The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 24 September 2013

Session 4

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CONTENTS

HEALTH AND SPORT COMMITTEE
27th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rachel Cackett (Royal College of Nursing Scotland)
Claire Cairns (Coalition of Carers in Scotland)
Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
Pam Duncan (Independent Living in Scotland)
Dr John Gillies (Royal College of General Practitioners Scotland)
Karen Hamilton (Borders Public Partnership Forum)
Dr Christine McAlpine (British Geriatrics Society – Scotland)
Ruth Stark (Scottish Association of Social Work)
Gabrielle Stewart (Allied Health Professions Federation Scotland)
Dr John Taylor (Royal College of Psychiatrists in Scotland)
Dave Watson (Unison)
Ian Welsh (Health and Social Care Alliance Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 24 September 2013

[The Convener *opened the meeting at 09:46*]

Subordinate Legislation

Fish Labelling (Scotland) Regulations 2013 (SSI 2013/254)

The Convener (Duncan McNeil): Good morning. I welcome members and the public to the 27th meeting in 2013 of the Health and Sport Committee. As usual, I remind those who are present to switch off mobile phones, BlackBerrys—I do not know whether BlackBerry is going to be around for too long, so we will need to change the script—and other wireless devices, as they often interfere with the sound system. Members of the public may notice committee members using tablet devices instead of hard copies of our papers.

We again have apologies from Richard Simpson, and Malcolm Chisholm again joins us as the Labour Party substitute.

The first item on the agenda is subordinate legislation. We have three negative instruments to consider, the first of which is the Fish Labelling (Scotland) Regulations 2013 (SSI 2013/254). No motion to annul has been lodged, and the Delegated Powers and Law Reform Committee has made no comments on the instrument. Do members have any comments on it?

Members: No.

The Convener: Does the committee agree that we have no recommendations to make on SSI 2013/254?

Members *indicated agreement.*

Glasgow Commonwealth Games (Enforcement Officers) Regulations 2013 (SSI 2013/258)

The Convener: The second instrument before us is SSI 2013/258. No motion to annul has been lodged, and the Delegated Powers and Law Reform Committee has made no comments on the instrument. Do members have any comments on it?

Members: No.

The Convener: Does the committee agree that we have no recommendations to make on SSI 2013/258?

Members *indicated agreement.*

Glasgow Commonwealth Games (Games Locations) Order 2013 (SSI 2013/259)

The Convener: The third and final instrument is SSI 2013/259. No motion to annul has been lodged, and the Delegated Powers and Law Reform Committee has made no comments on the instrument. Do members have any comments on it?

Members: No.

The Convener: Does the committee agree that we have no recommendations to make on SSI 2013/259?

Members *indicated agreement.*

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

09:49

The Convener: Agenda item 2 is continuation of our evidence taking for stage 1 of the Public Bodies (Joint Working) (Scotland) Bill. I warmly welcome our first panel: Claire Cairns, network co-ordinator, the Coalition of Carers in Scotland; Pam Duncan, policy officer, Independent Living in Scotland; Ian Welsh, chief executive of the Health and Social Care Alliance Scotland; and Karen Hamilton from the Borders public partnership forum.

In the interests of time, we will go directly to Rhoda Grant for the first question.

Rhoda Grant (Highlands and Islands) (Lab): One of the criticisms of the bill is that it concentrates on bureaucracy instead of principles and outcomes. Is the bill sufficiently well drafted to allow the meaningful involvement of carers and service users and, if not, what could be added to make that happen?

Pam Duncan (Independent Living in Scotland): First of all, thank you for the invitation to give evidence—we very much appreciate it. I also want to say at the top of this evidence session that disabled people welcome the integration of social care and health services, in the hope that it will result in seamless service provision.

The bill’s principles are good but could be strengthened to make a clear statement that integration is about the delivery of services for people and those people’s experiences. As a result, we suggest the inclusion of something akin to the independent living principles that were added earlier this year to the Social Care (Self-directed Support) (Scotland) Act 2013. Health and social care are absolutely essential material supports for disabled people to participate in society and lead an ordinary life, as without them many disabled people simply cannot participate in society. I could not have got out of bed this morning, never mind come here to give evidence, without good social care that is accessible and which I can control. Equally, the health services that I access as a disabled person are essential for me to live and cope with my condition.

In short, given that these matters need to be considered in the context of equality and human rights, and given our fundamental belief that health and social care infrastructure is essential to the delivery of equality and human rights for disabled people, we think that the Scottish Government could really put its head above the parapet and lead the way in Europe by including in the bill a provision that specifically related health and social care to disabled people’s right to participate in society and lead an ordinary life.

Ian Welsh (Health and Social Care Alliance Scotland): As the committee knows, the bill will be a piece of enabling legislation, which means that there is much that is not in it. One thing that ought to be in it, however, is the determination to apply human rights principles, and we and our partners will certainly bring forward an amendment to that effect. The legislation setting up the Scottish Parliament enshrines human rights legislation, but we believe that our proposal will embed that even more in the Scottish context.

The commitment to health and social care integration as described in the bill is absolutely the right thing, and the Cabinet Secretary for Health and Wellbeing has shown exemplary commitment to it. In saying that, I should add that we are not members of the same party. However, to come back to Rhoda Grant’s question, I think that the challenge will emerge back in the places where action is going to take place—in other words, the health boards and the nascent health and social care partnerships.

There will be a default position in which structures and budgets take prominence, but the jury is out on whether the new health and social care partnerships will get to the point of putting in place the vast array of supporting guidelines that pay significant attention to the rights of carers, disabled people, people with long-term conditions and the principles of co-production, putting people at the centre of services and indeed fundamentally redesigning services in the context of public service reform. The bill’s strength is that it offers the local partnerships the flexibility to get on with integration but, in my view, its weakness is that the health and social care partnerships might simply default to a bureaucratic transition.

Pam Duncan talked about seamless transition. When I was in local government, we always used to talk about seamless transitions. The danger is that we get a seamless transition and do not get a fully thought-out approach to the philosophy of delivering services locally in a new way—not just a cheaper way, but a much more inclusive way. In my view, that opportunity will be lost if the new health and social care partnerships do not go beyond the words in the bill and are not encouraged by the supporting guidelines to make the third sector, in particular, and the individual full partners in the process.

Does that help to answer your question?

Rhoda Grant: We will have to amend the bill to make it work properly. You say that the guidelines and, I suppose, the sentiment behind the bill are moving in the right direction. How can we amend the bill to make it focus on the things that you say are important? That is the challenge for us.

The Convener: It would be helpful if witnesses could go through the chair, because Claire Cairns and Karen Hamilton may wish to respond to the first question. I do not know whether you do—do not feel any pressure to do so if that is not the case—but it would be helpful for the committee if you could respond to Rhoda Grant's first question.

Claire Cairns (Coalition of Carers in Scotland): That is great—thanks.

We, too, welcome the bill's focus on outcomes and the principle of strengthening the involvement of carers, but we think that it could be strengthened in various ways. When the first proposals on integration came out, we held quite a lot of consultation with carers. They felt that, for integration to be successful, it was absolutely essential to have not just carer engagement but meaningful carer engagement, and a move beyond involvement towards co-production. There are several ways in which that could be strengthened, perhaps not through changes to the bill but in the development of the guidance and regulations.

One suggestion that carers made was that carers should be recognised as equal partners. They are recognised as equal partners in the carers strategy and as partners in care in the Community Care and Health (Scotland) Act 2002. It is important that reference is made to that in legislation, or certainly in guidance and regulations. It is important to realise that carers are also service providers, so the extent to which their views are taken into account needs to be equal to the extent to which the views of paid workers are taken into account.

One comment that was made in our consultation was:

> "If integration embraces carers it should get better but it won't if it is an afterthought."

It is all about ensuring that carers are involved in all the structures from the top down. At the moment, there is a question mark over whether carers will be represented on partnership boards and whether they will have voting rights. I know that that has been discussed. Carers overwhelmingly want that, but it requires to be resourced. There is a lot of talk about resourcing the third sector to get involved, but there is little mention of resourcing the involvement of carers and service users, which is essential if engagement is to be meaningful, as carers keep saying that it needs to be.

When we talk about carers, we are talking about a wide community of people. A carer could be a young person or an older person who is looking after a partner, and they could be dealing with a range of illnesses, disabilities or other conditions. It is quite difficult to capture their views and to feed that information into the process, and that needs to be resourced. We have put together best practice engagement standards. Our way forward would be to use the expertise that already exists in carer centres and to have a network of forums that representatives can go back to as a community of carers and feed their views through. However, as I said, that will need to be resourced.

There are other ways to strengthen things. Ian Welsh mentioned co-production rather than consultation. It is extremely important that, like other key stakeholders, carers feel that they have ownership of the process and that they are at the table from the beginning and not just as an afterthought. We also recommend that they should have a role in signing off the plans, for example through a local carer organisation. There has been talk of interface organisations signing off the plans, but we also see carer organisations having that role.

Another quote from our consultation was:

> "Good to talk but more important to be listened to."

We heard that a lot. I know that, as integration goes through in the bill, a lot of the process will be about looking at the guidance and regulations, but I think that it is important to have this discussion and to give thought to such matters from the beginning.

The Convener: I ask Karen Hamilton whether she wishes to respond.

10:00

Karen Hamilton (Borders Public Partnership Forum): I do not think that I have anything to add to what my colleagues have said.

Rhoda Grant mentioned bureaucracy in her first question. I can appreciate that a bureaucratic framework is part of the process. I do not want to support that, but if we do not put the relevant structures in place and people do not know, for example, who they are responsible to, who they are accountable to and how the chain of command works, I do not think that the process will succeed. One of the issues with previous attempts has been that issues such as who holds the resources and how funds are transferred have been a bit muddy. It is bureaucratic, but up to a point it probably needs to be to make the system work.

Ian Welsh: We will all bring forward a range of amendments. We would suggest, for example, that insufficient engagement should be grounds for ministers not to approve the integration plan. That would be a mechanistic way for ministers to ensure that the local partnerships—many of which have first-class engagement plans—are held to account for lack of engagement. We will bring forward an amendment on that issue as well as on others.

The Convener: I ask Pam Duncan whether she wishes to comment.

Pam Duncan: Thank you for giving me a second opportunity on the same question. As members can probably imagine, we have a few suggestions on how the bill could be amended. One is specifically to lift text from the United Nations Convention on the Rights of Persons with Disabilities and include it in the considerations in preparing integration plans in section 3 of the bill. We have given a bit of thought to how that could fit in nicely. As I said, that would be a good step for Scotland to take to show that it takes human rights seriously and puts people rather than bureaucracy at the front of health and social care.

I will make two other points. The first is on portability and the principles of the bill. If the bill is about the individual, it would seem odd if there were any barriers to people moving around between local authority areas, particularly given that, in the new integrated systems, we could have 32 different systems with, for example, one health board covering two or three different social care areas or local authorities. There is an opportunity to iron out some concerns that disabled people have quite frequently raised about the impact of moving from one local authority to another. Unless we take the opportunity to address the issue, there is the potential for quite a lot of confusion. We have ideas about how we could strengthen the bill in that area.

We have recently published a toolkit called “All together now”, which is about working in co-production with disabled people and which has been endorsed by the Cabinet Secretary for Health and Wellbeing as a useful tool to have in the box to make the integration plans work. As Ian Welsh said, we want that to become an integral part of whether the plans are signed off. We think that the toolkit could help people to get it right and to engage with the process.

The Convener: We are familiar with many of those themes, but the hard question for us is: what is there in the bill that will deliver on the recurring themes that we have heard from you in the past? How will the bill deliver the outcomes that you want? How will it bring about a shift in power from local government and health boards?

Ian Welsh: That is a big question. I speak as a seasoned campaigner who has worked locally—I sit on the health board and, as you may know, I used to lead a local council. Some of you sitting round the table will have seen successive initiatives over the past 14 years from local health care co-operatives onwards. As Karen Hamilton said, the difference is that there will be a consolidated budget. There will be a real pool of money—it will not be kid-on money—and there will be a statutory responsibility.

The words in this enabling bill reflect the Christie principles. They reflect the requirement for public service reform, they insist on personal outcomes for people and they insist on co-productive techniques.

The challenge is that, when we move from the centre to the periphery—although that is not the periphery but the centre to those who serve such communities—there is an overwhelming requirement for culture change, which can happen only through action. For example, health boards and local authorities are bridling a bit about the third sector’s requirements for plan sign-off, and I know that MSPs will be concerned about that as well, because there is a statutory responsibility. Where we have had collective sign-off for change fund plans over the past three years, we have had quite a significant change in the culture of how local officials work with their partners. The sign-off of plans is not a power thing for the third sector; it is a mechanism to get collaboration and culture change in services.

I have referred to the supporting guidelines. I take Karen Hamilton’s point that we need a bureaucratic structure. The problem with structural reorganisation is that, although it provides a chance for a year or perhaps two years to change how we operate, if we seamlessly continue to do what was done before, we never get the engagement with change. However, there is loads of good practice across the country in different pockets. East Renfrewshire provides a good example, as it already has inclusive working and co-productive working, with carers at the table and disabled people discussing their services. East Renfrewshire is also looking at moving from downstream investment to upstream preventative action.

I am sure that there will be loads of amendments to the bill to produce a good piece of legislation, but the challenge for all of us will be to ensure that the local partnerships do not become enmeshed in simply meeting the budget. If that happens, we will not get the transformative change that is required.

Claire Cairns: As I said, we consulted carers on integration. It was interesting to get their views about integration in general and whether it would improve their lives or have a negative impact on them. There were positive and negative views about the impact of integration. About 52 per cent thought that things would stay the same; 33 per cent thought that there would be an improvement;

and 14 per cent thought that things would get worse, for a variety of reasons.

When we looked at what carers thought would make integration successful, a few key points emerged. We have said that engaging carers in the new structures was the number 1 point. Another issue was co-producing plans and ensuring that people have ownership of any decisions that are made. As Ian Welsh said, another point was ensuring that people are at the table for signing off plans.

A very big issue was ensuring that resources are directed towards carer support. A lot of the policy integration—in reshaping care for older people and so on—is looking at shifting the balance of care, shifting resources from acute services to the community and having people stay at home longer, living independently. That really requires the involvement of carers. If we do not provide resources for carer support, that will have a hugely negative impact on carers' health and wellbeing. If we are saying that more care needs to happen at home, in the community, it makes sense to direct resources towards that.

As Ian Welsh said, there have been really good examples through the change fund. As members probably know, 20 per cent of the change fund had to go towards carer support. That acted as an excellent catalyst for developing new services and ensuring that carers were integrated into the process and that developments took their needs into account. We would like something similar to happen with integration, to ensure that carer support remains a priority.

The big one that a lot of carers mentioned was culture change and leadership. A lot of people said that whether integration would work would be down to not processes but individuals. That is about all the partners working together and being committed not only to the process but to making the engagement and co-production meaningful. That means embracing people coming into what some might see as their territory and being prepared to listen to and involve those people.

Karen Hamilton: We have talked about third sector involvement. I will highlight a risk that might exist. A few weeks back, I attended a third sector involvement session down in Melrose. It was well attended, with people from probably 60 or 70 organisations coming together. The feedback from that was that it is difficult to integrate the third sector and have people speak with one voice. People articulated that themselves. There are sometimes commercial conflicts and different principles.

Although I welcome the fact that we are involving the third sector in the process, I note that there is a risk—it is a watch point for the committee—in that we should not assume that the sector has a single voice or is a single body. There are a lot of people with conflicting views and we should not gloss over that.

The Convener: They have all been here to give evidence as well.

Pam Duncan: I will make a similar point. Disabled people sometimes suffer from what we call majoritism. It is difficult for seldom-heard voices to make their point through things such as the third sector interface, because it attempts to represent a large group of local people. Throughout our engagement exercises, disabled people told us that they and their directly accountable organisations must play a key part in looking not just at the outcomes but at how money is spent and how policies are developed from the start of integration right through to monitoring and evaluation.

Many disabled people's organisations are operating at below a critical mass. We are saying that we really need to be engaged, and disabled people are innovative because they have to be. When I get out of bed in the morning, I need to think of solutions to a lot of problems. Health boards, local authorities and others in our society could draw on that. However, that needs to be resourced and supported, and many disabled people's organisations are struggling with that.

Section 26 of the bill contains a commitment to reimburse expenses for people's involvement, which is important, but it should also be recognised that something extra is needed in the resourcing of community-based organisations, and not just the wider third sector, for them to become accountable and give input on plans. We go further and suggest that ministers should recognise disabled people's organisations. The bill states that ministers will recognise organisations that they think are representative. We argue that DPOs, as directly accountable organisations of disabled people, should be considered throughout the bill in that respect.

Richard Lyle (Central Scotland) (SNP): Good morning. It is nice to see you again, Pam. Sorry—I am not singling you out.

I return to the point that Claire Cairns made about the percentages. It was interesting to read all the submissions, and the issue that I will raise runs through all of them. The Coalition of Carers in Scotland's survey asked:

> "Should carers have a guaranteed place around the table in the new integrated structures?"

and 100 per cent of respondents said yes. In fact, there are eight yeses in the response—it sounds like "The Vicar of Dibley".

Ian Welsh stated:

> "As proposed, Health and Social Care Partnerships will only be accountable to health boards and local authorities. There is a risk that the proposals for integration ... will represent a backwards step. The third sector and people who use support/services should be included within membership of Integration Boards".

Do you feel that you should all have a seat at the table and be involved under the bill to ensure that you have what Pam Duncan called for earlier—a voice?

Ian Welsh: Absolutely. To take Karen Hamilton's point, I note that, as a collective, the third sector in Scotland is massive. It is fair to say that it is hugely misunderstood. When you all go back to your constituencies, I bet that you find a different third sector organisation every week. The sector has a massive reach.

The sector is not unorganised. In the evidence that the committee took from the Scottish Council for Voluntary Organisations and the Coalition of Care and Support Providers in Scotland last week and in the evidence that it will take from other strategic intermediaries, such as us, it will find a significant common thread on the requirements for giving a voice to carers, disabled people and third sector organisations that aim to put people at the centre of services. In that regard, I disagree with Karen Hamilton.

10:15

Emerging from the chaos or the maelstrom of activity that sometimes happens in Scottish public life is a requirement for every local partnership to have a third sector interface that is tasked with providing some kind of voice. There is a mechanism locally and nationally to give a much more unified voice to the third sector and carers.

Integrated boards are required to take care of business such as the transfer of staff and the structures quite quickly. However, when we move beyond Christmas and head towards April, local healthcare and social care partnerships will be required to walk the walk. It would be a poor thing if they did not.

There should be a disabled person presence and a carer presence. The concerns about that in statutory terms—in sign-off terms—are vastly overstated. I do not recall many occasions, even in my local authority life, when we have been divided significantly over budgets in health and social care. It would be a huge signal of inclusiveness for health and social care partnerships if those people were given a voice. Having one representative of the care in the community sector, one representative of the disabled population and one third sector representative against maybe eight statutory sector representatives seems reasonable to me.

The Convener: What is more important to securing an improved outcome for individuals—having those individuals on boards or having a human rights focus to every decision that is made? Is one option exclusive of the other?

Ian Welsh: Pam Duncan can answer first.

Pam Duncan: Thank you for deferring to me—I appreciate that, as I was eager to get in.

I do not think that the two aspects are mutually exclusive; I think that one is needed to guarantee the other. Under the Scottish Human Rights Commission's approach to human rights principles—the PANEL approach—the first word is "participation". We cannot have one without the other. It is really important to include the representatives whom Ian Welsh described as key partners in order to deliver on the human rights aspirations.

Rhoda Grant: Are you saying that, rather than have someone from the third sector interface on a board, you want carers, service users and service providers separated out, so that each can express their voice individually on behalf of the group that they represent?

Claire Cairns: Yes.

Karen Hamilton: Yes.

Pam Duncan: Yes.

Nanette Milne (North East Scotland) (Con): I will touch on the Social Care (Self-directed Support) (Scotland) Act 2013. People who have spoken to us have wondered how self-directed support will work once the services have been integrated and budgets have been pooled. The SCVO has said that self-directed support is probably vital to the working of integration. What effect will the proposed new arrangements have on self-directed support? Will they help it or hinder it?

Pam Duncan: We have asked similar questions, because we are not 100 per cent clear—I am not sure that the bill is 100 per cent clear—about how those things will work. We have always said that people should be able to apply the principles and practices of self-directed support when they exit hospital to access services in the community, and that should continue throughout.

We are integrating two systems. One is based on eligibility and is free at the point of delivery—the national health service—and one is based on eligibility criteria that are broadly outlined nationally but are, in effect, determined locally. Most cash-strapped local authorities are delivering according to high-level criteria, so that is literally life-and-limb provision. That, too, will have a huge impact on the provision of more care in the community.

If there is to be more care in the community—which we support—the situation needs to be looked at, because we do not want to unblock a bed in hospital and allow someone to go into the community if they are only going to get up in the morning, get fed, have their bum wiped and go to bed at night. We want social care that is much more than that. There are many questions about how SDS will fit with that and, more broadly, how social care will be delivered in the future, given the funding crisis that local authorities and social care services are experiencing.

Throughout the engagement events that we held, we heard from disabled people that there is a large amount of unmet local need for social care. One way to make SDS work well as part of an integrated system—there is a vision and we can see that it can work—would be to start recording unmet need so that we know what is missing. Until we do that, I do not think that the local partnerships that come together will be able to determine how much money is needed for social care or for healthcare. To get to that point, we need to start recording unmet need.

That was a slight diversion from Nanette Milne's question, but there are a number of questions about how SDS will work.

Ian Welsh: I agree with everything that Pam Duncan said. However, there is no indication that the situation will worsen; the question is how quickly SDS needs to be accelerated. That is partly down to resources, but it is also partly about answering a larger question. SDS is focused almost exclusively on social care, but there is a developing argument about applying SDS in health settings as well.

Some good work is being done in Scotland, and my organisation has an officer who is looking at self-directed support in health settings. I nearly said that the challenge is to take the fell hand of accountants off health budgets, but I do not quite mean that. At the moment, health budgets are locked in a particular paradigm, but come the day, come the hour, maybe a third of a health board's budget will be located in health and social care partnerships. In that setting, there will be the opportunity to look at SDS in a different way.

I hark back to my original point. Health and social care partnerships and the statutory agencies need to look at integration as an opportunity to refresh and reform the way in which they think about things. They are locked into crisis management of budgets and timetables for delivery, and they need a bit of space to do fresh thinking about what policy and practice mean in the 21st century. If they do not get that, we will not see an acceleration in SDS for social care or any innovative approaches to SDS in health settings. My plea is for the new health and social care partnerships to look at health and social care services through a new prism.

Nanette Milne: Both those responses are helpful. Since care in the community was introduced, it has been recognised that it is not a cheap option and that, to work properly, it requires resources. I agree with Ian Welsh's point about the need for a culture change in how things are looked at. That is perhaps the only way in which SDS will work. It is helpful to have that on the record.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): The discussion has probably moved on a bit since I first indicated that I wanted to come in, because I was interested in the mechanisms for embodying the bill's principles. I completely agree that the principle of co-production should be in the bill, but I was wondering about the mechanism for ensuring that that happens. In that respect, Ian Welsh's comments about who should be on the board were helpful.

I was also wondering about the current mechanisms, one of which is the public partnership forum, which has not been asked about. You want the principles in the bill and people on the board—which is fine—but will those other mechanisms still exist? I presume that the third sector interfaces will remain, but do you still find the public partnership forum, which I note has been commended in two of the submissions, to be useful? How will all that fit together? Do we simply need a multiplicity of forums and mechanisms to ensure that this happens?

Karen Hamilton: At the moment, PPFs are a bit at sea because there is some confusion about where they fit in and, indeed, about how representative of the public's views they are. As they tend to be made up of people with vested interests, one might argue that their views are skewed. The PPF that I represent really does not know what the situation will be and has not been able to identify in the legislation as drafted any guidance or information on where it will fit into the new health and social care partnerships.

Moreover, although the PPF has various subgroups such as patient reference groups, we are concerned that we do not have reasonable representation from the carer population or particularly good representation from young people. There is an opportunity to look again at the formulation of PPFs and the role that they might play in the new partnership set-up.

Claire Cairns: We undertook a project in the Highland pilot area, when it was moving towards integration, on how carer engagement and structures for such engagement worked there.

What we found—and I think that this is typical of most areas—is that the environment can often be confusing and cluttered. As well as public partnership forums, there are often quite a lot of specialist forums or groups and it is difficult to discern where decisions are made, where information is going, where the flow is and whether discussions on particular subjects make it to meetings at which decisions are made about budgets or service development.

Whatever the new structures are, they must be meaningful and we must not ask too many carers to be involved in too many groups. Carers want to be involved in meaningful groups that make the decisions; they want to be listened to; and they want to be resourced so that they can attend not only those meetings but meetings of their carer forum or group to allow them to bring forward information from that reference body of carers.

Those are the lessons from the Highland experience. They kept a lot of structures and just added new ones on top of them, which put quite a lot of strain on people's involvement. People want to be involved in the decision-making process but, as I have said, they want to ensure that their time is well used.

Ian Welsh: We talk about moving to new structures but the fact is that the world is messy. Going back for a moment to the archaeology of all of this, I note that the Scottish health council was tasked with setting up public partnership forums for the health service and did so diligently; it is also responsible for monitoring how well health boards deliver that mechanism. Although Karen Hamilton's points about representation on the forums are properly made, I have to say that the NHS still has an active participation network that serves its purpose relatively well and which in some areas is excellent—although in others perhaps less excellent. Moving to a new structure that brings another tranche of services to the fore and which contains a different participation network will be a challenge.

10:30

To answer Malcolm Chisholm's question, I think that what will happen, practically, is that the existing structures will be mapped on to the new partnerships for a while and something will emerge. I know that the Scottish health council has designed an inclusive new model, but I think that, in the first instance, the public partnership forums will be mapped on to the new health and social care partnerships.

I go back to my first point—there will be a requirement on the new health boards to look at engagement. There are engagement guidelines; Pam Duncan referred to them. The Scottish Community Development Centre has developed national standards on community engagement, which are applicable here, but it is not a tidy world. Over the next year and a half, work will have to be done to build new participation methods. As I said earlier, in the first two years there will be a focus on building something new and much more inclusive.

Pam Duncan: In the same way that we would not ask a men's organisation to represent women, we believe that it is fundamental that disabled people's organisations can represent disabled people. On that basis, we think that it is extremely important that their ability to engage with the structures that you have described or the third sector interface is strengthened because, in times such as these, it is difficult for organisations to grow their capacity to do that.

We believe that, by taking a social model approach to health and social care—as we do—disabled people's organisations will be able to offer a broad view of the real impact that health and social care can have on people's lives, the difference that it can make to their participation and the crucial role that it plays in relation to their human rights and their being equal in society. It is important that such a broad view is taken, particularly when we are looking at the preventative agenda, which, as well as being about treating conditions and providing care and support, is about enabling disabled people and other service users in health and social care to lead an ordinary life and to play their full part in the community. I think that DPOs have a unique lens through which to provide key invaluable information and engagement.

Malcolm Chisholm: Thank you—that is helpful.

I have one more question, which I think goes to the heart of the matter in a slightly different way. Ian Welsh said that one third of the health board budget would go into the health and social care integration arrangements, but he also said that there was a significant common thread between his evidence and that of the organisations that we heard from last week.

I do not know whether you followed last week's proceedings, but I think that at least two out of the three organisations on the panel to which you refer were very concerned that minimal amounts of money would be put in by health and, possibly, local government, and they suggested that there should be more national direction on that. In fact, I think that at least one of them, if not two of them, suggested that budgets for the bodies should be set nationally. What do you think of that suggestion? If you do not support it, how can you ensure that the appropriate sum is put in, given that some people are concerned that the acute sector in health, for example, will put in very little?

Ian Welsh: I do not always agree with SCVO or CCPS. Sometimes, that is partly because I am still involved locally. The approach that is taken will vary. There is a tension between central direction and local control. MSPs will be more aware of that than any of us. My view is that health and social care budgets should be decided locally. As a former elected member, perhaps I would say that. There is also a tension to do with the extent to which acute care money is allocated to the budgets; the approach to that will vary across the board, too.

To put that in context, the bill is enabling legislation; it is a piece of partnership legislation. Therefore, the budgets that go in will depend on how good and trusting the local partnerships are. Already, the approaches vary. For example, at least one of the local authorities in Ayrshire is putting in some of its children’s services, while other authorities are not. I do not agree with my colleagues that it is all about packing in additional resources. It is about maximising the best outcomes for the local population.

Pam Duncan talked about unmet need. Sometimes, scant regard has been given to trying to meet population need in the localities. To me, that is an important part of the process. My son is disabled and I am a carer but, to be honest, my interaction with the health and social care systems is minimal. My son is 30 years old and he kind of strolls through without making an impact or getting any significant support in any shape or form. So a local response to circumstances is needed.

It is not all about resources, but it is about partnership. Another dimension that we have not even talked about is the issue of locality planning and how general practitioners face their communities. I see that John Gillies, who is on the next panel, is sitting behind me in the public gallery. Fantastic work is being done in localities to link the community to GP practices in a much more significant way, and that needs to be part of the landscape. My view is that it ain’t all about money, but it is all about how people work in partnership locally.

Pam Duncan: I agree that it is about using resources differently as well as how we address some of the unmet need. That might involve new resource, or it might be solely about how we use the existing resource differently. Ian Welsh’s point about variability in local partnerships’ approach takes me back to my earlier point about having the principle of portability in the bill. Although variability and local decision making are important—I could not possibly sit here today and advocate, as I have done, that disabled people need to be so deeply involved without recognising that decisions need to be made at community level—that should never come face to face with someone’s human rights.

For example, the system should not make it almost impossible for someone to move from one area to another or, as could end up being the case, from one street to another. That is why I again make the point strongly that the bill should include a provision on portability so that end users do not experience significant disadvantage if they choose to move around for education or employment or just because they fancy a different area. It is important to put that in the bill, particularly given the issues that Ian Welsh has described.

Claire Cairns: When we look at the issue, it is useful to look at the initiative on reshaping care for older people—obviously, it is a front-runner on integration—and some of the lessons that we can learn from the change fund and the move towards joint strategic commissioning. In some ways, decisions were a bit easier with the change fund, because it was additional money and it was all about pilots to start to deliver some of the principles behind integration and preventative services. However, when we start joint strategic commissioning, we are asking people to be incredibly brave, because we are asking them to look at money in a different way and to start to consider where to disinvest in services. Currently, partnerships really struggle with that.

I was involved with a joint improvement team in a review of joint strategic commissioning plans to see where carers fitted in. Across the board, the review found that the plans could have been braver on disinvestment. There was little mention of that and very few solutions had been suggested on shifting money from acute services into the community. That is where areas will struggle. Decisions will have to be made on how directive to be and on whether to say how much money needs to go into the pot or whether decisions can be made locally. From the experience of the reshaping care for older people initiative, it seems that there will definitely need to be encouragement for partnerships to be brave. It is difficult for them, because the decisions have to go through local authority decision-making processes that involve accountability to councillors and so on. Those things quite often hold people back from making brave decisions.

Karen Hamilton: I was going to talk about the different structures and accountability processes, but I will go back briefly to where PPFs fit in. Ian Welsh mentioned that, for a couple of years or so, they would be mapped into the new system. A watch point is that we do not lose that golden opportunity to improve them, make changes, make them more effective and broader, and so on. If we do not do that in the early days, there is a danger that they will get lost and wither on the vine.

Some of the submissions mention guidelines, which are missing at the moment, as are overarching principles. Many things that we have talked about today could be fed into overall guidelines and principles, and I make a plea not to forget that as a principle in terms of public representation in the new bill.

Mark McDonald (Aberdeen Donside) (SNP): I note the comments about who should be around the table. The more people who come to the committee and say that they want a seat at the table, the more I think that some of those integration joint boards will need pretty big tables. However, I take on board the points that have been raised.

At our previous committee meeting, the representatives from the third sector were quite clear that they saw their role as being part of the strategic planning side of things and that they would take a step back when it came to the commissioning of services. Where do you see the organisations that are relevant to your interests fitting into their role if a seat around the table was to be afforded to them? Would they fit with the strategic planning, the commissioning, or both? How do you see that working?

Ian Welsh: I am not sure that Annie Gunner Logan would agree that CCPS, for example, would simply be involved in the strategic dimension and that it would then step back. A significant piece of work is being done by the joint strategic commissioning committee and I am sure that the evidence from that will be fed into the guidelines.

Beyond that, there is a tension between the definition of commissioning and the definition of procurement. For those of us who have been around quite a while, the move in the early 1990s—I cannot remember the date—to compulsory competitive tendering led to a public procurement regime. What happened then, certainly in social care, meant that much of the social value of procuring a service lost out to cost. I cannot speak for Pam Duncan but I speak for myself when I say that we ended up with the obscenity of e-auctions for domiciliary care, for example. Local authorities were constrained by that regime.

A much more sympathetic response to commissioning would be to design a service with service users and private sector and third sector organisations that have developed expertise in the work against a background of the public health requirements for a locality. A much more nuanced approach is coming. If we go back to local authorities or health boards now, we see people who procure services rather than people who commission services. Reshaping culture and values when we design services will involve bringing organisations in, rather than having them compete across a table.

Mark McDonald: I would be interested in hearing any other views before I ask the follow-up questions that arise from that.

10:45

Pam Duncan: We need to be clear that it is not just about saying, “We would like to have a seat around the table, too.” It is about understanding the value of listening and engaging with different people in order to get it right, which is really important. That is probably why everybody is saying that they want to be at the table. There is also a nervousness about who will represent people at the table and put their views across. It is not so much about the size of the table as about how representative the table is. We need to get the representation on the table right and convince local people—I mean communities as well as communities of interest such as the LGBT community and so on—that the mechanisms for engagement with that table are strong. It is less about the size of the table than about how we resource the representation around it.

Karen Hamilton: A third element, in addition to the planning and commissioning of care, is scrutiny. I think that that is what we are talking about. The people around the table do not need to be the planners or commissioners, but they certainly need to be the scrutineers who ensure that the services are being delivered effectively and economically. It is important that we recognise the scrutiny role of those around the table.

Mark McDonald: I come to this from a similar perspective to Ian Welsh’s in that I, too, am a parent carer and understand the interactions that take place. I have two follow-up questions. First, does the role that you envisage necessarily require a seat at the table? Is there another way in which the function that you seek can be carried out without there needing to be something in the bill about it? Reference has been made to having something enshrined in the guidance and the regulations.

Secondly, how would you ensure that, as you put it, the right organisation represents people? In my constituency, a range of organisations provide similar services in different localities. How can we ensure that we have the right voice at the table, so that people do not feel that they have been unnecessarily excluded?

Ian Welsh: In every health and social care partnership, there is a third sector interface that is charged, in part, with signing off the change fund, for example. That would be the logical third sector representative.

A secondary issue that is implicit in your question concerns the cluster organisations that are out there. In my view—I am speaking from a practical point of view—every health and social care partnership should fund an engagement officer who sits within the third sector interface and is tasked with working with the partnership's officers to ensure that there is coherent and consistent representation through the various working groups that are set up to look at services. The cost of that person's salary and the on-costs would be, say, £50,000 out of a potential health and social care partnership budget of about £150 million. That would be one way of getting coherent and consistent activity. Pam Duncan and Claire Cairns may have another view, from a carer's perspective.

Pam Duncan: At all the consultation events that we held, our members said consistently that they feel that they need to be represented around the table. That is partly a response to the historical oppression that disabled people have faced in society and a fear that—to use a phrase that I heard recently—if you are not at the table, you are on the menu. That may sound controversial and antagonistic, but I do not mean it to be.

It is important that disabled people who use the services on a daily basis are able to bring the unmitigated voice of that experience to the table. That is why I would advocate strongly for having disabled people's organisations around the table. They are directly accountable to their members locally and can bring the unmitigated voice of experience to the table.

The fact that they are disabled people means that they have to navigate barriers and problems in society and find solutions on a daily basis. Health and social care partnerships should want to bring those factors on board, but not just to tick a box and say that they are including disabled people; they should embrace them so that they do exactly what the bill's policy memorandum suggests in terms of health and social care integration.

Mark McDonald: On the second point that I raised, I am interested—

The Convener: Does Claire Cairns want to come in?

Claire Cairns: Yes. My point is similar to Pam Duncan's. We have already referred to the focus groups and the consultation that we did with carers, so members will know that 100 per cent of carers felt that they should have a guaranteed place around the table. Richard Lyle referred to the number of yeses, and I want to clarify that on our carers message board we directly quoted their responses, and one person wrote eight yeses.

Carers felt that one of the potential negative impacts of integration was that they would lose some of what they have already gained in having a place around the table. Members might know that in 2011 carers were given a guaranteed place around the table with community health partnerships. If that does not happen when we move to integration, carers will see that as a massive step backwards.

The point about how to get the right person at the table is a good one. I have already said that carers cover so many different age groups and conditions that it is quite difficult to get one person to represent that range. There is already a very strong network of local care organisations, which I see as being very much the experts. It would not be too difficult for partnerships to go to their local care organisation and devolve that representative function to it. In terms of supporting representation, provided that they were resourced to do it, local care organisations would do that work very well.

Mark McDonald: I think that that deals with my second point.

I have a final question. We have had evidence from the Convention of Scottish Local Authorities on the bill's scope and the potential for widening it in future. COSLA wants it to be very narrow and to deal with adult services only. That would mean that further legislation would be required if, for example, we wanted to roll out integration to children's services. Obviously, most of your organisations deal not only with adults but with a range of individuals who come into contact with social care and health services. What are your views about the ability of ministers to widen the scope of the bill, should the approach prove successful? My view is that if we simply say that widening the scope to children's services can be done locally but that we will not have a wider roll-out, we will end up in the same situation. In other words, we have a couple of areas that serve as pioneers and just crack on, but there are other areas for which legislation is absolutely necessary to get the change that we want to see. I am interested in your views on future widening of the bill's scope.

Ian Welsh: Our organisation has not taken a view on that. Personally, I do not support COSLA's view on the issue, but that would not surprise COSLA. I think that when the 32 health and social care partnerships shape up, there will be an interesting mix, and not all of them will opt simply to have older people's services. There will be other services in the mix, such as community health and mental health teams. In fact, there will be the full panoply of services. The notion that in the near future we would return to produce additional legislation would be mind blowing for us.

We are much more interested in seeing the health and social care partnerships as a conduit for change locally. There is a very significant agenda for change to be delivered. The legislative context will allow the proposal for integration to be delivered, and I think that that is enough to be going on with.

Claire Cairns talked about the change fund being new money, but health boards would say that it was not new money but their money. However, it was money directed at the point of change, and my understanding is that at the end of the change fund there will be a similar, potentially enhanced, sum of money that can be utilised for health and social care innovation. I commend that approach. For health and social care partnerships that would be an opportunity to do things differently. You do not need a lot of discretionary money to do things differently at the local level, but you do need some money. To tie that into your question, it would also provide an opportunity to test new approaches and new client groups within health and social care partnerships. I disagree with COSLA on the issue.

Karen Hamilton: We have to allow for the legislation covering all age groups, not least because of the point of transition for younger people—certainly younger people with disabilities—moving through services. The system is already complicated enough; if someone had to transfer from one structure to another, it would become even more so. That is an absolutely critical point.

The local authorities and the health boards need to be able to make those decisions themselves. I know that some already have. I believe that Highland has gone down that route, with the lead agency model. We are already there in some ways so I think that we need to stick with that.

Aileen McLeod (South Scotland) (SNP): I want to pick up on some of the points that Ian Welsh made around locality planning. This comes from an issue that arose at last week's evidence session with a number of organisations, including SCVO, when we discussed the capacity implications for the third and independent sectors for which the operating environment remains quite challenging. How do we build capacity in communities when more acute care is coming back into our communities? Obviously, there is a key role to be played by our GPs, who are central to much of the roll-out of integration. I am conscious that we will take evidence from Dr John Gillies, from the Royal College of General Practitioners, in the next panel.

What do you think is the best way for us to build that capacity in communities? Proposals came from the general practitioners at the deep end group in March, which talked about health hubs built around GP services involving, integrating and innovating in relation to progressive health and social care initiatives and approaches to the health and social care partnerships.

Ian Welsh: That is a great question. My organisation and the RCGP—I am sure that John Gillies will say more about this—are working on a good project called improving links in primary care, which involves working with GPs to build greater cohesion and provide more information in localities. My organisation is about to work with the deep end group on a related Scottish Government-funded project that will try to establish the efficacy of link workers in deprived areas working around a series of deep end practices. The long-term objective is to prevent people from requiring medical services. If the evidence shapes up after a couple of years, I believe that that will be a practical model that could be implemented in all deep end practice areas.

The wider question of building capacity is challenging. There is already a programme of building capacity through the joint improvement team. I do not know whether the committee will take evidence from the joint improvement team, which is a Scottish Government vehicle that delivers fantastic work in localities, building capacity around co-production, for which it has a very good toolkit. The programme will build an improvement network in the third sector interfaces. In effect, such capacity building is a skilling-up exercise. However, in my view the third sector interfaces, which have a change fund sign-off function, really require a bit of additional human resource investment to allow them to step up to the plate.

11:00

As a national resource, the change fund support team, which, as Aileen McLeod will know, is currently hosted by the alliance, will be given a bit of additional resource so that it can become a health and social care support team. That team, which is governed by the third sector but involves the Scottish Government and the joint improvement team, will also help to skill up the third sector interfaces. Therefore, there will be a bit of national support and a bit of other support—although a bit more is certainly needed—for the third sector interfaces.

However, there is a larger question about the extent to which DPOs and carer organisations are resourced to deal with the change. Claire Cairns represents a whole coalition of carers, but she is only one person so she will not be able to attend every health and social care partnership. There is a requirement there, but that requirement is quantifiable and realisable.

If I was speaking from a sectarian interest point of view, I would say that the amount of money required is infinitesimal compared with the £12 billion that sits in the statutory health board budget. Now, I do not have the political capital or authority to be able to cull resource from that, but I suggest that such practical requirements need to be addressed. The financial memorandum to the bill provides some scope to build a bit of support there. For example, the alliance will start to build a small—but we hope influential—initiative called the health and social care academy, and SCVO will be undertaking some pathfinder projects along with Voluntary Action Scotland. However, we could do with more money to tool up the interfaces so that they are prepared for health and social care integration locally.

Claire Cairns: The change fund already provides some good examples of capacity building. In a few areas in Scotland, it has funded the development of carer forums and the training and support of carer representatives. That has been very successful in improving carer engagement and making that more meaningful, so that carers feel supported and that they are being listened to. Those developments have made the experience a lot more valuable for carers and have ensured that carers are connected to other carers in the local area. That could easily be replicated across Scotland.

The change fund has also funded some really good examples of increasing the capacity of carer organisations to provide support to carers. Over the years, with more older people and more carers, more people are coming forward who need support—that has been an issue for quite a long time. For example, in Stirling funding has been provided for two hospital discharge workers. They are based in the hospital setting and identify carers at an early stage and help them with the transition back into the home to ensure that the carer’s needs are considered alongside those of the person being cared for. There is good evidence to demonstrate that such interventions, as a good example of joint working, help to avoid future crises for carers and future readmission to hospital.

Another example is in West Lothian, where there is an older carers worker who works closely with the local authority’s reablement team. Whenever a reablement package is being arranged for someone, the older carers worker ensures that the carer is trained alongside that. Reablement is excellent—as I am sure you will know, it can help people to regain their independence—but if the carer is not also trained and supported, it is very easy for people to go back to their old ways of having things done for them.

Such things increase the capacity both of carers to engage and of local carer organisations to provide the support that is needed to assist integration.

Aileen McLeod: Thank you. That is very useful.

The Convener: There are a few issues that we have not covered yet. One is charging and the concern that has been expressed about cost creep. We know from previous evidence how emotive that issue can be. Perhaps we can roll that up with the broader outcomes, the inspection and complaints procedures and how people will be able to exercise the rights that we spoke about earlier. I ask for some brief responses on those issues, as we have written evidence from you as well.

Pam Duncan: I have said this to the committee in the past, so it will come as no surprise to you to hear me say that disabled people and their organisations believe that to charge people for a service such as community care, which is so crucial to their independence and their human rights, is unfair and unparalleled. We do not charge anyone else for the privilege of enjoying their human rights in the same sense.

We state in our written submission that we believe that the issue needs to be addressed in the bill, not least because of that unfairness, but also because of the bureaucracy and the difficulties around how we are going to tell which parts of the budget are chargeable and which are not. None of us wants people to start charging for services that people would ordinarily have got from the NHS for free; equally, we do not want people to continue to have to pay for social care when, without it, they could not possibly participate in society.

We have done some work on the matter and we believe that the cost is approximately £50 million across Scotland. That is the amount that is collected in charges for social care. In the grand scheme of things, that is not a huge amount of money, but the charges can represent up to 100 per cent of a disabled person’s income. When we look at it from that point of view and consider that many of the people who pay the charges live in poverty, it seems unfair. I believe that we need to address that as a society.

On complaints and reviews, we were surprised to see that the bill is quite silent on complaints processes, particularly given that there are different processes for health complaints and social care complaints. We note that the duties in the bill follow the delegated function. In a situation where a health board delegates a function to a local authority, where would someone complain to and which process would they use? We accept the Scottish Public Services Ombudsman's recommendation that the processes be aligned as closely as possible, but we would go slightly further—this might not surprise you—and suggest that there probably needs to be an independent mechanism for people to make complaints.

We have raised some concerns about the complexity of the system. This is not a slight on the ombudsman in any way, but the issues are so detailed that it will be extremely difficult to deal with them at a national level in the depth that is required. We recommend that there should be locally independent mechanisms, perhaps in the form of tribunals.

The Convener: Does anyone else want to comment?

Ian Welsh: That was a comprehensive response on the costs.

The Convener: I thought that it was pretty comprehensive, I must say.

Ian Welsh: Maybe I could just say a bit about the outcomes. Again, I congratulate the cabinet secretary and his team, as there has been a comprehensive and inclusive consultative process. There was a working group on outcomes, and I am pleased to see outcomes enshrined in the bill.

However, there is a larger issue. There is a shift towards trying to focus on personal outcomes for individuals—again, that is part of the culture change. My son will be quite different from another young man who has cerebral palsy, and that young man will be different from another young man who has Down's syndrome, so personal outcomes are really important. We have a series of reports coming out called "We've got to talk about outcomes", which I think will be informative for the committee, and I will be happy to furnish you with them.

Finally, Pam Duncan talked about human rights, and we have a document called "Being Human", which will give the committee some more background on the issues. It describes the rights-based approach to health and social care integration.

The Convener: Thanks, Ian. We look forward to receiving that additional information.

We appreciate both your written evidence and your oral evidence today. Thank you all very much for your attendance.

I suspend the meeting to allow us to set up for the round table.

11:10

Meeting suspended.

11:16

On resuming—

The Convener: We resume the evidence-taking session with a round-table discussion. This is the fun part—we all get to introduce ourselves.

My name is Duncan McNeil. I am the MSP for Greenock and Inverclyde and the convener of the Health and Sport Committee.

Dr John Gillies (Royal College of General Practitioners Scotland): I am the chairman of the Royal College of General Practitioners Scotland and I have been a GP for many years.

Bob Doris (Glasgow) (SNP): I am a member of the Scottish Parliament for Glasgow and the deputy convener of the committee.

Rachel Cackett (Royal College of Nursing Scotland): I am a policy adviser with the Royal College of Nursing Scotland.

Richard Lyle: I am an MSP for Central region.

Ruth Stark (Scottish Association of Social Work): I am from the Scottish Association of Social Work.

Gil Paterson (Clydebank and Milngavie) (SNP): I represent Clydebank and Milngavie.

Gabrielle Stewart (Allied Health Professions Federation Scotland): I represent the Allied Health Professions Federation Scotland.

Rhoda Grant: I am a Highlands and Islands MSP.

Aileen McLeod: I am an MSP for South Scotland.

Dave Watson (Unison): I am the head of bargaining and campaigns at Unison Scotland.

Dr Christine McAlpine (British Geriatrics Society – Scotland): I am a consultant geriatrician in Glasgow and I am here to represent the British Geriatrics Society.

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

Dr John Taylor (Royal College of Psychiatrists in Scotland): I am the vice-chair of the Royal College of Psychiatrists in Scotland.

Mark McDonald: I am the MSP for Aberdeen Donside.

The Convener: Thank you all for that. Bob Doris will kick us off, but I will do my best to bring in all of the panellists. The MSPs know that the panellists' contributions will take priority over those of politicians. We will try to listen.

Bob Doris: Listening is not something that politicians are always good at doing. I will try to keep my question as brief as possible. The round-table introduction is probably a good starting point, because the question is about stakeholder involvement and which stakeholders—all the witnesses are stakeholders—should be specified in the bill.

We would have to build a new, larger committee table if we were to involve all the stakeholders who would wish to have a formal input into health and social care integration. How do we ensure that all relevant stakeholders have an input into that integration? To what degree does that have to be specified in the bill?

I am aware that there is a nervousness around the fact that, as soon as we start to specify stakeholders in the bill, if an organisation is not represented, we get a two-tier system in stakeholders. I am also aware of how unwieldy it could be, depending on the strategic implementation.

What are the witnesses' views—not only those of their organisations—on stakeholder involvement? What should be in the bill? How do we ensure that it is dynamic and focused but not unwieldy? How do we ensure that it is important?

Rachel Cackett: One of the important points that we must take into account to begin with is what the involvement is for. Many people have a justifiable desire and need to be around the table in different ways.

One issue for us—which will not surprise you, given the RCN's submission—is that, although the policy memorandum to the bill is very clear on what the bill is trying to achieve, that is not always translated into the wording of what is on the face of the bill. I know that our organisation is not alone in saying that.

One of the key issues for us is the fact that the bill does not address what we think should be fundamental to any care service: the issues of quality and safety. With those issues missing from the principles of the bill, other issues that follow on from them are also therefore missing. Those issues include the really important issue of how we give assurance—to you as MSPs, to the governance committees of the different organisations, to local councillors and to the general public—that the services that we are commissioning and the services that are being delivered in an integrated way are genuinely safe.

I was very interested in the discussions in your first evidence session this morning because of the issue around the acute sector that came up. I have been working on these issues for the past 18 months to two years, and I have noticed how often the issue of the acute sector becomes about acute sector moneys rather than the quality of care that is delivered—care that may now be in the community rather than in the acute sector.

On the basis of that, it will probably not surprise you that, speaking from the point of view of nurses as part of the clinician community, I think that we have a fundamental role in ensuring and giving assurance that the quality and safety of care that is delivered is absolutely top notch.

It strikes me as somewhat surprising, given that we are debating the bill post the Francis report, that that point is not clearer on the face of the bill. There should be ways of writing it in. I think that there are many ways that we can do it, but there should be ways of ensuring that the primary legislation makes that quality and safety of care a key point and that those who are responsible for assuring it at a local level—whether that is the director of social work or the director of nursing—have a clear route to give that assurance to those who are governing.

Dave Watson: Bob Doris's question raises the issue of governance of the joint bodies, and I think that there is some confusion, in particular with regard to the body corporate option.

From our perspective, the staffing governance is particularly unclear. As you will know, in the health service we have a strong, internationally renowned staff governance framework. It is slightly different in local government, but nonetheless there are statutory and non-statutory provisions there. Our concern is that there are a lot of big decisions that the bodies could make if the budgets are allocated to them and that those decisions will impact not just them—because in most cases, they will not be the employer—but other employers. The staff governance arrangements around that seem to be somewhat muddled and confused.

An example of the issue would be the mess that we got into with the Police and Fire Reform (Scotland) Bill. We pointed out when the bill was going through the Parliament that staffing governance was not clear, and the Justice Committee spent six months dragging in the players to try to sort it out afterwards, so there is a lesson to be learned there.

The risk of leaving staffing governance muddled is that, as the Convention of Scottish Local Authorities and others have rightly pointed out, the bill has a massive barrage of powers for ministers. Reserved powers are fine—you would expect that in the bill—but the powers of direction are immense. In my experience, they are the most immense that I have seen at any time.

The risk is that, if the bill does not deliver the outcomes that ministers want, the approach might lead to top-down integration models. As we have seen from the work that the Scottish Parliament information centre has done and the work that the Association of Directors of Social Work has done on the international studies, top-down integration simply does not work.

Gabrielle Stewart: The Allied Health Professions Federation Scotland represents 12 professional groups and we are about the same size as the number of medics within Scotland. The previous witnesses talked about inclusion within the bill team when the bill was being created—we have not been included, but we definitely want a seat at the table. We are involved at the rock face, getting people home or helping them to remain in the community, and we think that, if we are not included within the decision-making joint boards, there will be a real loss of experience and of the positive contributions that allied health professionals can make.

Dr Gillies: The issue of stakeholders is difficult, but I tend to agree with Rachel Cackett that being a stakeholder depends on what you bring to the table.

What we do not want to do is embark on considerable legislation with all the costs and upheaval that that will entail and end up with something not very different from what we have at the moment. Many of us are concerned about that and, in my view and the RCGP's view, we need to ensure that by April 2015 we have a system that has the capacity to innovate, do things differently, and release the talents and capabilities of all the professionals and service users who are stakeholders.

We feel that there should be general practice representation on the partnership boards because we are responsible for making often crucial decisions on whether someone stays at home or in a homely setting or goes into hospital. Given that we make such high-impact decisions with regard to the system's operation, we should be able to bring our views to the table.

I hope that I will have an opportunity to talk about how locality planning will function in the new system because I think that it is a really crucial element of the bill. The bill needs to make a difference to what happens to individuals, whether one calls them clients, patients or service users. In that respect, what happens at locality level is probably as important as what happens at partnership level, and general practitioners—and, indeed, social workers, AHPs and community nurses—could play a major role in shaping local services.

I will have more to say on that matter, but I think that that will do for now.

Dr McAlpine: As an acute clinician, I think that I have a reasonable awareness of the issues on the acute side of things. I was therefore slightly concerned about one or two comments in the previous evidence session.

It was suggested, for example, that the acute sector could be a source of money that could be moved into the community. We must be aware that older people in particular are very big users of acute care, and in this discussion we should remember that an unplanned admission is not necessarily a bad thing. The term "avoidable" needs to come in somewhere. There is a lot of discussion about the cost of unplanned admissions, but many of the people involved have had acute strokes, heart attacks or pneumonia. Those things will continue to happen and are expensive, because hospital care itself is expensive.

I think that geriatricians welcome integration, but we need to look at smoother pathways. Older people are concerned about the extent to which they have to hang about for treatment and the fact that they do not know how to get things, and we should look at how systems can be made better. The role of AHPs is absolutely key to that.

As for stakeholders, if you asking about who should be at the table and why they are there, I have to say that health and social care are both a bit bedevilled by lobbying groups, who are, of course, there for a purpose. We need to examine how we make the care of older people and indeed all patient groups most efficient and effective, because that is what consumers are looking for.

Ruth Stark: I want to approach the question by considering the actual interface between health and social care. For the social worker getting involved in integration, it is all about working with people who are facing change in their lives, and that should be our starting point when we are trying to measure where we are going with this legislation.

Social workers are interested in three issues—three Ps. The first is preventing people from going into acute services. We are also interested in social protection, which is, after all, a key part of our role, and I have consistently made it clear that one of the bill's unintended consequences might be its effect on our responsibilities in that respect. I am thinking, for example, of child protection, of children whose parents are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, of human rights issues for those so detained, such as their right to live in the community, and so on. The third P that I am concerned about is participation. The people in the driving seat must be those who are using our services.

11:30

I was very struck by recent evidence from the Mental Welfare Commission for Scotland about the development of the Edinburgh crisis centre, which has helped people subject to the necessary intervention of a compulsory treatment order to stay in the community. That has resulted in fewer hospital admissions in the Edinburgh area, as people are now being treated in the community. The centre is a really good example of how people are addressing the issues of prevention, protection and participation.

The question is whether the stakeholder body that you are asking about will address such issues. The important point that emerged from the evidence from the previous panel of service users is that they need to be in the driving seat with regard to what is happening to them. Anything that happens in our services must feed into that message.

Dr Taylor: Before I answer the question, I should point out that I am representing mental health services this morning.

The health and social care partnership board must represent the partnership, and we need corporate governance and a clear understanding that the responsibility of every board member is to represent everyone, not just special interest groups. That is what I expect from health boards, and I assume that the same will apply to local authorities.

There is a need for wider consultation of stakeholders, because we need to involve everyone. The groups in question cover a wide range of people; I know, for example, that my local patient and service user group would like to be represented on each of the health and social care partnerships. We certainly need mechanisms to allow that to happen.

Mental health groups are concerned that they will not be represented because the fact is that not everyone can be represented. However, if your group is not represented, it will become non-functional. I have attended meetings with large groups comprising chiropodists, podiatrists, dentists, mental health professionals and people involved in older people’s services. The problem is that things do not function if too many people are present, but I think that those are practical organisational issues that will be sorted out at a more local level.

Bob Doris: I just have another brief question, convener, because I know that we have a lot to get through.

I am struck by the fact that most of the witnesses focused not on structures but on how their own stakeholder group can be actively involved in improving and changing services. Interestingly, Dr Gillies suggested that most stakeholders are interested in locality planning and Dr Taylor mentioned the need to distinguish between the strategic board’s corporate governance and the involvement of interest groups in locality planning.

Do the witnesses think that the majority of stakeholder involvement should be focused at a local level and that we should get locality planning correct and then signed off by the strategic board? Going round all the witnesses again will be time-consuming, which perhaps backs up the point about whether a strategic board can comprise everyone and still achieve focused decision making. Is locality planning the issue for most stakeholders?

The Convener: You have asked the question, Bob, so we will just have to take a risk about who comes in. Rachel Cackett and Dr Gillies have already made bids.

Rachel Cackett: Locality planning is a key issue, but the bill is fairly sketchy about it and at the moment we do not entirely understand how it will work in practice. We have been told that it is the way for professions to get involved, but we would disagree. Although it is very important that those with local knowledge on the ground—the service providers and those who are using the service—are engaged in development, we must understand how the process fits in with the joint strategic commissioning process.

Strategic commissioning is a powerful process that will involve making decisions about investment and disinvestment, and assurance will be needed that any care that is commissioned is safe and of good quality. The link from that to the governance boards and back up to the partner agencies will ensure, similarly, that we have good-quality care that is delivered by the right people in the right place in accordance with the needs that have been identified.

Locality planning is key, and especially important in ensuring that there is wide involvement, but if it becomes the only focus for involvement we will start to miss out on assurance mechanisms and the important strategic oversight of professionals and others in supporting the governance of the new bodies.

Dave Watson: We have argued in our submission and elsewhere that services should be designed from the bottom up in conjunction with users and staff, which was a key element of the Christie commission’s report. It is not easy to put that into practice, and there is a tendency to look for top-down solutions, which we would not support.

On locality planning, we need to see the detail. Part of the problem with locality planning in Scotland has often been that it has not been very local. In other words, there are genuine localities, but services have not drilled down to those levels, largely because local authorities and health boards are very large—there are those who argue that there should be fewer such bodies, but we are not among them; we have the largest such organisations in Europe.

I agree with Rachel Cackett. My concern is that, given the powers and the strategic role that the bill assigns to ministers, the scope of localities to design services could be prescribed by that top-down driver. We need to have a reasonable input into the strategic as well as the local side.

Dr Gillies: I would not disagree with anything that Rachel Cackett has said. We are talking about “and also” rather than “either/or”—of course, we will need some professional involvement at the quality assurance and strategic commissioning level. However, the things that will make a difference to individual patients and clients will happen in localities. We will need effective partnership and co-ordination between the professionals, the public and the service users at a locality level, and it is very important that the bill allows for the type of subsidiarity that will enable that to happen.

The Francis report in response to the Mid Staffordshire tragedy has been mentioned. Since the report’s publication, we have had two more interesting reviews from England: the Berwick report and Sir Bruce Keogh’s report on hospital services in England. What came through in both those reports was that quality and regulation is determined not only by structures but by the culture and working relationships on the ground.

Determining what happens and building good relationships at a locality level will be the deciding factor in whether or not the bill is a success. That means having the right sort of professional involvement—including from the groups that are represented round the table today—and some involvement with communities and the community planning process.

As Ian Welsh mentioned, we have models for engaging communities and providing access to local services—through the search engine for the access to local information to support self-management, or ALISS, project, for example—which could contribute to the process.

Dr McAlpine: I agree with what has been said. Our view is that there should be some sort of strategic overview and key goals. From a locality point of view, we must acknowledge that, even if we look only at the older population, some parts of Scotland have a very elderly population while others have a younger or a prematurely aged older population. In parts of Glasgow and in other areas of Scotland, locality planning is key to deciding what the particular local needs are for the population.

One thing that could be done is to look at what was funded through the change fund, which has been mentioned this morning. Most people would acknowledge that some of the things that were funded have worked extremely well, while others have worked less well, which has usually been associated with a reluctance to share things.

Our view is that the key to the integration will be trust. The people—service users, carers, professionals and so on—in the locality planning groups have to trust one another so that they are able to work together, reach an agreement and proceed on that basis.

Gabrielle Stewart: There needs to be a local and a strategic element for allied health professionals. Local planning is really important, but in order to have good strategies you need to understand the workforce. We now have one allied health professional director in each health board, and they will be a useful mechanism as there is one person for 12 professions.

We need to understand the potential of the workforce. We already work across health and social care, in housing and education, and with the third sector, so we have quite an integrated professional body that could really help to shift the balance.

Dr Taylor: To support what I said earlier, I answered the question about locality planning, but I took it for granted that we would have robust clinical governance structures that involve all clinicians. Those structures need to be widened to include particular local authority responsibilities, such as the governance of purchasing services and legislation at that level. The structures need to be expanded in order to develop a concept of care governance—that will be key. Any health board would expect that robust clinical governance structures would be developed for any service in which it is involved.

The Convener: I thank Gil Paterson for his patience.

Gil Paterson: My question is on the same theme, convener.

Dr John Taylor, in his first comments, came closest to saying who he thinks should not be on the joint boards. Almost every submission that we have had has mentioned that integration is not about bureaucracy or structures, yet we are hearing that practically everyone wants to be on the joint board.

The health service is diverse and contains many functions, as is social work, which contains many different sectors. However, it appears that the board will consist of only two sectors, which are the two big vested-interest groups.

Since the private sector and the voluntary sector make up the third leg of the partnership, is there enough room on the board for even just one person to represent everyone else, as well as the two big vested interests that we are trying to bring together, in order to deliver better services?

Does anyone else have any opinion on who should not be on the board, rather than who should be on it?

The Convener: I do not know whether that is a fair question, but the witnesses can go ahead anyway. I see that Rhoda Grant wants to come in. Are you going to answer that question?

Rhoda Grant: No—I just wanted to add something. It is a good question, but do we need everybody on the board if we have the mechanisms right so that people are empowered to make decisions, right down to the service user at ground level? Is the issue who is on the board, or whether we have the structures right with regard to where the decisions that affect individuals are made?

The Convener: Does that bring us back to the comparison between the lead agency model and the body corporate model?

Dave Watson: The obvious answer to the question of who should not be on the board is, of course, “Everyone other than the people we want on the board.” That is a very easy judgment.

More seriously, though, Gil Paterson has made a fair point: there are an awful lot of diverse interests. The problem is partly down to the governance structure, if we go for the body corporate option. If we go for the lead authority model, the structures are already established—although they would perhaps need to be developed, as others have said.

The difficulty in the body corporate option is that putting in another element—whatever that might be; it could be any of the ones that we have argued for, or another—would upset the delicately planned corporate governance structure. Essentially, the model is aimed at providing a balance between health boards and local authorities, with an alternating chair and other such arrangements.

It is important that we get full user engagement. I have also argued that the staff who deliver the services have an important role in terms of influencing. My point is that we need to reach users, not the other delivery arms. Sometimes, there is confusion between those in the charitable sector who deliver services in a semicommercial way, and those who represent a user interest and have no commercial interest in delivery of services. We need to separate those two sides.

11:45

Gabrielle Stewart: If we want to change the culture, we need to change the people who are sitting around the table. If you simply bring together the people who have sat around the table in a council and the people who have sat around the table in a health board, you will not get effective change. We need to bring in allied health professionals, other professionals and users in order that different decisions can be made.

Dr McAlpine: I agree with that. As I said earlier, you have to think about what the people are there for. Historically, a lot of things have been done by lobbying groups, and you have ended up with dementia versus learning disability versus arthritis and so on. Some of that relates to finances and financial perceptions. There have to be on the boards people whose key remit is to work towards goals of integrating services, and who are not there with a particular representative-group hat on, and so are able to consult other parties and relevant people and bring those views back to the board. For example, you clearly could not have someone from every allied health profession, but you need someone who can bring back the views of people from the acute side, from primary care and so on. You want people who are there with a remit to communicate and to make joint decisions, with a clear idea of why the decisions are being made.

Rachel Cackett: In answering the question, I would come back to the first point that I made, which concerns the question of what it is that people are around the table to do. To pick up on Dr Taylor’s point around governance—or clinical governance, as we would have called it in the NHS—there is an important issue about how we can ensure that governance of our services is right from a care point of view.

We have an issue—I think that there are in the bill lots of such issues that we have not yet ironed out—around the fact that we are trying to bring together two quite different organisations. From a health point of view, we would, as a matter of course, have on every board a director of nursing who would have responsibility for the quality of care that is being delivered by that board; in that board, that is the ultimate assurance mechanism on quality of care. That is a standard element of the governance arrangements in the NHS, but that is not replicated in councils, which work on a very different level and whose directors of social work do not have quite the same role as the directors of nursing in the NHS, because of the structures of local democracy.

The bill proposes, in the loosest sense, to bring together two mechanisms that have slightly different expectations of how we may facilitate governance. The director of social work and the chief social worker are clearly there to give advice to local councils, but they do not do so in quite the same way as the director of nursing would as an executive member of an NHS board. We have to grapple with what that means in the body corporate model, particularly when we are creating a new body, and we have to remember that, as the bill is written at the moment, the strategic plan of the body does not have to get sign-off from the parent bodies; it is signed off at that level, with a lot of responsibility given to that board to ensure that the services that it is designing and planning for the future are the right services and are fit for the local population.

The question that we should keep coming back to is this: why are people around the table? What is their function in the governance, in the body corporate model?

Ruth Stark: I want to return to the last point about governance and the point that Dave Watson introduced in relation to where the chief officer sits in the integrated model, and I want to remind people that the chief social work officer has specific statutory responsibilities that relate to people’s liberty, in terms of the powers around child protection, the detention of people under mental health legislation and the advice that is given to courts, in terms of criminal justice. There are some key issues there that are not the same as the health service responsibilities.

When I looked at the provisions in the bill about the person who will be the chief of the integrated body, I was left with a question—I do not know the answer—about who is chief of what and who is the chief when it comes to some of the other statutory responsibilities that fall to the social work profession, and how do they fit into the integrated plan? I envisage that there could, on some issues, be conflict between the chief of the integrated body and the chief social work officer’s responsibilities, and there could be conflict about the health elements, given the statutory responsibilities that certain people have in the NHS.

There is not clarity in the proposed governance structure and I cannot see that it takes us beyond principles that were outlined in the Social Work (Scotland) Act 1968, the children’s legislation, the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000, and adult care and support legislation. Those are all critical areas that involve social care and social work decisions. How are such decisions to be made under the proposed new legislation? How is the governance worked out? I see no clarity about that.

Dr Gillies: The background is important, and I have not heard the issue being raised. When we look at the evolution of the partnerships and the locality planning groups, we see that most people who work for our local authorities and health boards are employees. It is important to note that most general practitioners and some other community providers, including pharmacists, are contractors—we work for the national health service according to a contract, but we are not employees.

When one considers how GPs, pharmacists and other primary care contractors will contribute to the new arrangements, it is important to remember that they will need additional support. If a GP has to leave her practice for an afternoon to attend a group, she will have to be replaced by a locum. Such support arrangements need to be considered when we think about how we contribute to the future. Many of those issues are covered in the “All Hands On Deck” report, which was produced for the joint improvement team. If the system is to function, GPs will have to be supported to attend the meetings. It is important to include provision for that.

The Convener: Everybody around the table and all the evidence that we have received agrees that integration is a good idea. Politicians have tried to bring about integration in the past and have not been successful. Maybe we do not all agree about how, but we are all here and maybe there is frustration that we are here considering legislation to produce the general cultural change that has not happened so far.

I have a list of questions. Is legislation necessary? Why have we not made progress without it? How do we create the required cultural change? Is it, as we heard during the previous evidence session, about introducing more positive enforceable human rights for the clients who use the service in order to create a different sort of environment at corporate board level? Is it about incentivisation? Is it about a change in the GP contract? What practical things do we need to do to improve the experience, the quality and the outcome for people who are in receipt of care?

When we spoke to people yesterday in Inverness, they were very enthused about what they can do. They feel liberated by the Highland experience. However, we know from our visit that it is a long-term experience. The real hard choice may be about redesign—or it is, further down the line. What do we do? If we accept that things need to change, and if legislation is not appropriate, how will we do it?

Dr Gillies: I will take up the challenge. First, in RCGP we believe that legislation is absolutely necessary, welcome and overdue. We have increased and appropriate expectations of health and social care because of the demographic shift to a more elderly population, the rise in complex conditions, multimorbidity among patients with long-term conditions and the deprivation in Scotland. We do not, however, have a health system or a social care system that is designed to address those problems. The bill should go some way towards addressing that.

As service users or patients, people do not distinguish between a health need and a social care need; that has been the case for many years. When I started in general practice, the difference between a health bath and a social care bath was carefully explained to me. I had thought it was just that an old body needed a bath.

All the things that the convener mentioned are absolutely necessary. For general practice, we need the continued development of a Scotland-focused contract to ensure that the skills and innovation of GPs can be used outside their practices and at the interfaces with secondary care and social care.

I keep talking about locality planning because I think that the culture change has to happen at local level. We cannot impose culture change from the top. That was attempted in England with the hospital service and it failed. The way forward is a combination of helpful changes at partnership level and strong localities to help to shape the service.

Rachel Cackett: The RCN is very clear that services should be seamless wherever you are. I agree that people who are in receipt of services do not perceive a difference between health and social care. Our difficulty at the moment is that our health and social care services are configured so differently, within such different paradigms, that to bring them together is a real challenge.

Do we need the bill? There are things in the bill, and particularly in the policy memorandum, that we support absolutely. There are things that need to change and supports need to be put in place. As I have said, the translation from the policy memorandum to the bill is not always as clear as it could be. Assuming that the bill progresses to stage 2, I am concerned that we may end up with an awful lot of amendments. I hope that that leaves us with a bill that has integrity.

There are many examples where things are already working very well. We have examples in nursing and social work teams of people working together very well on the ground. Our difficulty at the moment in taking that forward and expanding it is that quite often it needs time, and time is an expensive commodity in the public, third and private sectors.

Some years ago, at the start of the single outcome agreements, we held an event for lead nurses to talk about the impact of planning and single outcome agreements, and some of the things that nurses should be thinking about. I talked to two nurses; one was working in an area where integrated working was not going well, but the other said that it was working well where she was. Those two nurses were very close to each other geographically. Their different experiences came down to the amount of time that had been freed up in their teams to allow really simple things to happen—for example for a social worker and a district nurse to sit down and explain to each other the limits of practice within their regulatory bodies, and what they were allowed to do and not allowed to do to enable proper joint work.

I agree with John Gillies that some of the big cultural shifts will have to happen locally. However, that will mean ensuring, first of all, that there is enough resource—wherever someone works and whether or not they are an independent contractor—to allow the organisational development support and space for that to happen. We are, and we should be, asking our front-line staff to work very differently, so we should be committed to ensuring that they have the resources to do that.

In addition, we need to ensure that, all the way up the chain—to the very top—that push towards integrated working across what are, at the moment, two very different systems is seen and is valued at every level. That comes down to how, at national level, what goes through in the Public Bodies (Joint Working) (Scotland) Bill, what is being done on our community planning processes and what may be going through in the Children and Young People (Scotland) Bill in relation to planning for children, matches up and is as seamless at that level as we expect it to be when it comes to what our front-line practitioners do. Unless all that works together, nobody will make this work.

12:00

Dave Watson: At the risk of dismaying the convener even further, I have a slide that I use at conferences that lists all the initiatives and legislation on the issue over recent years. Believe me when I say that I had to use very small print to fit them all in. Over recent years, I reckon that, on average, there has been an initiative every 18 months. To be honest, if you talk to representatives of staff at the sharp end about the bill, as I have done, they will tell you that the view of front-line staff is, “Here we go again.” They think that it represents another moving around of the managerial deckchairs, and they question whether it will make a huge amount of difference. That is the honest appraisal of staff at the sharp end.

In some areas, the current structure works well, but in others it has broken down. I went to one local authority—which will remain nameless—where the relationship with the health board had broken down. The staff at the sharp end said that they just got on with it anyway; they muddled through. Although they felt that it would have been nice if the high heid yins could have sorted things out, they just got on with delivering the services. Sadly, that is the reality.

To be more helpful, if we look at international studies on the subject, of which there is a long list—I will not go through them; they are mentioned in our submission and in others—they are about getting the relationships right, respecting professional identity, aligning management and getting staff engagement right. Two themes come out of all that work. I have been involved in this area for more years than I care to remember and I was an expert adviser to the Christie commission, which looked at the issue extremely closely. The first thing that hit me was that, as John Gillies said, we need a bottom-up design. There is no top-down, one-size-fits-all solution.

Secondly, it is about people. If we read the bill, we find about one section on staff. The policy memorandum has half a paragraph on staff. The consultation paper, which ran to 64 pages, had half a page on staff. Therefore, my general message would be that, if we are to make integration work, we have to get the people bits right. Frankly, I think that there is too much focus on structures and budgets, and not enough on people.

Dr McAlpine: Similarly, I think that although geriatricians are keen to ensure that older people access acute care when they need it, we are aware that some people do not need to be in hospital, and we certainly feel that some people could leave hospital more promptly. We need to be aware that a big part of the work is to look at how we deal with the increasingly elderly population and the fact that we simply cannot afford to have all those people in hospital in the future. That is a big imperative.

There is sometimes a concern that it all comes down to the view that, given all the different organisations that are involved, if we can just get someone else to deal with the issue, we will shift it out of someone’s responsibility. We have to look at and learn from places such as Highland, which we talked about earlier, and Lothian, which has the comprehensive assessment service for frail older people. Funded through the change fund, it is very much about looking at all the different organisations in primary care, secondary care and social work, seeing how joint responsibility could be taken for improving services, and working together with everyone involved, with the common goal of improving the efficiency and effectiveness of services. There are places where that has worked, but we are probably not always good at spreading information around. It comes back to staff thinking, “That’s this week’s initiative. There’ll probably be another one along next week,” “More pilots than the RAF,” and so on. Unfortunately, those are the sort of comments that we hear from staff.

Malcolm Chisholm: I am prompted by Dave Watson’s comments in the last contribution but one, so I suppose that this question is for him, although it is a more general point. If the approach has to be bottom up and structural change is not the answer, is the bill necessary? More generally, what positive things can we get out of the bill? We have had some comments on that, but I am interested in the comments on quality in the RCN submission. Do the witnesses agree that we ought to build more into the bill explicitly on quality? Another point in the RCN submission that perhaps does not feature strongly in other submissions but which relates to other work that we are doing in the Parliament is about the extent to which it is right or wrong to separate this work from the work on children’s legislation. I am interested in that, too.

As I said, I was prompted by Dave Watson’s comments, so perhaps he can say whether the bill will contribute anything or whether it is just something that he and his members will have to put up with.

Dave Watson: I suspect that I veer towards the latter but, at the end of the day, it can be useful as long as it is enabling legislation that sets a framework. I am simply saying that there is not much in the bill that tackles what needs to be done to get health integration right. If the committee thinks that the legislation and all the words that you put in it will cut the ice, I am sorry to say that they probably will not. It is all the other things that we are talking about that will cut the ice.

I entirely agree with the point about quality. However, although we talk about healthcare integration, the way in which care is delivered in this country, particularly in the community, is a national disgrace. It is delivered by staff who are generally on the minimum wage—sometimes not even that—and certainly not the living wage. They are trekking around. The other day, at a meeting with a group of members, I asked them about the 15-minute care visit, and one of the staff said, “Fifteen minutes? That’s a luxury. You should see what I have to do on a day-to-day basis.”

That is because money is already tight in the area. We can write lovely phrases about quality in legislation—I am all for them and they are great—but we need to address the fact that, by 2030, we will have to find another £2.5 billion to meet the additional costs that are coming down the road when we do not meet the current costs. That has consequences for quality of care, which is the real disgrace. So my answer is this: by all means pass legislation and put warm words in it, but if you want to do something about the issue, you have to sort out issues such as the way in which care is delivered on the ground.

The Convener: We had an attempt at that in a previous committee report.

Dave Watson: Indeed you did.

Ruth Stark: I agree with Dave Watson, as that is what our members say, too, but I want to talk about something that has not yet been mentioned. There is an assumption that we are talking about people who are already engaged in health and social care services. One of our members' tasks is to reach out to people who are not engaged with services, but those people do not seem to be factored in. We have articulate carers and service users, but an awful lot of people out there who are affecting the statistics on things such as poor health, particularly in places such as Glasgow, are not engaged. Our members reach out to those people, but somehow we seem to have factored them out of the discussion and out of the bill. I do not know how we engage with them, but if we are talking about stakeholders who need to be listened to, they are stakeholders who need to be listened to.

Gabrielle Stewart: I have a comment on the point about including allied health professionals—sorry, but I have lost my train of thought because I was busy listening to Ruth Stark. We want to keep people at home and save the Government money. We have quite a lot of evidence to back up the fact that including allied health professionals in services certainly creates a cost saving.

We have heard about the change funds and good examples. I have my thought back again—it was about being much more evidence based in deciding what we do. That involves looking at things that have worked well, working out what staff ratios made them work well and then sharing that good practice. That is fundamentally important. Although we welcome the bill, it does not talk about quality. The principles are good, but they are not expanded enough. For example, what does "wellbeing" mean? There are risks involved in the bill in that it is purely mechanistic and is not going to create the change that we want to happen.

The other issue was around staff saying, "Here we go again." A lot of our staff report that they are already working in an integrated way but the systems stop them from working together. For example, they do not have computers that communicate with each other. We had the single shared assessment, but people could not share that assessment other than in written form. In this day and age, we need to talk about integration of the technologies that we use and look at the barriers that prevent communication on the ground.

The Convener: Rachel Cackett was name-checked a couple of times by Malcolm Chisholm.

Rachel Cackett: I was. It will not surprise him to hear that the RCN agrees with the RCN submission that quality should definitely be mentioned in the bill.

On the issues of what is not in the bill and information technology integration, we have talked to our members and there is a report on our website from a member conference that we ran at which IT came high up the list of priorities. We have a system in which front-line practitioners are being asked to share care but they cannot share a medical record. That does not make much sense. There are things that must happen outside the bill that we cannot expect legislation to deal with.

On what Dave Watson said about social care visits, we are interested in seeing quality mentioned in the bill. I hope that it would be more than warm words. It should certainly be about more than looking at the quality of healthcare. One of the reasons for including consideration of quality in the bill is that a consequence of the bill, if we take it to its logical conclusion, is that we will go down a line of commissioning that will almost certainly involve increased procurement. We have some questions about which bits of the budget will go down a line of procurement and which might not—I know that some of that has been dealt with through conversations on self-directed support. In the context of an increased culture of procurement, we should ensure that the quality of care is central to the contracts that will be held and delivered through the new commissioning routes. We should not contract on the basis of cost alone.

I know that we have to be pragmatic and realistic in the landscape that we are in, which is that the public sector does not have the money that it used to have even within what are seen to be protected NHS budgets. Not even the NHS has the money that it used to have because costs are spiralling. In that context, we must ensure that there is something to counterbalance what we see now, which is a tendency to contract on the basis of price. That is not good enough. We need to write something into the bill to deal with that.

The second issue is staffing. At the end of your first evidence session today, a question was asked about the capability of staff, which is central to what we are talking about. It is why we need to think differently about services and perhaps why we have not yet got there in the way that we would have liked. If we are talking about taking services from the health side out of the acute sector and locating them in the community, we need a community clinical staff group that is equipped with the right skills in the right place to deliver the required level of care. In some areas, initiatives such as virtual wards and hospital-at-home services are being developed and delivered across partnerships. Those are important early leaders in how we might go about delivering those services. However, the question is whether we are investing enough to ensure that we have the skills to deliver good-quality care in the community for those who need it, which will become ever more complex given the demography that we are dealing with. I suggest that we are not quite there yet.

The Convener: The financial memorandum to the bill cites a budget of £2 million per annum for health and social care IT.

Rachel Cackett: My understanding is that that is existing money. I know that work is going ahead to look at coming up with an integrated IT strategy by 2014. That is just one year before the process is due to go live. I wait with bated breath to see whether that is enough, given the problems that our members tell us that they see on the ground.

12:15

The Convener: I asked the question in the knowledge that the money is never enough.

Dr Taylor: I go back to the original question, on whether legislation is required. In respect of our members, surprisingly few, if any, psychiatrists said that legislation was not required, partly because I think that it was in answer to the question whether integration was a good thing, and they generally felt that it was.

In many ways, the history of mental health since the 1960s has been about closing large psychiatric hospitals, moving services into the community, and developing community mental health teams, with social workers as core members of those teams as often as not. The best examples of mental health work in Scotland have already gone a long way down that route to achieve what people are trying to achieve in mental health. Obviously, there are variations in different areas.

I suppose that the main concern has been around whether there will be disintegration, and one issue is the number of local authorities and health boards. Is 32 the right number? Is it too large or too small? The number probably matters less than the fact that there are different numbers of health boards and local authorities. We want coherence. Will there be different local authority and health and social care partnerships within the health board area developing different services, or will there be cohesion?

The Christie report often talked about different local authorities working in partnership over areas. An opportunity has been missed to encourage partnership working. It is about having an agreed strategy and agreed coherence of systems. Local authorities already commission services—certainly out-of-hours services—across several health board areas. We have heard other examples, and that is generally considered to be a good idea. A lot of what happens in mental health happens out of hours, so services need to be commissioned over larger areas, and certainly commissioning in individual local authority areas would often not be sufficient. Local authorities will often commission even their own mental health officer services across several local authorities.

Dr Gillies: We made the same point about the need for IT systems that share information across boundaries. As the convener said, there is never enough money for IT. The NHS is famous for throwing money away on IT—certainly in NHS England—but we hope that the bill will be a driver to push that process forward.

Dave Watson and Rachel Cackett brought up the issue of capacity. Last night, I spoke to a GP in Leith who had been on call during the day on Friday. She had had more than 60 patient contacts on the phone, in home visits and in surgery, and she felt that that was possibly beyond the limit of what could be safely dealt with during the day. That was in a fully staffed surgery in Leith.

If we are talking about doing more in the community and adding responsibilities to those of clinicians, doctors and nurses in the community, that will have to be carefully thought through if it is to work. There would be no point in saying that we need to look after more people in the community without having the clinical capacity—I think that I would include AHPs in that—to deal with the resulting workload. Innovative ways of working, including virtual wards, could be used to develop capacity, but we in general practice certainly feel that there is a need to increase the number of GPs to deal with demographic change, and integration will play a part in that.

The Convener: I want to pick up on points that Rachel Cackett made about quality and the impact of commissioning and procurement on that. I am thinking back to our report on elderly care and the national care standards, which are now more than 10 or 12 years old. I think that the Scottish Government accepted that a review was necessary, on the committee's recommendation. Is anybody aware of what is happening with that review?

Rachel Cackett: My understanding is that we are now waiting until early next year for the review to begin. I think that work has started and there have been a few public participation and clinician participation events around Scotland.

I agree with where I think your question comes from. If we are going to have a lot of local variation, and we are all talking about the importance of the changes being very much locally led, it should still mean that wherever someone is in Scotland, they should be assured of a national standard of care, even if the way in which those standards are delivered locally is very different. Like you, convener, we are still waiting for the care standards to be updated and made relevant to the situation in which we are all working and receiving services. We should also remember that those care standards, which are setting specific at the moment, do not necessarily cover all the areas of the journey that someone might take from being at home with a low level of services to being in hospital with high levels of acute service.

I would be very keen to see, as I understood we would, the two things happen in parallel. We know that the bill says that the integration plans and the strategic plans must have regard to the outcomes and the principles, but perhaps there is also an argument for them to have regard to care standards as set by the Scottish Government.

The Convener: Does anyone else have a view on that? Is there support for that view?

Dave Watson: Absolutely, but we did have a review of the social care procurement guidance and the rest of it and, frankly, it had no impact at all. You can ask our members in the voluntary sector and even those in the private sector and they will all say exactly the same. Essentially, there is a race to the bottom in that area. Standards are not the issue; it is about how the service can be delivered at the cheapest price.

Gabrielle Stewart: The AHPFS is developing quality service values for all our staff; they should be introduced in the next couple of weeks or so.

Ruth Stark: It is all very well to talk about the standards that are set, but there is the issue of the inspection regimes that are in place to measure the quality of care. They fall very short of doing the task that they are empowered to do. That is partly because authorities and workplaces do not want their dirty linen washed in public. Getting to the root of what some of the issues are in care inspections is a very complex task and it is not sufficiently resourced, or some of the methods are not getting to the issues, and that can lead to unsafe practice.

There are also some issues that my association has tried to take up with the Care Inspectorate and others about employers' responsibilities in the area of providing high or competent standards of care. We have not yet got that culture right in terms of how we measure standards. We can rewrite the care standards but, if we do not somehow empower the standards that are put into practice, we will have another task to do. That still has to be addressed.

The Convener: The issues about the inspection regime have most recently been in acute settings and residential homes. The committee has had discussions about what will happen when we move to more care being delivered across the community. If we face a big challenge now in hospitals and residential settings, the challenge in the community will be really significant.

Ruth Stark: But the real judges of the quality of care are the people who use the services. How are we listening to them? There is a big issue about how easy it is for people who use services to make complaints or observations to the people who are charged with carrying out the inspections. That level of communication takes us back to the Christie report and to what happens on the ground and how people feel empowered to communicate with one another about the quality of care.

If that does not happen at ground level, we will continue to have incidents in which people are not well looked after. There is a real issue about how to empower people to communicate at that level. You can set standards and goals, but if you do not listen to what happens on the ground, you will not achieve anything.

Bob Doris: I have listened carefully to various things, including the point about the need to get the IT right. I still have the scars from two committees in relation to the IT for waiting lists and the TrakCare system in greater Glasgow in particular.

Although this is not a commissioning bill, commissioning could play a greater role in it, and I have listened carefully to some of the concerns about commissioning.

The key point about the bill is that it aims to compel local authorities and health boards where integration has not happened. That is probably why, for some people round this table, it is a bit sparse because it is almost a bill to compel integration in areas where it has not happened, rather than a bill to dictate what that will look like. I note, however, that COSLA thinks that there is too much in the bill already and that it would like us to strip some of it away. It is important to mention that.

Mr Watson said something that I thought was quite positive. [*Laughter*.] I will not say that it surprised me.

Dave Watson: I like to surprise you.

Bob Doris: That is for sure.

You said that there are examples in local areas of people just getting on with it and that there is good practice. This afternoon in the Parliament, we will debate "The keys to life", the learning disability strategy, which is all about health and social care. This afternoon is the time to debate that. In that debate, we might also mention the situation that has arisen in Glasgow because staff or service users have not necessarily been included in service redesign. I will let that sit, but it is an example of another area in which people could just get on with closer health and social care integration. Much of the focus has been on adults, elderly services and children's services, but are there other examples of where you would like local authorities and health boards—with the stakeholders of course—to just get on with it?

Dave Watson: Given our difficulties with the bill, I would be wary of leaping into new areas before we have sorted the current ones. I find that I agree with the COSLA submission more often than is probably good for my career. COSLA is right about many of those issues.

The example to which I alluded earlier was, interestingly, in learning disability. When a local authority and health board in an area not a million miles away from yours, Mr Doris, fell out and that was all over the newspapers, I spoke to one of the learning disability teams. I asked whether there was a problem, but they said no and that they just get on with it and muddle through. My point is that staff should not have to get on with it and muddle through. It is possible to put frameworks in place. It is a question of getting the balance right.

Where we can do something useful, I agree that it should be bottom up. I have said several times that I agree with COSLA. The problem with compelling is what you compel. The way to deal with the issue is certainly not for a person in Edinburgh to tell everybody what to do. That is where I agree with COSLA in relation to the powers, and we made a similar point in our written evidence. You can help from the centre with the frameworks. We have talked about that in relation to care frameworks and standards and, as we said in our submission, staffing frameworks.

All too often, people in this room, in particular those of us who have a trade union function, spend their time reinventing the wheel with this type of public service reform, over staff transfers, pensions and procedures. That might seem to be boring and mundane, but it is the stuff that causes disputes and difficulties at local level. I hope that you will take from our evidence on this point that we have set out what could be a useful national staffing framework that then educates local staffing frameworks and which stops us reinventing the wheel on some issues. It is not about deciding from the centre, but it is about setting out some common grounds.

As a trade union lawyer, I can see dozens of potential legal difficulties with the bill as it stands in terms of staffing issues. For example, when a hospital closes as a result of a budget change, the question will be who made that decision. Was it the health board or was it the third party? Have we worked out how staff will be seconded? Have we sorted out the issues of staff on different terms and conditions? The answer is no. Such matters are mundane, but they are absolutely key to getting better integration at local level.

12:30

The Convener: When we were in Highland yesterday, I raised the industrial relations problem and the risk, which COSLA and others have referred to, of underwriting equal pay claims and everything else. We spoke to health people but, perhaps naively, they discounted that level of risk, as the practice in Highland has been free from that. Your experience might be different, but it is important to put those views in Highland on the record.

Dave Watson: Sure, but I urge caution for two reasons. First, Highland has not chosen the body corporate model, but most of the legal difficulties that I am highlighting come as a result of the unknown body corporate model. Secondly, in Highland, the difficulties of a straight staff transfer situation and having one clear employer have not all been resolved and there will continue to be difficulties. We had to reinvent the wheel through countless hours of work in Highland just to get things to work, so it was not an easy process. All I am asking is whether we want to reinvent that 32 times in the next few years.

The Convener: I appreciate that.

Dave Watson: In my view, there is no need to do that. We are a small enough country to be able to do that as part of a national framework.

The Convener: You will not want to agree with COSLA again, but it questioned whether the Scottish Government would underwrite any equal pay claims. Do you see that as a significant risk?

Dave Watson: Equal pay is certainly one of the risks in a range that includes the equality duty and equality impact assessment duties. Equal pay could certainly be an issue, as the law stands. We have not sorted out the outstanding equal pay issues—that of course is an issue for another committee—and health and local government still have outstanding cases. My desk is groaning with the number of legal cases that I have on the issue. Frankly, we would all like to avoid creating a new tranche.

Gabrielle Stewart: I have one more point about the bill’s remit. The integration of two bodies does not prevent integration with other services. However, as Rachel Cackett said, the issues are time and investing in staff, who perhaps have the potential to be more creative with their services. Integration should be seen more broadly as involving services for housing, mental health, children and education. There are many opportunities, and I see the bill as a step in the right direction.

The Convener: On that note, you have the last word, Gaby. I thank you all for the written evidence that you provided and for your appearance here today.

Meeting closed at 12:33.

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