prominently in our discussions, as will the whole issue about acute budgets. However, I will not pursue that now, as other members have questions.

Bob Doris (Glasgow) (SNP): I think that Mr Eccles said that leadership on health and social care integration has been inconsistent over the past decade or so. I am sensitive to the need to respect local democracy in councils, but constituents regularly come to my surgery to talk about the malaise and the breakdown in relationships, for example when an elderly relative needed residential care or was in and out of hospital frequently. Work does not always seem to be joined up in the way that it should be—although there is some fantastic local practice on the ground in Glasgow.

As a member of Scotland's Parliament, should I be considering whether there is a need for the bill? I know that the issue is one of outcomes for the individual, not structures. Is the time right to legislate, or should we wait for another 10, 15 or 20 years for some parts of Scotland to get on with the integration exercise that we hope would be happening without the need for legislation?

I will ask you, in a second, whether you think that the proposed legislation is proportionate, but can you comment first on the need for legislation, given the fact that it is not just about structures, although the structures are in there to enable things to happen? Is the time right for legislation in the first place?

Andrew Eccles: Yes. It puts down a marker, and it is important that the issue is not off the agenda. It is 12 years since the previous round of attempts to establish some of the issues, and there is a concern that they might start to disappear off the agenda. Having a bill puts down a marker, and there is no harm in that. The bill strikes me as open enough to interpretation regarding what localities might do, which is useful.

It is worth bearing in mind that integration is not a panacea. It will make things better on the ground, one imagines, if it is done well, but a whole range of issues exist alongside it, including unmet need and budgets. There has been some slightly wishful thinking in the past that if we get integration right, those issues will effectively disappear. I suspect, however, that your constituents will still be coming to you five years down the line, even if we get this right. Some of the other fiscal pressures are not going to disappear.

Alison Petch: If you had asked me the question 12 months ago, I would probably have said no. Now, the process has gone too far to stop. One therefore has to capitalise on the opportunities in the ways that we have been describing, and we should try to home in on elements such as the acute transition and the transition from hospital to community. The bill should be seen as a final attempt and a final opportunity to get things right. If people do not seize the opportunity, the cynicism

and scepticism will be very great in the future, and it will be difficult to revisit the matter, given the history. If you were now to withdraw from legislating—from viewing the bill as a catalyst for those areas that have perhaps not been at the forefront—some of the energy would be lost. It is too late to retreat from it.

Andrew Eccles: An important aspect is the expectation that Government may have of what can be achieved. That is not to say that we should not push the bill and that we should not hope for things to develop from it, but if we consider the history, we can see that one of the problems has been people being overambitious about what such proposals might achieve. That would scupper the bill. We need to think about it a bit more carefully, and more in relation to the longer term. We should be acutely aware that there are some areas of Scotland where there is truly excellent working between health and social care at the local level, and that there are other areas where, for whatever reason—it might be to do with previous attempts that have been made—there is a degree of scepticism. People are at different places. Expectations that do not necessarily match where the different areas are in terms of possible outcomes would kill things as regards the legislative process.

Bob Doris: On whether the bill is proportionate, many of the submissions have focused on structures. My reading of the bill and the political narrative around it is that this is not really about structures. Yes, structures must be established and signed off, and they have to be proportionate, but the point is that we must use those structures for the strategic commissioning of services and developing a more joined-up working approach, which is happening already in some parts of the country, but not in others. My hope is that the bill will ensure that that will happen in all parts of the country in a speedier and more strategic way. I do not want to draw you too much on the structures, but is the level of detail in the bill proportionate?

10:30

Alison Petch: I repeat what I said earlier: you can beef up some of the underpinning principles to the extent that you can introduce into the legislation some of the much more important areas that we have discussed. In people's minds, it may well be that it is not about structures, but if we look at the bare bones of the bill, we will see that it inevitably tends to talk about the need to produce a plan. We have had community care plans, which people spent inordinate amounts of time producing. The critical thing is whether people go out and do something differently. You cannot legislate for implementation, but you can perhaps draft some phrasing—I am not an expert at all on this—that tries to reinforce the message that you have just given: that we recognise that it is not about structures. People can look at the bare bones of the bill and think, "Well, that may be what people are saying, but I don't see much of that reflected in here." The message tends to emerge more strongly in the policy memorandum, for example, but that is the danger of a bare-bone bill. In the past, there have been moves to have much more conversational introductions. I do not know whether that approach is a possibility.

Andrew Eccles: That is an interesting point. I suspect that there is that bareboneness precisely so that people do not get locked into a top-down, heavy approach that tells organisations how they will do things, especially given that different areas of Scotland are at quite different stages. However, the danger is that we will end up with something that is too light in terms of prescription. I would not necessarily prescribe procedures—again, I am cautious about what the outcome measures might be—but I would like to see more weight given to a recognition of learning from some of the research that has been done in the past 10 or 15 years. As Alison Petch said, that is in the policy memorandum to some extent. If the bill is light on structures and organisation—although they are certainly still in there—perhaps the idea of cultural change, which is missing but which needs to be in it, could be emphasised a little bit more. That is an important issue.

Bob Doris: Those comments lead me to think that the bill is probably proportionate. I refer in particular to what Professor Petch said. I think that she has said twice now that she would like to see more in the bill about the principles of integration. In our next evidence session, others, including the Convention of Scottish Local Authorities, will obviously have the opportunity to say more about their views. Some partners have said that they would like to see less about the principles and structures in the bill and have asked for that—they will have their own reasons for saying that. You have described the other side of the coin. You say, "Actually, you could say a little bit more about that, please, to beef it up," and you call it a "bare-bone" bill. That gives me a little bit of assurance that the Government has perhaps steered a middle course to get the balance right.

I know that there is not a question in what I have said, but are there any comments on steering the middle course? I will not come back in with a supplementary question.

Alison Petch: At the end of the day, we must remember that the act would become the backcloth against which the activity would take place, but in respect of day-to-day relevance, whether on the front line or at more senior levels in organisations, legislation is not really what drives

day-to-day delivery. Therefore, as you have said, one perhaps has to steer a middle course. However, without repeating what I have said, there are one or two areas relating to budgets and the roles of housing and other partners in which you could be much more proactive.

Mark McDonald: You have given evidence that we cannot expect that just changing an organisation's structure will enable it to deliver. We accept that; the culture is a huge element. On the other hand, you say that we cannot legislate for the culture in an organisation—we cannot legislate to make people enthusiastic, although it would be good if we could. Does simply having legislative underpinning increase the accountability of those whom we expect to deliver on the agenda?

Andrew Eccles: Yes—that will be the case by definition, given that organisations will have clear responsibilities.

Mark McDonald: A lot of the examples that have been cited of good intentions that failed to materialise in delivery in the past perhaps lacked the legislative underpinning. Such work was driven simply by the power of good intentions, whereas the bill mirrors the intention to deliver but also provides legislative underpinning. Might that make the current approach stronger than previous approaches, which did not have such underpinning?

Andrew Eccles: I am not sure that what you describe is my recollection. I was seconded into local government in 2001 and 2002, precisely at the time of the joint future work. I remember that a number of really quite directive circulars were issued about the expectation for organising protocols and who might have responsibilities.

You might be getting at the experience of community health and care partnerships in Glasgow, which perhaps provides an example of a lack of clarity about responsibility for decision making in the two organisations that were involved. Issues clearly arose there.

I am not sure that I read in the same way as you the comparison between what was expected for accountability last time and what is expected this time. I take your point that it is clear that there will be accountability, but I am not sure that that was problematic last time. It might be clearer this time because of the joint officer having sole responsibility, which CHCPs tried to do.

Alison Petch: We must avoid having false confidence that the bill will necessarily lead to a better solution. We must be cognisant of the experience in Northern Ireland, where structures did not necessarily deliver what was hoped for. I was a researcher and it is almost a researchable question to ask whether the bill will deliver better than a less mandated pattern for the future.

As I said, the fact that the bill has raised the profile might lead one to be optimistic, but it must be appreciated that hard work on all the other aspects that we have focused on is required. In itself, the bill will not create a magic solution.

Mark McDonald: I would not want to give the impression that I think that simply legislating will solve the problems that have existed. I merely suggest that increasing accountability might push the agenda forward more quickly.

Do we come down to the point that we are talking about the people in organisations? Do some organisations have people who are getting on and driving forward the agenda, while other organisations have people who are—for whatever reason—unable or unwilling to drive it forward?

Alison Petch: I would have thought that the former is about 80 per cent of the case. We must also bear in mind the question whether the proposed arrangements will have unintended consequences. What will be the impact on children's services in some areas if they are not included in the partnership? As with any such development, there are gains and losses. We must have the people—the leaders—who can navigate that and deliver the solutions, regardless of what has been mandated in an area.

Mark McDonald: I take your point. COSLA says in its submission that it wants the bill to be tightly written to cover only adult health and social care. That would limit the ability to expand the model, if it proved successful. Perhaps we can touch on that in the next evidence session.

I think that I understand where you are coming from on the implication that outcomes can be counterproductive. However, I presume that the only two things that we can measure are the input and the outcomes. To me, the outcomes are more important—provided that we get the measures right, obviously—because that is what affects people at the sharp end. Can simply focusing on outcomes be counterproductive? Is how we select the outcomes that we measure the important point?

Andrew Eccles: Part of the general problem in public policy in the United Kingdom in the past 15 or 20 years has been importing what I would call context-free management, particularly into public sector agencies, as we broadly refer to health, social care and so on. The management processes and output processes probably work very well in particular organisations that manufacture motorcars or whatever, but importing ideas wholesale on an outcome basis seems problematic to me. I am not against the idea of outcomes per se, but the problem with emphasising them is that doing so can damage some very good, creative, interesting work.

Perhaps we need to start with the idea of doing something creative and positive with the facts as we see them on the ground, and then learn from that—and from mistakes made in doing it. You might be doing the right thing but doing it wrongly, but you can learn from that if you are doing it at the local level. If people are working towards a set of outcomes that do not make much sense or which have been transported in from another area, they are essentially always working on the wrong basis because they are working towards a series of outcomes that do not reflect the reality of what is happening on the ground.

Alison Petch: I think I need to make a fundamental clarification that will show where I might disagree with Andrew Eccles. We must distinguish between something being driven by the delivery of outcomes for the individual, which should be at the heart of the process that we are discussing, and perhaps the more traditional outcome-based accounting-type approach, which I think is the one that Andrew has questions about. The difficulty is that the word "outcomes" now means different things.

Mark McDonald: I entirely take on board that point. My concern is that in the past we have often measured the success of things by how much money gets thrown at them, rather than by results for individuals.

Andrew Eccles: In the past, we have measured the measurable, which is a process that often means avoiding dealing with complexity. A lot of managers might well be engaged precisely in the process of measuring the measurable as opposed to really getting to grips with complexity, which is sometimes not easily measured.

Mark McDonald: Do you think that we measure too much?

Andrew Eccles: Personally—certainly, given the sector that I come from—I think that we probably do and that we need to sit back. The interesting analysis of this area comes not from the UK but from people in continental Europe who do quite a lot of work on UK public policy. I would be happy to recommend some interesting studies that ask why Britain shapes its public policy as we do. Although the evidence base for the accounting approach to measuring the measurable shows that it is demonstrably problematic, we continue to do it. I think that that is partly because people have become very skilled at doing it in the past 15 or 20 years, so it is hard to retreat from that and think outside the box.

Alison Petch: The difference is perhaps epitomised in the distinction between measuring bed occupancy or delayed discharge, for example, and measuring the extent to which an individual who has been discharged from hospital arrives home having had a good experience and is not back in hospital two days later.

Mark McDonald: Is there not an inherent danger that if we say that we are not going to measure X, Y or Z, those of a cynical disposition will imply that we are not measuring that any more because we cannot meet the targets that we have set, or that we are trying to hide something from the general public? Is that not the inherent danger in reducing the number of measurements that take place?

Andrew Eccles: Maybe that is the cynicism that we need to get over.

The Convener: That did not sound like an endorsement, as was alluded to earlier, of the prescriptive nature of the bill.

HEAT targets and the use of outcomes have been criticised, but measurement must be a serious part of the bill. Measurement will be applied—some people think to a worrying degree, if it becomes prescriptive—because if people do not reach this, that or the other target, the minister will have the power to intervene.

10:45

Alison Petch: The proposed outcome measures for health and social care integration at the national level represent an attempt to grapple with the need for a more nuanced, sophisticated understanding of targets. The system is not perfect, by any means, but there has been an attempt to put greater emphasis on outcomes for the individual—not just where they are but how they experience care. That is a significant improvement, as far as I am concerned. There have been advances in trying to get more sophisticated measurement.

I absolutely agree with Mark McDonald about retreating completely from measuring outcomes. Measurement is much more about trying to get an understanding of the reality of the situation than it is about crude indicators.

Andrew Eccles: I agree; I also agree that there has been movement in that regard. My point was that attempts to set outcomes were historically very process driven. I am advising caution because different parts of Scotland are at quite different stages. I remember working with organisations a decade ago in which interesting and creative local practice quickly became usurped by the idea that people would be parachuted in to manage integration. There needs to be sensitivity around allowing things that are working reasonably well on the ground to flourish effectively.

Outcome measures are entirely useful in some cases, as Alison Petch said, but I am expressing

caution because they are often broadly based on accounting principles, which can be very counterproductive. The question is what the outcome measures will do and to what extent we take account of the fact that there are areas of Scotland that are in quite different places in relation to the point at which we might decide to intervene. That seems to me to be a pretty sensitive issue.

The Convener: Do you agree that outcomes partly change the culture and environment in which people work?

Andrew Eccles: It depends on the outcome. If the outcome is what is good for the individual, that might well change people, but a broader set of structural, organisational or procedural outcomes such as accompanied what we were doing 10 years ago can often be problematic and counterproductive.

The Convener: Outcomes are not necessarily bad in themselves, if they are defined and supported by the people who deliver and receive the service.

Alison Petch: That is key to the whole endeavour, and it brings us back to the new model of partnership working, which is about partnership not just among professionals but with individuals. If we are talking about how we motivate and provide opportunities to the workforce, particularly front-line workers, to work with individuals to consider how they can enable them to achieve the outcomes that they want and to have a better life, that is really what should be at the forefront of the approach—the panoply of mechanisms and structures should fall in behind that. That remains the vision that we must try to achieve; that is what should be driving the approach.

It is all about the cultural change that we have been talking about. We must not lose that in our discussions about the outcome-based accounting of the past and so on. From my reading of the bill and the policy memorandum, it seems to me that much of it is about making a difference for the individual.

The Convener: Whether or not the bill is proportionate, I think that everyone agrees that things could be better. We are all muddling towards a situation in which services are delivered better.

Perhaps one way to change culture is to stop thinking in terms of the armies of social workers, medics and so on—who are all human beings, after all, and everyone finds change difficult, wherever they work—and to think about giving people who receive care positive, enforceable rights. Would such an approach sufficiently change culture? Would starting from that point influence the targets, outcomes and so on? Rhoda Grant and Bob Doris talked about what MSPs deal with, such as how individuals are assessed, where they are placed, whether they get a 15-minute visit or a quality service and so on. Perhaps there should be enforceable rights for people at that point.

Alison Petch: There is a strong movement towards having a human rights focus in relation to care, which I absolutely endorse. However, just introducing such an approach will not change things overnight. We must recognise that there will be a long evolution.

During the past 30 or 40 years we have moved in the right direction. We throw up our hands in horror at things that happened 20 years ago, when people were still living in long-stay hospitals. Self-directed support is in place and we are starting to see heartening improvement. If endorsing such approaches can accelerate the move along that continuum, that is all to the good, but just putting the words in the bill will not make it happen.

Andrew Eccles: I agree. In effect, we already have a human rights approach. Article 8 of the European convention on human rights is about dignity, so in circumstances in which people's health and social care is not safeguarding their dignity they have recourse on that basis. I am not sure that that helps us with the fundamental point about how we achieve integration of health and social care. Statutes might have their uses as motivators, triggers or whatever, but they will not fundamentally alter the most important issue, which is how we change the culture in relation to people's ways of working

The Convener: Do you expect the bill to be any more successful than previous bills that tried to address the issue?

Andrew Eccles: That is a big question. The attempt to be slightly less prescriptive about how people might achieve things at the local level is useful. The bill as it stands is a shell, into which much about leadership and changing attitudes must go. It is all in there—the bill talks about leadership and training—but I would like more emphasis on the sheer cultural shift that might be required to make things work.

The Convener: You just lost your academic status and slipped into giving a politician's answer.

Andrew Eccles: In that case I will give you an academic's answer: I do not know.

Alison Petch: I would like to think that professionals and the wider community in Scotland will build on the bill to move forward on integration. I am repeating myself when I say that I do not think that the bill will necessarily overcome challenges that have arisen in areas. It is not a magic bullet.

The Convener: We talked about the need for leadership and about attempts over a decade or more to address a situation that is well known to all of us. What have the learning institutions done in that decade to develop leaders and visionaries?

Andrew Eccles: The learning institutions have provided a very substantial research base on the whole area of integrated working. It is all out there—I brought with me a copy of stuff that Simon Caulkin has written on targets in public policy. There is a lot of material on that, and a lot of stuff has been written on integration.

I worked with integration managers in the past, and it struck me that people were so wrapped up in getting through the day-to-day business that they had no space to consider the research. I would say, "Precisely the area that you are talking about has been written about. You should have a look at the research." The work is there, and it needs to be accessed. When I have worked with front-line managers, in particular, I have always been struck that they are under a lot of pressure and do not have much space to develop their knowledge of what is out there.

I am currently teaching social work managers, who have a powerful protected space of one day a week in which they can start to explore the stuff, a lot of which is new to them even though it has been out there for a while.

Alison Petch: I have a final anecdote for the committee. I used to be involved in a postgraduate course at the University of Glasgow, which brought together managers from a range of backgrounds, including statutory and independent agencies. They came in for a day a week, over a couple of years. The learning that they did together was incredibly powerful—it was not so much about what they heard from us. I remember a health board planner talking about the dreadful difficulties of people not emptying beds. Someone from social work said, "Imagine that that was your grandmother. Would you want her shifted overnight?"

We should make space and find finance for such interdisciplinary learning—I gather that finance is an issue—because it is a powerful experience.

The Convener: If there are no more questions from members, I thank the witnesses for their time and evidence.

10:57

Meeting suspended.

11:03

On resuming—

The Convener: We now move to our round-table session with local government representatives. As is the usual practice in such sessions, I invite everyone to introduce themselves.

Duncan Mackay (North Lanarkshire Council): I am the head of social work development in North Lanarkshire Council.

Bob Doris: I am an MSP for Glasgow and the committee's deputy convener.

Soumen Sengupta (West Dunbartonshire Community Health and Care Partnership): Good morning. I am the head of strategy, planning and health improvement in West Dunbartonshire.

Nanette Milne: I am an MSP for North East Scotland.

Peter Gabbitas (City of Edinburgh Council): I am the director of health and social care in Edinburgh.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Susanne Harrison (City of Edinburgh Council): I am the integration programme manager in Edinburgh.

Rhoda Grant: I am an MSP for the Highlands and Islands.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Ritchie Johnson (Aberdeenshire Council): I am the director of housing and social work in Aberdeenshire Council.

Malcolm Chisholm: I am the MSP for Edinburgh Northern and Leith.

Ron Culley (Convention of Scottish Local Authorities): I am the chief officer of health and social care for the Convention of Scottish Local Authorities.

Richard Lyle (Central Scotland) (SNP): I am an MSP for Central Scotland.

Councillor Peter Johnston (Convention of Scottish Local Authorities): I am the COSLA health and wellbeing spokesperson.

Mark McDonald: I am the MSP for Aberdeen Donside.

The Convener: I am Duncan McNeil, the MSP for Greenock and Inverclyde, and committee convener.

Bob Doris will begin the questioning.

Bob Doris: I have a general question. Some local authorities are further down the road to health and social care integration than others. The Public Bodies (Joint Working) (Scotland) Bill will put such integration on a statutory footing. For those witnesses who consider that they have already travelled far down that road, how does the bill dovetail with what you are doing?

Soumen Sengupta: I am not here to tell councils or others how to develop their business, particularly with regard to local democratic processes. I will therefore talk about the long track record of joint working between the council and the health board in West Dunbartonshire.

In October 2010, when we came to enact the community health and care partnership, there was a history of substantial joint working at all levels, particularly the front line, so it felt comfortable and right. That is not to say that staff did not have a lot of questions or that there were not concerns that had to be worked through; indeed, there were challenging issues, including the need to think about territory. However, we had a sound basis on which to do that and the partners involved were keen. Therefore, we, in common with a number of other areas, such as East Renfrewshire, have a much longer involvement in this work. In Inverclyde, which is in the convener's constituency, integration at the structural level is well progressed.

We are probably in a position in which the bill will not make a substantive difference to how we do the day job. The day after the legislation is enacted, the world's operational services will pretty much be the same as they were the day before.

The bill raises interesting opportunities on accountability. As we mentioned in our submission, we are keen to streamline accountabilities in the public sector arena that we work in. For all the opportunities that partnership working provides, and given each of the conditions we are trying to tackle, a person can find themselves trying to report to multiple stakeholders at different times. It needs to be clear who is accountable to whom and for what. A shared set of outcomes that relates to the spectrum of the health and social care agenda would also be powerful because it would provide a clarity of purpose for the organisation and the staff, and—we would hope—parity of expectations for our local community, and a clarity of fairness on what MSPs and other elected officials should expect from organisations and the leadership of those organisations.

The need to manage ambition was mentioned in the previous session. The bill is an ambitious step for Scotland, but we should not get overexcited about what a structural change or other changes in the bill will do. Those changes are only part of the solution; there is a lot more work to do.

I am sure that all areas—even those that are not as structurally integrated as we are—do similarly innovative work on the ground, that there is lots of joint working between staff, and that we all have examples of good practice that we could bring to the table.

The Convener: Panel members should come in when they want to.

Duncan Mackay: I caution the committee that there are partnerships that may appear to be more integrated than others, but those with integrated structures may not in practice, on the ground, be more integrated than those that do not have the same structures. The partnerships that have the same structures may or may not be achieving better outcomes than those that do not appear to have the same level of structural integration. By way of illustration, in North Lanarkshire, we have been working towards integration in many ways over many years. We have a suite of integrated services, such as day services for older people, as well as integrated equipment, and integrated adaptation and addiction teams. In fact, those services and the general partnership approach have been consistently well evaluated by external inspections—they were recognised as recently as 2011 by the Nuffield Trust as one of four worldwide exemplars of integrated working. It does not necessarily follow that the structural arrangements of a partnership—inevitably, there will be 32 variations across Scotland—lead to better outcomes for individuals. I caution the committee that, as members heard in the previous evidence session, there can be a somewhat tenuous connection between the structure and the intended outcomes.

Councillor Johnston: In answering the question, let me first put my remarks into context. From a COSLA perspective, we believe that the integration of health and social care is the cornerstone of public sector reform. We very much support the direction of travel. We recognise that an outcomes-based approach that uses resources flexibly, promotes co-production, early intervention and prevention and facilitates service integration is the way ahead.

Mr Doris is absolutely right that we start from a situation in which some local authorities and their NHS partners have already gone some way down this line. Those who know me will be aware that I am a member of West Lothian Council, which is one of the leading councils in this respect, as, likewise, is Highland Council, which has used a different model and has taken a lead agency approach. As my colleague Duncan Mackay has said, other councils have developed arrangements in a different way.

The experience of having all those different starting points leads COSLA strongly to take the view that the bill is in some parts too prescriptive, particularly on the issue of scope. As we argue strongly in our submission, the starting place for all partnerships should be adult social services, but the bill should provide local flexibility to allow the integration to evolve and develop not on the basis of structures imposed by ministers but through local flexibility, local knowledge and local leadership. As we heard earlier, joint working comes not through structures but through local leadership and local cultures developing. That is fundamental to the success of this project of further integrating health and social care.

Peter Gabbitas: In a way, I agree with my colleague from North Lanarkshire Council. I hesitated to respond to that first question on what progress we have made because, in terms of the bill, Edinburgh might seem to be very far forward on integration: I have been the joint director for eight years, West Lothian has had a joint director for a similar time period and, more recently, joint directors have been appointed in East Lothian and Midlothian, which are the other parts of the area that is coterminous with the NHS Lothian area, so we have joint directors in place. At the end of this month, we will have completed a whole year as a shadow health and social care partnership. In terms of what the bill is signalling as the direction of travel, we might seem to be very far forward.

However, I feel that we still have an awful long way to go on integration. There are examples across the country of really well integrated services, whereas in those areas that appear to be fairly well advanced in structural terms the position is very mixed. What counts, I think, is not so much the governance arrangements, although those are important. What I am interested in and passionate about is whether we are making a difference to the lives of the people whom we serve. Are we making our services more seamless? Are the people whom we serve able to see the cracks between the statutory services? Those are the things that I am passionate about.

Ritchie Johnson: I agree with the comments that both Duncan Mackay and Peter Johnston have made.

To give an illustration, in Aberdeenshire we do not have the same formal structural integration that has been described in areas such as Edinburgh. However, like many other councils, we can point to a lot of good joint working practices by joint working teams—particularly in a rural area, where it is essential in order to reflect rurality—and we are doing a whole lot of work around the issue.

Although we believe that, ultimately, legislation would not have been required to move us on, nonetheless the bill has been introduced and, from our perspective, we want to push on. As well as the structural elements, which are inevitably needed, it is even more important to backfill and to support the change with a series of initiatives on leadership, communication and culture, as the committee has already heard this morning. We need not just one approach but a series of things to make the change work and to make a difference. I keep challenging my team and my colleagues with questions about why we are doing this. We need to make a difference to the people who receive our services. If that is not what the change is about, we are missing something. I am not saying that anyone is suggesting that that is not what the bill is about, but we need to keep coming back to that question or we will get drawn into a lengthy debate about structures and principles. Although that might be interesting and of some importance, it is not the key tenet of the agenda. We have to focus on why we are doing this and challenge our teams regularly on that basis.

11:15

The Convener: If integration is going along swimmingly, why do we need the bill?

Ron Culley: I suppose that we could answer that question in a number of ways. In one sense, legislation is an admission of failure; we are saying that we have not been able to do something of our own volition and that we still have to overcome some barriers.

The committee has heard from my colleagues today that a lot of good work is being done locally that is knitting together practice between social work and health, and that will continue irrespective of the bill. However, the bill can address some barriers that still exist in the way in which the health service works with local government. I am thinking specifically of the situation in relation to integrated resources and the extent to which we can start to plan with a total resource for an entire population, particularly the way in which we can integrate the acute sector into that environment. After all, the non-integration of acute care not just with social work but with primary care has probably been the biggest failure of the past decade. Acute care has sat out on its own. One of the fundamental strengths of the integration agenda that the Government has advanced is that it is not prepared to see that happen any longer.

The reality is that, as we move forward in demanding financial circumstances, in what is likely to be a flat-cash situation for the next few years, we need to be smarter about how we use our total resource. Historically, we have probably invested too much in secondary care at the expense of social and primary care. If the bill allows us to be more imaginative in how we use

our total resource, and if we can begin to deploy our collective resources more effectively over time, that will be a success and it will justify the legislation, but there are a number of big caveats that relate to our capacity to do that.

Peter Gabbitas: A few reasons stand out as to why the bill is important and necessary. In terms of governance, as it has been described to me by council lawyers, the Local Government (Scotland) Act 1973 suggests that any committee that has been formed by the council has to be made up of two thirds of elected members and only one third of the alternatives. Different councils have interpreted that in different ways, but my council's solicitors are quite clear about that. If we create a committee and try to establish a partnership body, we cannot do that if another organisation has two thirds of the votes on it. That is not an equitable distribution. There is therefore a governance issue.

There are also issues to do with assets and different accounting regimes, which arise not so much with the bill but with the regulations that will follow in due course. There are issues with the budgets that will, again, be addressed by regulations and the work that is being done on the back of the legislation.

The bill is therefore required for a number of reasons, but the biggest one for me is to do with community health partnerships. If we look at what they were asked to do by the original legislation, we see that one of their responsibilities was for commissioning and influencing acute services. However, community health partnerships were not established in a way that allowed them to do that effectively. How health and social care partnerships have been positioned and the responsibilities and power that are given to them could fundamentally change the relationship and power balance between primary and social care and the acute sector, and make that a much more equitable relationship than it ever was in community health partnerships. The bill is therefore very important from all those perspectives.

Malcolm Chisholm: There is a kind of continuity between the opening comments and those of the previous panel. We all agree that structural change is not going to deliver what we want, but we are probably going to end up talking about it a lot because a lot of the concerns of local authorities are in that area.

I am interested in what people like and do not like in the bill. My question is really for Peter Gabbitas. I was struck by the City of Edinburgh Council submission. Peter Gabbitas has told the committee some things that he likes about the bill, but the City of Edinburgh Council says —and I do not know whether this is true or not; it is an open question—that there is a gap between the original proposals and what is in the bill and that it has concerns about the position of the corporate bodies and the chief officers. That might move us into talking about structures and technicalities, but it is an important point. I wonder whether Peter Gabbitas could explain that and whether any other council has a similar concern. We all get the message that local authorities do not like the degree of prescription in the bill when it comes to local authorities, but I am interested in hearing any other concerns that councils might have. That is one that I picked out from the City of Edinburgh Council submission.

Peter Gabbitas: When we introduced ourselves at the beginning of this witness session, the convener described it as a session with people from local government, such as Councillor Johnston from COSLA. I am actually from the NHS and local government because I am already jointly accountable officer, and I see the issue through the lens of the NHS and the council.

We put before the committee an NHS Lothian submission, which contains issues and concerns that I will happily summarise, and I also put in front of the committee the corporate response from the council that took into account all the departments in the council, including people in corporate governance, legal, housing, and all sorts of other areas of the council. The response is a composite reflection of corporate concerns.

As the director of health and social care, I have a more narrow view, but I will try to summarise the concerns that are in the submission about how the bill is drafted. The first issue is about scope, which was touched on during the first discussion. The bill is not particularly prescriptive about acute services. That might well follow in the regulations, but there needs to be at least a minimum requirement around acute services. My colleagues in the NHS are more hesitant about that, and they are right to be concerned about it, but colleagues in local government would like the bill to be more specific about what acute services should be in it.

The NHS's main concern is about the body corporate, its legal status, and its relationship with the parent body. At times, the bill is a bit confusing and unclear about the relationship with the parent body, and I think that that is because it is trying to empower and give a status to the health and social care partnership. In doing so, however, it does not make it clear what the relationship of the body corporate is to the parent body and, as a consequence, both parent bodies in Lothian are concerned about that. Some things do not require the parent bodies' approval and it does not actually say in the legislation that the plan for which it is responsible has to be signed off by the two parent bodies. We can assume that that might

be what is required implicitly, but the bill does not say that explicitly.

Also, in relation to that, the bill does not say that the parent bodies are to appoint the jointly accountable officer. How the bill is written implies that the health and social care partnership is established and then it appoints the jointly accountable officer. In my case, it is kind of academic because the two parent bodies, NHS Lothian and the City of Edinburgh Council, already have a jointly accountable officer and it is me, but it is more about the principle and what the bill is saying about the power balance between the parent bodies and the organisation.

On delegation, it is not clear whether the parent bodies will retain ultimate responsibility. One of the tests for me would be that, if the health and social care partnership did something really awful to a patient, who would be legally accountable for that? Would it be the health and social care partnership or, in some way, would it be the two parent bodies, or would it be all three? That is not terribly clear from the bill.

There are other concerns about that power and authority, specifically from the NHS viewpoint. For example, the bill says that ministers may appoint people to the integration board directly. There is concern about that power because the policy memorandum implies that it is the two parent bodies that will appoint people to the board, whereas the bill says that ministers may appoint people to the integration board. That implies that, at some stage, down the line a minister could just arbitrarily decide to appoint people who are not members of the health board or the local authority. I am sure that that is not the intention, but at present the bill gives ministers that power.

I think that that is a fair summary of the issues. Well, it is a summary—I do not know whether it is fair; that is for you to judge.

The Convener: Was Malcolm Chisholm alluding to the original consultation? I think that some of the written submissions claim that there has been a departure from the original consultation. Is that the point?

Malcolm Chisholm: That seems to be what some people are saying, but I do not have a view on that. However, it would be interesting to know what the witnesses think.

The Convener: Can Ron Culley address that aspect?

Ron Culley: Yes. I do not think that there has been a departure in terms of the policy intention, but there is a very clear departure in terms of what the bill allows. That is why we are fundamentally concerned about the current articulation of the integration project in the bill, particularly in respect of its scope. All local government functions are within the scope of the bill as it is written. Through regulation, a Scottish Government minister could bring any local government function within the scope of the legislation—not just social care but education, housing or whatever. We are fundamentally opposed to that.

We think that there must be a bill that represents the policy intention and that this bill does not do that. That is why we have strongly advocated an amendment that would provide a much tighter definition of the local government functions that may or may not be delegated. The policy intention is all about adult social care, so we want a bill that carries out that intention. That is our fundamental concern.

Peter Gabbitas went on to talk about many other areas in which the bill offers up powers to ministers. Again, we are concerned about that. We can look at the issue on two axes. One is the relationship between the NHS and local government. We were comfortable with that discussion and wanted to see reform advanced in that area. The other axis is the central/local dimension. We think that the bill will give far too much power to the centre. We want partnerships to be given more authority and responsibility to get on with the job. Our objection is not to legislation as such but to the way in which the bill has been framed.

Gil Paterson: My point is similar to what has just been said about the legislation. When thinking about issues like this, I always try to place myself in a context that I am comfortable with, which is the business community. If customers at the sharp end say that something needs to be changed, and the business representatives, middle management and upper management say the same, what are the directors going to do about it?

It has been said that legislation is sometimes like using a sledgehammer to crack a nut, but it can be used as a hammer to knock down a door or barrier in order to achieve ends that everyone is crying out for. However, I have not heard a single person say in evidence that there is a need for change and for integration to take place. Is legislation the only way for integration to take place? Let us be fair about it and not kid ourselves. Some people say that everybody is moving ahead on the issue. Why, all of a sudden, is everybody moving ahead on it? If integration is such a good idea and everybody thinks that it is needed, why has it taken so long to do it and why is the only way to make that happen legislation?

11:30

Soumen Sengupta: I will try to give part of an answer to that question. I suspect that colleagues will be able to chip in and flesh it out.

My understanding is that, across most of western Europe and in other countries, health and social care integration has been talked about over many years almost as the mother-lode solution to a wide range of problems. I think that, for all of us around the table, it is clearly not the magic bullet or panacea: that will have come across to members. Nonetheless, it is talked about as being a good thing if we could create a structure to get the public sector working that way.

In my thinking about that in our work I ask—as do my colleagues—the question that Peter Gabbitas talked eloquently about. What does integration mean for the end user? How will it make things better for the end user in the way that Ritchie Johnson talked about? It is not just about the acute side, although that is a big issue that we need to look at; it is as much about home care in district nursing, for example. What opportunities are there to provide seamless care to the same clients—patients and so on—such that multiple staff are not being used and we make the best use of resources? Those are the strategic commissioning decisions that we can talk about and which Ron Culley talked about earlier. There is a wide range of enabling elements in the bill, and it strikes me that it is about encouraging integration.

We have also talked about the undercooked aspects of the bill—the bits in which it seems to have not quite got its head round the ambition behind what it is talking about. Peter Gabbitas also eloquently covered that. It strikes me that that is down to the fact that, at the heart of the matter, we are talking about creating an instrument that allows serious commissioning—it is no longer about joint commissioning; it is just about commissioning—between two different types of public sector bodies: NHS territorial health boards and local authorities. Those bodies are set up to operate in different ways with different accountabilities and different scopes, which Ron Culley pointed out.

We know that local authorities organise their services and function in a range of ways—social work and education services, and social work and housing services. Sometimes services work together and sometimes they work apart. We get a bit hung up on trying to create connectivity between public sector bodies, which I think is because of the issues that Peter Gabbitas talked about.

The bill is trying to do something noble and progressive, but that comes a bit unstuck when we ask how we will do that and what the governance and accountability issues are. To some extent, the bill compensates for that by providing far too much detail on, for example, how to put together an integration plan, which seems to be very bureaucratic and procedural. The bill has not quite got its head around some of the big macro structural elements.

Ritchie Johnson: On the challenge around why legislation is needed if everything is already going swimmingly, I said earlier that our council's position is that we do not favour legislation, but that is not to say that we do not recognise that we need to do more collectively with health colleagues and other partners. It is about trying to unpick how we can get a better set of integrated services.

We have deliberately started talking about "integrated service delivery" rather than just "integration" as shorthand; "integration" sometimes implies structural discussions, and we do not want to focus too heavily on that. We come back to using "integrated service delivery".

We have taken that through our councillors, stakeholders and staff; we are looking at layers of issues. There is the macro element, which we have reflected on today and which involves national central Government and local government, and there are regional issues—for example, with NHS Grampian and the three local authorities in NHS Grampian's area. There are also CHP-level, council, service and locality issues. All that needs to be pulled together coherently if we are really going to really push the agenda forward. I think that most people would say that they are up for that, as is absolutely right, but it is about understanding that the landscape is fairly complex.

On governance, to pursue Peter Gabbitas's reference to the body corporate, the chief officer and their responsibilities, we have not fully got our heads around that, either. In Aberdeenshire, we are very close to confirming our position on the model, the scope and how to take matters forward, but we accept that we need to bottom out details on how things will work.

On Peter Gabbitas's example relating to something going wrong, scenario planning or scenario setting might be a helpful tool for asking, "What if ... ?" We could imagine a circumstance and ask how the body corporate would work in that circumstance. What would be the actual responsibility of the chief officer versus, potentially, a director of housing or social work, the council or the chief executive? It is about teasing out those relationships and understanding who ultimately makes the decision, how that works, and whether we have the balance right between empowering the local partnership and the

democratic accountability that some members will wish to retain.

Duncan Mackay: This is an interesting dilemma for parliamentarians. I think that we are hearing widespread support for the policy aspirations for integration, but I think that I am right in saying also that we have a piece of legislation that does not mention adult social care at any point. When Parliament is trying to legislate in that area, there is a dilemma: many of the aspirations could be achieved without legislation, but many might not be achieved with legislation. Officers in local authorities will need to know how to pick their way through the ambiguities in the bill, as it is currently framed, and in the aspirations to achieve the best possible outcomes for the citizens whom we serve.

Colleagues have touched briefly on acute care. My understanding is that it is a ministerial intention that significant elements of the acute sector need to be part of the integration arrangements if they are to work. Certainly, the policy memorandum for the bill is explicit that it sees two disconnects, one of which is the disconnect between acute and primary care. As it stands, the bill does not actually address that. I know that a national working group has been looking at the subject and that the views of some people on this panel will differ from those of NHS chief executives. However, from an operational perspective, fixing that disconnect is absolutely fundamental to realisation of the policy aspirations.

My local authority, North Lanarkshire Council, has three acute general hospitals, but because of the geography of the local authority, people are admitted to and discharged from seven hospitals in four different health board areas. Integration will not help us to manage those complexities. It would help us if part of the required arrangements recognised that people's experience is so contingent on the acute sector working well and on building strong filters that prevent people from coming into the acute hospital environment when they do not need to. If the bill does not facilitate those things, it will not achieve the aspirations that we all share.

Mark McDonald: I have a question on the ministerial power. I understand the concerns that are being expressed, but there is a flip side to that. When the bill is rolled out and proves to be successful, if there is a desire to roll it out to include children's services, for example, and the bill defines too narrowly a specific element of social care function that refers only to adult health and social care, we will find ourselves around this table again discussing more primary legislation to include children's services. That will be like taking a sledgehammer to crack a nut, if the legislation works when we roll it out. How could the bill include that expansive element while retaining a focus that would assuage the concerns of local government?

I take the point about wanting the arrangements to develop organically at local level, but does not that leave us running the risk of finding ourselves in the same position as we found ourselves in at the outset of the current process, when we were sat around a table discussing why local authority A and health board A were pressing ahead with the agenda, but local authority B and health board B were not? Do we run the risk that some will press ahead with the agenda while others will need a bit of a legislative kick up the bum?

Ron Culley: I suppose that there are a few things to say. I will be clear about the COSLA position. We are in favour of local partnerships being able to secure additional service areas coming into the integrated partnership—there are too many of our councils that have already integrated children's services in their arrangements.

Our objection is not to the type of expansion that is done in the context of local circumstances; we object to the potential for a Scottish minister to say, "We require you to integrate children's services." The reason for our objection is that such integration was never a part of our discussion with the Scottish Government over the past two years in advance of the bill, nor is it a part of the policy memorandum. The policy memorandum is clear that the bill's focus is on adult social care and health services.

We welcome the opportunity that Mark McDonald speaks of, but we do not want the minister—or any future minister—to have the potential ability to force people down that line when it was not consulted on and is not part of the policy memorandum.

In terms of local arrangements, we are comfortable with the legislative framework guiding activity over the next period, but we want an enabling legislative framework in which local partnerships are empowered to use that total resource imaginatively. We think that there are benefits to the bill, but a directive approach will not work.

We want to invest our time and energy in the commissioning agenda, and we want to make local partnerships the bedrock of that agenda in order to ensure that we can use the resource differently in a very difficult financial context. The way we will get there is by writing enabling legislation. It is not about taking powers to the centre, but the opposite: giving powers to localities and saying, "That's your total resource—use it imaginatively in order to meet the outcomes of

your local population." That is how we will get success.

Councillor Johnston: Mark McDonald has clearly hit on a live and difficult issue. I am glad to hear that he recognises the importance of allowing these things, in his words, "to develop organically". It is interesting that the bill requires that the integration plan be underpinned by substantial locality involvement and consultation. That makes it clear that it is local communities, from the bottom up, that are going to drive the changes.

I am here wearing my COSLA hat, not my West Lothian Council hat; our council has integrated children's services. I emphasise again that integration in West Lothian evolved over time, through people building up relationships and working together, which is the only way we will do this. Imposing a structure centrally will not work—in fact, it will hinder genuine cultural change, and the ability to integrate services locally and deliver joined-up services, which is what we all want.

That is where COSLA is coming from. We want flexibility to allow local communities, working in partnership, to shape the future.

Bob Doris: Mark McDonald was quite right to tease out more of the dynamics regarding the scope of the bill and the policy intention, and I am sure that the committee will reflect on that. Mr Culley and Mr Johnston talked about the need for "enabling" legislation, but such integration has been enabled for a long time—some places just have not done it. Mr Johnston rightly said that the bill is structured in such a way that the requirements on local authorities and health board partners are that the dynamic involve a bottom-up approach with huge consultation at local level.

The point of the bill is to give direction where there has been no change at local level, otherwise there is no point in having legislation in the first place. We could pass a bill that says, "Here's what we'd like you to do, but if you don't do any of it, the minister cannot step in." What would be the point of that?

11:45

I refer you to section 39, "Default power of Scottish Ministers", where a lot of the issues may emerge. If local authorities and health board partners cannot get around the table and agree a plan—I think that they will; I do not think that the power will ever have to be used—at some point the Scottish ministers should, surely to goodness, have the power to step in and make it happen. Maybe we can have a debate about whether—

The Convener: Can we just get a response? There are four people waiting to speak, including your colleagues. You have made the point quite well. Let us get a response to that.

Ron Culley: We do not disagree with that. Should Scottish ministers have the capacity to ensure that the legislation is followed? Of course they should—absolutely. We disagree with how the policy intention is articulated in the bill. We think that there is a drift, and we want to work with the Government and Parliament to correct that.

Bob Doris: Okay.

The Convener: Is there a clash of two cultures? We have 32 local authorities and a more centralised set-up for health through the minister. Is there a drift because of that? I do not mean a conflict of interests, but the cabinet secretary's interest is in defending his portfolio's budget, and he is more susceptible, on a daily basis, to being lobbied and to hearing anxieties from the acute sector. Many of us politicians chase after that and put a lot of pressure on the cabinet secretary to deliver. Does some of the drift come about through that?

Ron Culley: The NHS is a managed service and local governments are democratic institutions, so your observation probably has some weight. Ultimately, we want to ensure simply that the bill does what it says on the tin. The amendments that we would like to lodge, or see others lodge, would result in a bill that we would be more comfortable with—a bill that is in parts more empowering, less directive and less prescriptive.

Use of authority at national level is clearly important in underpinning any legislation—we absolutely accept that. What gives us serious concern is the introduction of discretionary powers, which we think are absolutely not necessary. There needs to be a legislative framework that we can all work within, but partnerships must be allowed to get on with the job. That is all that we are asking for.

Rhoda Grant: The discussion has moved on and we are getting to the nub of the issue, which is about having a bill to facilitate joint working rather than to dictate how it happens. That takes us back to the aim of the bill. We have been talking about shifting the balance of care from the acute sector to primary and home care. If we are going to do more of that, we can do a huge amount using telemedicine and the like, which home carers could help to facilitate. There could be a real opportunity to shift the balance in that way.

How can we do that? Some local authorities have undertaken an awful lot of work to push that forward, and there may be things in the bill that you think are blocking that, and which we need to look at. How can we take along with that move and change those who are more reticent, who perhaps do not have good working relationships

on the ground? How can the Government ensure that the same standard of care is available to Joe Bloggs regardless of which local authority or health board area he is in?

Peter Gabbitas: On that last point, my chief executive in health made me jointly accountable, with the director of nursing services, for unscheduled, or emergency, care. She manages the acute component of that and I manage the primary care, social care and community health component.

I will give an example of the things that we are doing to shift the balance. We are about to introduce step-down beds. Many other authorities have also done that, but what might be different about Lothian is that funding for that is coming from the acute sector. We have done the detailed calculations that say that we can manage with fewer acute beds if we have the step-down facility and the correct flow through. In social care, we are commissioning that. It is partly being commissioned by the private sector and partly being provided internally, but the funding ultimately comes from the acute sector. That is all happening without legislation; we are just doing it anyway.

Soumen Sengupta: I was going to pick up on a variation of that. Part of the way that we address the matter is by having a smaller number of individuals who are accountable for the totality of the work, as in the example that Peter Gabbitas talked about, where two extremely senior managers are responsible for the totality of the activity rather than three, four or five being responsible.

In our neck of the woods, at a much more local level, if someone has an issue with residential care and someone has an issue about the district nursing input, the same head of service—let alone the same director—will have responsibility for that, can be contacted about it and is empowered to deal with it because they have responsibility for the relevant budget, albeit that, at the moment, they are not pooled budgets but aligned budgets.

That provides a facility whereby, rather than there being 20 people to deal with an issue, there is one director—a single officer—and their team. That should create synergies and efficiencies in driving through change.

However, at the same time, that requires a marriage of solutions. As everyone has said, these are wicked issues. That has come through repeatedly from all our submissions. It is a case of, "How do you eat an elephant? One bite at a time." The bill is an important bite, but it is only one part of the process and there are lots of other things that have to go on at the same time.

Ron Culley: The debate about shifting the balance of care is pivotal. One of the reasons why we have come down so hard in favour of the introduction of acute budgets to the integrated resource is that without that, it will be difficult to redesign services.

I will make a slightly wider point. Across the NHS and local government and, indeed, into the third and private sectors, there is a fairly widely shared view that, into the future, there will simply not be enough money to cope with the change in structure of our population and increasing levels of demand. Investing in prevention and reconfiguring how we provide services will all help, but will never eliminate the basic problem, which we will need to address in time. That is not necessarily something that can be solved through the bill, but we want the Parliament to be aware that, over the next decade, we need a solution that is not only about how we optimise the provision of care.

There has to be a fundamental discussion about our expectations as a society, what the relationship between the citizen and the state should be in the future and how we pay for our care. Let us not lose sight of that as we move forward.

The Convener: We heard half an hour ago that the cultural change that is necessary can take a decade or 20 years.

Ron Culley: Yes.

The Convener: How do you square that with what you just said?

Ron Culley: We have always said that we need both. We need to change the way in which we deliver services. That is why we are in favour of integration to ensure that there is closer working between the NHS, local government and our partners in the third sector and the private sector. However, although that is necessary, it is not a sufficient guarantee of change. Alongside that, we need a more fundamental debate about how we fund care in the future, because it is just not sustainable.

The Convener: Does that not play back to Bob Doris's point that the imperative has existed for the past 10 years but the pace did not match the necessity to go forward?

Ron Culley: We accept that half of the argument. We accept that there is an opportunity in the bill to achieve a step change. That is fine, but there is another half of the argument that is not being heard and is being buried. That is, to put it straightforwardly, that there is not enough money in the pot for the future.

The Convener: Does anyone else have a comment? I will take witnesses first, but a couple of members are waiting, too.

Duncan Mackay: In relation to reshaping care and the balance of care of older people, it is important that the committee recognises that the proportion of older people in Scotland who are in care homes is significantly lower than it was 10 years ago. Some partnerships have performed successfully in reducing that proportion to a substantially lower level through commissioning a series of intensive alternatives, or intensive alternatives along with preventive measures—that responds directly to Rhoda Grant's question.

Those partnerships that have pushed the level of older people in care homes down to perhaps 25 people per 1,000—the Scottish average is 35 per 1,000—have reached the position that some activities are beyond our influence. Generally, they lie not in primary care—there is often good, strong partnership working between primary care and community social work services—but in the acute sector. That merits further analysis in the context of the bill.

Typically, people arrive at an acute hospital by one of four routes. One route is to arrive at the door, which raises the question whether they arrived there just because the lights were on, as one report put it, and whether they could have had better access to a general practitioner or other support, advice and treatment that would have prevented their arrival at the door.

Another route is through GPs, who are, as the committee knows, self-employed contractors under the national contract, over which there is limited local influence and no influence at all from a purely local authority perspective. Other routes are through NHS 24, over which local integrated arrangements have limited influence, and through the Scottish Ambulance Service, over which there is also limited local influence. The bill must address how to realise the policy aspirations in the context of those routes into hospital, instead of being silent on that.

Peter Gabbitas: I return to what Ron Culley said. If it is not already obvious, I say that I am passionate about integration and about shifting the balance of care, not least because our clients—or service users or patients—tell us that they do not want care in an institutional setting. If it is possible for them to have care in their home, that is their strongly expressed preference.

I am passionate about integration—I believe firmly in it—but it will not solve some of our fundamental challenges, given the amount of resources that we have and the demographic change that is coming. Integration can make a positive contribution, but it will not solve those fundamental problems. I am keen for us to remain sighted on that.

Ritchie Johnson: I will expand on what Ron Culley said, although I will not revisit the points that he made. A wider question concerns community planning as an approach and the focus on prevention to support shifting the balance of care. I agree with Peter Gabbitas that integration can help us to get in and about some of the challenges more directly, but it will not necessarily automatically solve them.

The change plans are examples of efforts to shift the balance of care. The sustainability of some projects that have been set up as part of that and which are intended to tackle earlier intervention work is still uncertain.

The focus of integration is on adult health and social care, but a range of partners, such as housing, parts of children's services and criminal justice services, which Duncan Mackay mentioned, can contribute to delivering the outcomes. Partnerships will have a formal set of responsibilities, but we must not lose sight of the wider world, which can influence and shape matters. That might come through joint commissioning strategies. Housing is an important element.

12:00

Nanette Milne: I am not sure how relevant my question is to the panel. Peter Gabbitas mentioned community health partnerships. One reason why they failed fairly early was that they failed to engage with GPs. The hope is that that will be improved this time round. We have not heard much about that in evidence so far. The other groups that we have not heard much about so far are carers and the people on the receiving end, who are the reason for the bill being introduced.

What do people round the table think will happen locally? Will the bill help to facilitate an improvement?

Soumen Sengupta: I will try to answer both questions. On the first one, colleagues round the table might have a different view—my position is different from that of Peter Gabbitas, as I am also an NHS officer. Many of the issues come down to looking at the relationship with general practice with regard to the model that Duncan Mackay spoke about. The leadership and management of the current and future partnerships have a responsibility to engage with professionals of all stripes and persuasions, including clinical professionals and GPs.

An interesting conversation is also to be had with the BMA and others about the GP contract nationally and how we create a set-up that obliges all GPs to be part of the discussion, so that it does not include only the ones who are interested in a particular area. That poses certain challenges,

because those staff are colleagues who provide services, so the more involved they are in the "management" of the service, the less time they have available to be part of service delivery.

There are a range of tensions and those are difficult conversations, but it is terribly easy for some of our clinical colleagues to say, "We have not been sufficiently engaged, because something was done that we did not like." There is an onus on all of us to do all this better.

In terms of patients, carers, and service users more generally, I am aware that to an extent the bill is one of a number of pieces of legislation that relate to the partnerships. Another one is the proposed community empowerment and renewal bill, which gives some powers to all public bodies. In effect, it just clarifies powers or obligations that are already in place for everybody in how we work and engage with our local communities. I am sure that everyone round the table will be able to give lots of examples of us working hard to do that, but complaints that we get and complaints that your constituents bring to you show that there are always instances when we could do better.

However, in addition to there not being enough financial resource across the public service, there are a range of different and increasing expectations. That ties in with Ron Culley's point. The issue is how we have a conversation with communities at large about what people are entitled to and should be expected to get from within the total available resources, so that those who need it the most get it, which means that, frankly, other people who are not in as much need might have to wait a bit longer or do not get something to the same extent. We will not be able to avoid difficult conversations, irrespective of whether the new arrangements are introduced.

Peter Gabbitas: Nanette Milne's observation about CHPs and primary care is right. I have recently talked to a lot of GPs about what the integration agenda might offer. As somebody who was responsible for Edinburgh's CHP for many years, I do not think that we effectively harnessed the hearts and minds of GPs in Edinburgh. I recognise that failing and we need to address it. We are doing specific things locally to try to do that, not least of which is the move back to a locality infrastructure with clearly identified managers to whom GPs can relate in a geographical area that makes sense to them. That builds on what we used to have, going back a while, when there were local health care co-operatives.

Also, we have not fundamentally addressed some policy issues. We have recently moved from a national contract to a Scottish contract, but the change is around the margins, because it is still a national Scottish contract and the number of things that we can determine locally is minimal. If we swapped the balance between what is determined nationally and what is up for local negotiation, that would put health and social care partnerships into a much stronger relationship with primary care, because we could pull a lot of levers that we do not currently control.

Having said that, I am sure that, if you took evidence from the BMA, you would find that it was horrified at the thought of moving away from a national contract. It took a lot of persuasion to get the GPs into a Scottish contract, let alone a more local one. However, that would make an enormous difference. Even a bit of change in the balance between the money that is determined at national level in the contract and what can be determined locally—there could be an 80:20 split, for example, with 20 per cent determined locally—would create a reason to get very active with primary care.

I talked a little about end users, but we have not talked about carers. Carers are fundamental. Everyone here knows the numbers as well as I do but, as I have often said, if carers just decided tonight to stop caring, the entire system would crash. We can never do enough to support carers. We are trying to do a lot more, and I am sure that every authority is doing the same. In the past few years my authority has dedicated extra money for carers, on top of any of the national things.

There is another area that we have not talked about and which was not talked about in the previous evidence session, either. So far, the conversation has largely been about two sets of employers: the NHS and local government. We have not talked about the role that the private and voluntary sectors play, which is fundamental. Some 55 per cent of my social care budget relates to external provision. In social care, 55 per cent of the service is externally commissioned whereas, in the health service, about 100 per cent is internally commissioned. That creates issues in relation to how we will develop integration plans. That is an important dimension, which we have not touched on at all.

Ron Culley: I agree with all of that.

We have been critical of elements of the bill, but it promotes a positive idea in respect of locality planning and it will put legislative force behind the approach. That will require health and social care partnerships to give thought to how they organise themselves locally—it is clear that they already do that.

In relation to something that Ritchie Johnson said, we are at a pivotal moment, as we have the bill that we are considering, and the forthcoming community empowerment and renewal bill, which will renew community planning. At the heart of that is not just the superstructure and how we plan

more effectively for localities using the total resource, but how we engage with communities and give life to the principles that Christie set out in his report.

When we engage with communities, whether we are involving general practitioners, carers or others, we must ensure that we do so consistently across localities, to ensure that we do not have a situation in which the health and care people come to talk to the community on Monday, the leisure people come on Tuesday, someone else comes on Wednesday and so on. Community planning has the potential to achieve that. We have always argued that the areas need to be strongly linked. At locality level, we can begin to make inroads into that and see arrangements develop.

Ritchie Johnson: We were asked about the part of service users and patients in all this. National outcome measures will be confirmed, but locally we have asked how we will know that our investment has made a difference, if we have invested in a different set of cultures, with a different set of expectations about services. We are considering how we can ask the people who directly use services what their experience is now, so that we can compare it with their experience in one, two or five years' time—so that we have before-and-after scenarios. For us, anyway, we need to get local intelligence so that we can understand the impact of the investment that we are about to make in the new partnership arrangements.

The Convener: What is in the bill for carers? How will it change their lives?

Peter Gabbitas: I am not aware that there is anything specific about carers. I go back to my starting point, which was on our aspirations for integration. We want to create more joined-up services. Quite often, the carer or the person who receives care has to co-ordinate services in their home. I hope that, as a result of the work that we are undertaking in Edinburgh, we can change that fundamentally, so that we are the ones who co-ordinate care, and we do it far more effectively. I often think about the person who is juggling home care and district nursing appointments, and the variety of people who might go into a person's home. Individual carers should not have to do that, and it is our responsibility to make that more effective and seamless. The bill's aspiration and its policy intent is to try to make that much more joined up and effective.

The Convener: Should the bill therefore say more about carers' and patients' rights? Should there be more positive enforceable rights in the bill to help to change that culture? If we accept that legislation, shifting budgets and working together can do it in part, why not have greater enforceable rights for patients? We had an answer to that in the private session. It was not a very good one.

Ron Culley: You have put me under pressure now. I think that the answer lies in good commissioning practice. Rather than identifying somewhat rigidly what people can expect, we should put our energy into good commissioning practice. As committee members know, that is developing throughout Scotland.

The committee has heard reports in the past that have been critical of commissioning capacity in social work and health, and we recognise that that is an area for improvement. Support for carers must be articulated through the creative use of resources. The idea of disinvesting to reinvest has been mentioned a couple of times. That is about trying to get more money upstream to support carers and the people in their lives and to ensure that carers do not have to draw on formal services, especially the more expensive ones in secondary care.

Good commissioning plans will be able to take us in that direction. Crucially, that will be based on an analysis of local population need and will be able to engage with local groups of carers and other populations. That is where the answer lies, rather than in a fairly rigid articulation of entitlement.

The Convener: That interests me because, when I speak to the people who are involved, they do not like the idea of enforceable patients' rights. That is what encourages me to keep asking the question. We know about the importance of continuity of care in health—that is well established. However, it does not apply in the community, where people can have several carers in and out of their home, including strangers, and different people at the weekends. Why does it not apply? We are talking about the right to be treated by an appropriately qualified person and not somebody who has just been recruited at the weekend.

A number of issues come to us through casework that would not arise in a hospital or other national health service setting, although sometimes such cases do occur. If more people are to be treated in the community and if those people are not protected by the rights that they would have had in a hospital setting, there is an inequity and a worry there. There is a perception that they will get something less valuable and not of the same quality. Unfortunately, in some cases, commissioning and procurement have worked to people's detriment.

Soumen Sengupta is up next, but I am glad to see that Ron Culley wants back in again.

Soumen Sengupta: I just have an observation. There is the Patient Rights (Scotland) Act 2011, so

there are other legal instruments that address that kind of issue.

Picking up on Ron Culley's point about the commissioning plan, that comes down to the quality of leadership and management in a particular area, irrespective of the management structure around the provision of services. Again, the issue is whether we would want that in legislation and whether that is the policy intent. That issue is really down to the calibre of the people who are on the ground providing the service, and how they provide it.

Everyone says that they know the value of continuity of care. At the same time, everyone has talked about scope for innovation. One downside and unintended consequence of being too prescriptive about entitlements is that it negates the scope for innovation in service models, particularly over time and given that needs and resources will vary between areas.

12:15

Ron Culley: I agree absolutely. I understand why people search for guarantees and why it is attractive for parliamentarians and other politicians to discuss the language of guarantees. The challenge is that guarantees create rigidity in the use of public sector resources, whereas the bill's major strength is that it creates flexibility in the use of those resources.

We can look at the total pot and use the money differently, but that is hard if everything is nailed down. That is why I think that, if we ensure that we have flexibility and if we build the capacity to improve in the commissioning agenda—I agree that we have more to do on that—support will gradually improve for carers and other population groups who absolutely require it.

The Convener: We have a focus on what care recipients get. Two years ago, the committee completed a very good report on the care of elderly people, in which we identified issues with commissioning, procurement, the quality of the workforce, what should be expected and how we train and pay the workforce. That is a good read for the holidays.

Malcolm Chisholm: One of the strongest themes in all today's submissions and statements is that acute care and particularly its resources must be centrally involved. That is one of the most interesting aspects of the bill, so I am interested in the model that will be used.

Acute care could be involved in a good way or a bad way. It must be involved, but I know that some in the health service fear that, if we went for the body corporate model and acute care was not part of that, we would be almost in danger of reintroducing a commissioner-provider split in Scotland, whereby 32 bodies corporate would have to negotiate with health boards. We do not want that in Scotland, but we want the acute sector and its resources to be involved. What model do people have in their heads?

The most important thing in health is to shift the balance of care but, if we add up shifting the balance of care and the demography, that shows that we will not be able to reduce in absolute terms acute health service budgets. That applies particularly strongly in Lothian, whose elderly population is to increase massively more than that elsewhere—it is to double in the next few decades.

Peter Gabbitas says that we have step-down beds that the NHS has paid for, but we also have extra acute beds that the NHS has paid for. As we shift the balance of care, we will not be able to reduce acute budgets, because of the demography. That must be taken into account. Some of the submissions suggest that people think that the acute sector will be able to reduce its resources, but I do not see that happening in this part of the world, although it might be able to happen in other parts of Scotland.

In view of those factors, what model do people have in mind for the acute sector's involvement?

Peter Gabbitas: I agree absolutely that we very much aspire to shift the balance of care so that fewer of our resources are used in the acute sector and in institutional settings. There is clear evidence that we are doing that from the national performance indicators. However, given the overall challenges and the demography that we face, it will be incredibly challenging to maintain the acute sector with the number of beds right now.

We have looked at that strategically in our work on a whole-system comprehensive plan. That plan shows that, if the currently rising trend in emergency medical admissions continues unabated—clearly, we do not want that to happen—we will require 800 more beds within the system. The issue is about the extent to which we might be able to affect that gradient, given that it would be an heroic and foolish assumption to think that we could reduce it to zero. Whatever the extent to which all our work on integration, on better unscheduled care, on providing alternatives to admission and on getting people through the system faster reduces that gradient, the gradient will still be there. Therefore, no one should have the notion that massive sums of money could be saved in the acute sector and shifted over into health and social care. Certainly, from all the analysis that we have done within Lothian, that is not the case. However, we want to work collectively to see how we can cope with the

pressures that are already in the system and that will continue over the next 10 to 15 years.

On the question which would be the best model, I do not have the model in my head and I have yet to meet the person who does—it may be that there are such people. I feel that we need to look at the issues in a whole-system way, so the acute sector certainly needs to be around the table and the health and social care partnerships need to have much more influence over acute spending than the community health partnerships had. However, at present I could not move away from that statement to say how we actually do that. We make it work in Lothian, but I could not say prescriptively what the model looks like right now.

Another issue, as Duncan Mackay said in respect of North Lanarkshire, is that whereas matters are relatively straightforward in relation to Edinburgh residents—the vast majority, if not all, of whom are cared for in Edinburgh—our Edinburgh hospitals also support people from East Lothian, Midlothian and West Lothian and, in addition, provide some services for south-east Scotland and certain services for the whole of Scotland. Acute care really has three different dimensions: tertiary specialist care, which health and social care partnerships are not involved in; scheduled care, which we are involved in in trying to influence demand, so the primary care component is important, because it makes the referrals; and thirdly—the three dimensions split into roughly equal thirds—unscheduled care or emergency medical admissions, which is the most important dimension for the health and social care partnerships to be getting in about. I gave an example of such involvement earlier today.

The Convener: Ron Culley wants a minimum share of the acute budget to go to the integrated budget. Is that not the case, Ron?

Ron Culley: Absolutely.

The Convener: Let us hear it then.

Ron Culley: This is a pivotal question, so I will make a number of observations about it.

First, under the body corporate model as that is constructed in the bill, the joint board will be relatively insulated from the two parent bodies. In other words, the bill invests power and authority in the joint board to design a commissioning plan and to see it being implemented. My NHS colleagues are slightly nervous about that because it will be within the gift of the joint board to say that it wants to use the acute sector differently—for example, it might not want to use the acute sector as much. The bill brings together all those collective resources into a single place and allows the joint board to make that type of decision. The fears emerge because the health board will not need to sign off on the commissioning plan.

In other words, the worry is that the budget for the acute sector will be disaggregated—after all, most health boards have more than one partnership within their territory—among a number of partnerships and then reaggregated based on the partnerships' preferred commissioning model and consumption patterns. All of that might not add up to the amount of money that is needed to run the hospitals. That is a genuine issue that we need to get past, but we have been working on it and I think that there will be a solution to it. However, I am also confident that the solution will not be that the acute sector retreats into something else and sits aside from all this. I think that how we use acute resources has to be at the heart of this.

Over the past few years, the work that has been undertaken on the integrated resource framework demonstrates that there is huge variation among GP practices in their patterns of consumption, including in their referrals to the acute sector. The argument is that reducing such variation will free up some capacity to use resources differently.

However, the bigger point—and I think that on this matter Mr Chisholm has come to the same logical conclusion that we have come to—is that because of the population's changing structure, integration in and of itself will not solve this problem. Over time, therefore, we will need to have a conversation about people's willingness to pay for care into their older age.

The Convener: But you are sticking to your argument that we need to take a minimum amount of money out of the acute budget for the redesign to happen.

Ron Culley: Absolutely. We will probably want to look at unscheduled care, or what is known as the emergency pathway, because it eats up about a third of the total resource. That will be pivotal, and we need to explore what that pathway involves. It is not just about front-door and accident and emergency services, but about all the elements of our acute general hospitals that become involved, such as general medicine, psychiatry and so on. Once we begin to think about the issue in those terms, we start to see that a substantial part of the acute budget is in scope.

It needs to be that way, however, because otherwise nothing will change. If we go through the pain of integration and nothing changes, I do not know what we will have done it for.

The Convener: What would a minimum figure be, and who would work it out?

Ron Culley: Peter Gabbitas and I would do it. [*Laughter*.]

The Convener: I am sure you would, but I am also sure that people in the acute sector would not agree with you.

Duncan Mackay: This is such a difficult question to answer and we are all wrestling with solutions. However, any analysis of the problem must start with an examination of the things that can happen only in an acute hospital environment and the things that happen in such an environment that could happen elsewhere. There will be points of clarity at both ends of the spectrum and points of debate and grey areas in the middle. However, if we do not do that, we will start from the quite pessimistic position that we cannot do anything that happens in an acute hospital anywhere else. If we assume that, we will not be able to explore, say, telehealth, the potential of which is untapped in large parts of Scotland and better developed in others. We have to start from the position that I have outlined before we can reach any meaningful conclusion about the organisation of services, and we also have to look at this as part of a whole system of which the acute sector is a critical element.

One of the issues in the acute and primary care sector is that often old-age psychiatry sits in one area and geriatric medicine in another. Many of the people who are supported and treated through the geriatric strand of activity will have significant cognitive problems, dementia and so on and I suspect that, if we got a group of them in a room and tried to guess which side of the house they were being treated through, that would not always be a straightforward task. That quite significant—and certainly challenging—area of potential integration and development has probably been explored more in some health board areas than in others.

In response to the convener's question about what would be a minimum, one could say that it is just geriatric specialties and care of the elderly medicine, but that is a very small part of the service provided by hospitals and, indeed, a very small part of most older people's experiences. Most older people will not go near the specialty—and nor should they. However, things will happen elsewhere in the acute system. Typically, someone with dementia who has been living well at home, often with support from family members or with statutory support, will fall and break their hip. The orthopaedic surgeon who treats them—and who will not necessarily have expertise in and knowledge of dementia—will identify the person as having dementia and will say to the family, "Your mother's got significant dementia. I don't think that she should be living at home." That starts off a whole journey, because no dementia specialist might have been anywhere near that person.

When we start to talk about minimums, therefore, things get difficult. I know that it is easy to set out a general anecdotal position, but such experiences will be familiar to many people who rely on health and social work services. That is the kind of interrogation that we need before we can reach a meaningful conclusion about which parts of the acute system should be included, but I think that if no part of the acute system is included we will struggle to achieve the policy's goals.

12:30

Soumen Sengupta: I very much echo other people's comments, but I think that three other points are worth mentioning. First, I am fairly confident that my NHS acute colleagues recognise such issues; they are not walking away from them and, indeed, are spending a lot of time thinking about them. Certainly in my health board area NHS Greater Glasgow and Clyde has undertaken a substantial clinical services review in order to quantify and grapple with these very issues with a view to reporting later in the year. After all, there are no easy answers to these questions.

Secondly, with regard to existing arrangements or indeed the new partnerships, I cannot imagine any senior management or leadership team having any vested interest in, in effect, fracturing acute service provision. I believe that everyone is acutely—no pun intended—aware of the need to think about not only how these changes are made but how they might work with other colleagues on making those changes. Preliminary scoping work has been undertaken in Inverclyde's community health and care partnership on its relationship with the local hospital and whether there are any opportunities to put things on a positive footing.

Thirdly, I know from work that we have been doing and conversations that I have had with clinical colleagues that an issue that keeps emerging is the relationship between GPs, acting in effect as gatekeepers, and their acute consultant counterparts in other services. To some extent, that ties into Duncan Mackay's comments. If locality planning promises anything, it is the ability to facilitate and strengthen, through the use of information technology and other means, direct relationships and communication between clinical staff working in primary care, including GPs, and our acute clinical colleagues across the board, to ensure that patients are not only supported properly on a seamless pathway but on the right pathway. Of course, that will involve understanding that these people are highly skilled and technically capable individuals who are able to work outwith their own narrow specialties and can exercise quite proper clinical judgments on some of these matters. We simply need to facilitate that.

Ritchie Johnson: It is difficult to define a minimum level of acute service and no one has an easy answer to that question. However, as I said earlier, we need to concentrate on the basic question of what we are doing this for, what we are seeking to integrate and what we want to improve; that might be a way forward and help to inform the debate about which components of the acute service might be better in scope than out of scope. Instead of focusing on the territorial or budgetary components of the issue, we need to come back to outcomes, what will make a difference to people receiving our services jointly, what should be brought into scope and which parts of the acute service would fall into that sector.

The Convener: We have come to the end of the session and I thank everyone for their attendance, participation, views and written evidence. I would like to think that, as far as the evidence is concerned, this is an on-going situation and if you read anything that you strongly agree or—as is more likely—strongly disagree with, we would be keen to hear your comments via the clerks.

Meeting closed at 12:34.

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