The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 2 April 2014

Session 4

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PUBLIC AUDIT COMMITTEE
7th Meeting 2014, Session 4

CONVENER

*Hugh Henry (Renfrewshire South) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Bob Doris (Glasgow) (SNP)
*James Dornan (Glasgow Cathcart) (SNP)
*Colin Keir (Edinburgh Western) (SNP)
*Ken Macintosh (Eastwood) (Lab)
*Tavish Scott (Shetland Islands) (LD)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Ranald Mair (Scottish Care)
Bill Nicoll (NHS Tayside)
Catriona Renfrew (NHS Greater Glasgow and Clyde)
John Walker (Perth and Kinross Council)
David Williams (Glasgow City Council)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 1

Scottish Parliament

Public Audit Committee

Wednesday 2 April 2014

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

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning and welcome to the seventh meeting in 2014 of the Public Audit Committee. I ask members, witnesses and the public to ensure that electronic devices are switched to flight mode so that they do not interfere with the recording equipment.

Agenda item 1 is a decision on whether to take item 4 in private. Do we agree to take that item in private?

Members *indicated agreement.*

Section 23 Report

"Reshaping care for older people"

10:00

The Convener: Item 2 is the section 23 report "Reshaping care for older people". I welcome to the committee our panel of witnesses: Annie Gunner Logan, director, Coalition of Care and Support Providers in Scotland; David Williams, executive director of social work, Glasgow City Council; Catriona Renfrew, director of corporate planning and policy, NHS Greater Glasgow and Clyde; John Walker, executive director of housing and community care, Perth and Kinross Council; and Bill Nicoll, general manager of Perth and Kinross community health partnership, NHS Tayside. We will be joined shortly by Ranald Mair, chief executive of Scottish Care, but I believe that he has a meeting with the Scottish Government at the moment.

Bill Nicoll and John Walker would like to make a joint opening statement. David Williams—and Ranald Mair, if he arrives—would also like to make statements.

Bill Nicoll (NHS Tayside): Thank you, convener. My colleague and I welcome the opportunity to provide oral evidence to the committee in support of its inquiry into the Scottish Government's reshaping care for older people programme and associated change fund arrangements. Since the inception of the programme in 2011, NHS Tayside has been building on the existing strong partnership arrangements with Angus Council, Dundee City Council and Perth and Kinross Council and with third sector organisations and Scottish Care representatives in each area.

We understand that Perth and Kinross has been cited positively for its leadership and outcomes for older people in the "Reshaping care for older people" report and the pilot joint inspection report for older people's services that was conducted recently for Perth and Kinross.

The strengths that are making a difference to older people and their carers in our area are: a growing focus on achieving positive individual outcomes for older people; the high motivation and strong commitment of our staff to improving the lives of older people in Perth and Kinross; the development of a strategic approach to community involvement and community capacity building; and a clear and shared vision and positive leadership from our managers at every level.

The change fund investments have made a clear impact in a number of areas, including the development of a rapid response service linked to

an immediate discharge service to improve discharge pathways and avoid unscheduled admissions, where appropriate. Our dementia work has been strengthened by the Strathmore dementia project, which has instituted a range of community-based supports for people with dementia and their carers. Investment and closer working relationships with Perth and Kinross Association of Voluntary Service are developing engagement capacity and linking volunteering capacity to those who are supported by local services on discharge from hospital.

I will now hand over to my colleague John Walker.

John Walker (Perth and Kinross Council): Thank you for the opportunity to speak to the committee.

There have been challenges in managing the process. We have been rigorous in taking a business case approach to targeting and evaluating our investments. Although commitments have been made by our partnership for as long as possible, the nature of the change fund is that we have fixed-term contracts for staff, which has resulted in the need to accommodate staff turnover.

The local authority and NHS Tayside have been innovative in the use of their resources to augment change fund resources and to provide funding support for local unscheduled care action plans. We have a particularly interesting test of change in our Angus and Dundee geographical areas that we wish to pursue in Perth and Kinross, which is about preventing unplanned admissions and getting preventative care to older people as quickly as possible.

Those developments are individually and collectively beginning to show a real impact in improving outcomes against rising demand as a result of demographics. The challenge is now one of taking forward improvement to a level of transformation, scaling up the developments and moving to sustainable delivery that is embedded in a way that means that care and support are provided alongside individual and community capacity building and resilience. We need to move the resources around the system in that way.

We have access to a rich source of data through the integrated resource framework, which provides knowledge of resource consumption across health and social care. Through the use of that data and by visiting general practitioner practices and building locality teams around GPs, we will manage to get some traction in relation to understanding the impact of GP decisions. At the moment, we use the framework to identify hospital admission rates from GP practices, in order to promote integrated team work and the use of alternatives to hospital.

The analysis of variation in resource consumption and health outcomes around GPs, together with the development of locality teams and an engagement process with local people that gives people confidence with regard to the way in which services are changed, will provide the conditions for planning the sustainable commissioning of services into the future.

David Williams (Glasgow City Council): Thank you for extending to the chief executive of Glasgow City Council an opportunity to speak to the Public Audit Committee. I am happy to speak on his behalf today.

Reshaping care for older people is a necessary and difficult social policy to implement. It is necessary for all the reasons that have been outlined elsewhere, primarily demographics and the level of public funds in the years to come. We simply cannot continue to do what we have done for years. It is also the right thing to do. Most people tell us that they want to remain in their own homes.

It is a difficult policy to implement, however, because it involves a change that is set within the context of incredibly complex interrelationships, dependencies and cultures between and across four completely different sectors that were established over countless years. Intermingled throughout all that is the level of expectation of what the state will provide when one reaches a certain age and level of functioning.

It will take time and patience to deliver the change, because of the profound depths of the difficulties that I have touched on. We should, perhaps, not be at all surprised by the conclusions that Audit Scotland reached recently.

In my view, creating the environment for change in a safe way will take more resource than 1.5 per cent of total spend over a time-limited period. At the very least, that should be taken as a request that the change fund not be removed at the end of this financial year.

Delivery of the proposal will require a step change in activity and pace from here on in order to deal with what is becoming an increasingly stretched environment. There is no slack whatsoever in the system. For instance, if two hospital social workers go off on long-term sick leave at the end of November, delayed discharges in the south of Glasgow will go through the roof two months later as a consequence. Obviously, the situation is considerably more complicated than simply those two social workers going off on sick leave, but such an incident is a trigger when there is no capacity in the system.

The need for pace will cause tension if, as we have done to date, we operate on the basis that we need consensus from all stakeholders before we do anything. However, the commitment to partnership working is absolute. It will take brave decisions at the local and national levels if we are to move towards the culture of early intervention and prevention being the norm rather than being seen as a project. That shift in the balance of care necessarily involves a shift in the relationship between the state and the individual; an emphasis on an acceptance of risk and the effective management of risk, rather than on risk aversion; and an acceptance of the need for pragmatism at times, rather than an insistence on an idealistic and unsustainable position.

The Convener: I believe that Mr Mair would like to make a statement.

Ranald Mair (Scottish Care): Yes. I apologise for my late arrival.

Scottish Care welcomes Audit Scotland's report on reshaping care. We were part of the advisory group on the report. Scottish Care has taken on a role of representing the independent sector nationally and locally in reshaping care and change fund partnerships.

It is important to note that the first paragraph of the report, on page 5, says:

"The public sector in Scotland faces significant challenges in reshaping care for older people".

It is unfortunate that the words "The public sector in" were used, because it is Scotland that faces significant challenges. The agenda is not just for the public sector; the third and independent sectors share it, as do the people of Scotland. The focus should be not narrowly on the challenges in the public sector but on the wider challenge that faces us.

More than half the social care provision in Scotland is delivered by the third and independent sectors. More than half the social services workforce is employed in the third and independent sectors. It is important from the outset to see us as full partners in the process. We have wanted to be such partners, so that we can step up to the plate in assisting with the reshaping of care and the shift in the balance of care.

Reshaping the care of older people involves a complex change programme. The experience has varied across the country. In parts of the country, the third and independent sectors have been accepted as full partners in the process, and it looks as if that will carry forward into the models of health and social care integration in those areas. In other parts, the process has been much more difficult. However, in general, we feel that progress has been made.

I will make a couple of other introductory points. The report says that limited resources have been shifted from institutional care to community services. When we embarked on discussions about reshaping care with the Scottish Government six or seven years ago, the goal was not to empty hospitals but to avoid the need to build more hospitals. Simply being led by the demographics would mean creating more acute sector provision to cope with demand. Against the demographics, if we have managed to stand still or reduce institutional care slightly, that is quite a success.

The danger is that, because there is a perceived need for reshaping care to be self-funding, spending must reduce in one area to fund development in another. However, in social work and social care in the 1980s, when we were developing community care and trying to end the reliance on psychiatric hospitals and so on, significant bridging finance was provided to create new infrastructure while the existing provision was held in place. After that, the hospitals were able to be closed. That programme went on over a period of years.

Additional funding to invest in community provision needs to be attached to the step change that is needed, but the danger is that we will not make the required progress if we think that we need to make a saving in the acute sector to fund development elsewhere. To be frank, given the demographics, that will not happen any time soon.

The coming year is important because of the transition to integration and the introduction of shadow boards. The change fund has been a dress rehearsal—our starter for 10. We must carry forward the learning from that into the brave new world of health and social care integration and strategic joint commissioning. That is the test. At that point, we will be playing with the whole £4.5 billion and not just 1.5 per cent of it. From my perspective, it is important that the third and independent sectors are accepted as full partners with public sector partners in the process.

10:15

The Convener: I thank all our contributors.

I want to clarify something with Mr Walker and Mr Nicoll. You spoke about the close working relationships in the integrated services in your area, but I was not clear whether there is a close working relationship that involves the CHP, the national health service and Perth and Kinross Council, a close working relationship between the CHP and Angus Council, and a close working relationship with Dundee City Council. Is there a close working relationship with all the councils,

which are working in a more integrated fashion? Does each council continue to work on its own?

Bill Nicoll: NHS Tayside as a body certainly works very closely with all the partners in each of the three constituent areas of Tayside. When we get down to the local level—in Perth and Kinross, for example—it is about all the partners putting their weight behind what needs to be achieved, as Ranald Mair said. In each of the three areas, the partnership is very strong between the part of the health service that is represented by the CHPs, the local authority, the third sector vehicle in each area, the third sector interfaces, Scottish Care and a whole range of other partners, including, as John Walker said, local community representatives, who are critical to success.

The Convener: But that does not answer the question that I asked. I understand that you have a close working relationship with each of the partners, but I am interested in whether the partners have a close working relationship with one another or whether they still operate on the basis of council boundaries and council budgets.

John Walker: We work very closely, but we work within our partnership areas, because we have different challenges in different areas. Dundee, for instance, has an inequality challenge on a scale that is far different from that in Perth and Kinross. Although we are talking about the reshaping care for older people agenda, Dundee, like everywhere else, has an eye on what can be done about people who, as a result of inequalities, suffer poor health under the age of 65 and will become dependent on services when they are past 65.

We are not working across the partnerships around Tayside in terms of a relationship across Tayside; we learn practice and change tests from one another. It is a matter of what has worked and what has not worked through the change fund. The relationships between the partners that Bill Nicoll described are very close within our own partnership areas.

The Convener: So you may find that, although there is a good working relationship between the NHS and the local authority, service delivery and priorities may be different in each area.

John Walker: Absolutely. It depends on the resources that are available, as well. For instance, Dundee does not have any community hospitals, but we all have a share in how Ninewells operates. We have community hospitals in Perth and Kinross, but Angus does not have any community hospitals.

It is really encouraging if we get the confidence of the public. Bill Nicoll recently attended a public forum involving 200 people. Members of the public went along to hear a conversation that we have been building with them on the future of an older people's home and a community hospital that are in close proximity to each other. The conversation is about the model of care that should come out of the hospital and the older people's home jointly in the future. The public walk away thinking not that they were there to close a hospital, for instance, but to listen to a conversation about how to improve local health services for the population.

The Convener: The integrated resource framework was mentioned. Is that an integration of the NHS systems and local authority systems, or does it enable you to share information between local authorities, as well?

Bill Nicoll: The integrated resource framework spans authority areas. NHS Tayside is one of the original demonstrator sites, and profiles have been developed for each of its three local authority areas. The information is available at a granular level: it goes down to individual clients, customers or patients—however one wants to describe them. We can aggregate the data across Tayside and look at the whole profile of resource consumption, or we can look at individual localities such as a GP practice population or a geographic locality, either in Perth and Kinross or more widely across Angus and Dundee too.

The data give us a huge range of intelligence, because they include all the health and care consumption not only in acute hospitals such as Ninewells, but through all the activity that goes on in any of our services. We can drill right down to an individual level and then aggregate the information to get a picture of how different communities and areas access and consume health and care resources.

That illustrates the variation that exists. Even after we have adjusted for population factors, we see variation that is accounted for by differences in decision making and the confidence that GPs have in the services around them, which can allow them to avoid the need to hospitalise patients. It is a rich vein of information and it can be used across the area to look at the patterns of consumption, regardless of whereabouts in Tayside an individual lives.

On John Walker's point, it is important that the agenda is very local. The differences between populations and how they are configured mean that the challenges in Dundee are markedly different from those in Perth and Kinross and Angus. It is important that the future health and care partnerships operate at that level and focus on the distinct issues that need to be addressed in their communities. That would be just as true for NHS Greater Glasgow and Clyde areas as it would be for anywhere else.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): On a point of information, the Public Bodies (Joint Working) (Scotland) Act 2014, for which reshaping care was very much a precursor, requires each partnership area to prepare a strategic plan and set up a strategic planning group. We are now looking—all of us, in various ways—at the secondary legislation that is associated with that work.

My understanding is that the joint strategic planning groups will be open to representatives from neighbouring authorities and health boards for precisely the reason that I suspect is behind the convener's question. It does not all happen in one partnership area; there is at least some scope for partnership across authorities.

Catriona Renfrew (NHS Greater Glasgow and Clyde): We are blessed with more partnerships than any health board in Scotland, as we cover six different local authorities. Annie Gunner Logan is right, and we certainly intend to bring the new partnerships together to work with us in planning acute services, which clearly do not respect local authority boundaries.

It is important that the new partnerships focus on the use of acute care by their population. Unlocking the current models of acute care will be fundamental, and—notwithstanding the point that the change is not just about a shift in resources—the reality of the economic climate means that we have to make best use of resources. At any given point in time, 10 per cent of our acute hospital beds have patients in them who are waiting for social care, so from a simple economic point of view we have to be more rigorous in addressing that problem.

The change fund has helped, and I agree with David Williams that the suggestion that is now being mooted that the change fund will end after the current financial year is a serious concern for our board. The fund has supported a significant shift for us in delayed discharges, and we have reduced by about 30 per cent the number of bed days that are lost in that way.

Bob Doris (Glasgow) (SNP): I want to drill down on the use of the change fund. The fund does not have to achieve everything. As a member of the Health and Sport Committee I am aware that it is about trying new ways of working. Sometimes they will work and can be rolled out across an area; sometimes they will not work, in which case we move on to the next thing. Through the change fund, failure sometimes affirms that a particular route is the wrong pathway to go down, so we try something different, and I am content with that. An audit would perhaps not detect such things.

However, given that the fund was always about new ways of working and about finding ways of mainstreaming that financial commitment around new ways of working, I am interested to hear from the witnesses an example of something that is working—something where you have already done modelling work on how to mainstream that funding.

I am not talking about whether there is a change fund in 2015-16 or 2016-17. I am talking about funding from your existing core budget, which I know is stretched and under strain—I appreciate that. However, there was never any doubt that the change fund was a temporary lump of cash over a set number of years, which was there to enable people to try new ways of working and then to model sustainability into the system as it was rolled out.

I am very keen to hear from witnesses an example of something that is starting to work and what steps they have been taking to mainstream that, irrespective of whether the change fund is extended. I appreciate the financial strains that everyone faces at this time but that was the task that the sector was given, so I am keen to hear some examples.

Ranald Mair: One of the areas in which we have seen most innovation is around intermediate care alternatives to hospital—step-up, step-down care. Most areas have developed models, although there is not a common language framework around them. In some areas, they are called virtual ward models; in others, they are called hospital-at-home models. The language of intermediate care is quite varied, which can sometimes make it more difficult to make comparisons. However, the use of alternatives to hospital has been one of the areas in which there has been significant piloting under the change fund.

The challenge is whether all the models are scalable—again, that is the challenge that comes through from the report. In a sense, the change fund has allowed some quite small-scale, sometimes quite high-cost, developments to try out models. The challenge then is to ask, which of those models can we embed and can we embed them at a scale that makes an impact?

For instance, some of the dialogue with Glasgow is around scaling up intermediate care. A model has been tested, but the work is not quite complete and the change fund is continuing to support the model. However, I know that there are similar developments in Edinburgh, in Fife and in other parts of the country, so I would flag intermediate care as one area in which there has been some real progress and where there is at least the potential for those models to become embedded. It is likely that the strategic

commissioning plans, as they come through, will all emphasise intermediate care for the future.

David Williams: I agree with Mr Mair about what we are increasingly calling step-down provision, which is there to facilitate some of the activity that Ms Renfrew referred to in relation to delayed discharges: to assist the discharge of patients from hospitals to avoid bed days lost and delayed discharges.

Within Glasgow, we have put a level of investment into developing the step-down model, which involves supporting patients who are deemed fit for discharge to have an intermediate place of full-time care as they continue their recovery and recuperation. The intention is preferably for them to return to their own homes and their own communities.

As Mr Mair indicated, that model is a relatively high-cost way of working and we need to consider how to scale it up in order to ensure that we continue to meet the agenda of not having people in hospital a day longer than they need to be. One of the important factors that we have to face up to over the course of the next 12 months is not just the integration of health and social care, but the move, from 1 April 2015, to a two-week delayed discharge target and how we meaningfully deliver on that target in order to ensure that people are coming out of hospital as quickly as they can. We are looking at scaling up significantly the number of and availability of step-down beds from within the private sector in Glasgow.

10:30

Within social work services, we have responded to the expected demise of the national care homes contract by looking at a local commissioning model. We are about to move to a framework tender of providers over the course of the next month, which will scale up and scale out, if you like, the level of expected purchasing and provision over the next five years. Within that, we expect to create an environment that will allow us to fund a significant scaling up of the step-down beds that are available under the integrated arrangements.

I also want to mention the success of reablement, which was initially funded by the change fund in the first two years to provide the specialist skill base that is required to deliver it. That has had some very significant levels of success in a scalable model in Glasgow. The challenge is how it continues to be funded. We had funding from the change fund for the first couple of years and the local authority has substantially absorbed the need to fund the continuation of that provision and the continuing scaling up of it. There have been significant results in the volumes of older people who are being reabled and are substantially regaining the skills and confidence that they had prior to the situation that led to a hospital admission. That is having a significant impact in throughputting people, if you like, in and out of the system. Money will be released substantially by ensuring that people are helped to be independent for longer and that they are not as dependent on state funding as they have been hitherto.

The Convener: A number of members want to come in—I think on the same issue—so we will let the discussion run for a bit.

Bob Doris: As we are getting other examples of models for scaling up, it would be good if you could perhaps write to the committee with more information on that.

I am sometimes not sure whether I am sitting on the Health and Sport Committee or the Public Audit Committee but, given that this is the Public Audit Committee, I would be interested not only in the numbers around the outcomes for patients—our constituents—but in the identification of mainstream cash and where the savings are, be it time-release savings or whatever. I get the picture, if you like, that more change fund would be good, but as a Public Audit Committee and a Health and Sport Committee member, I would like you to identify core budgets that can be used to scale that work up and get some of the time-release savings out.

The Convener: I ask that, when witnesses do that, they identify not only where the change fund has helped to identify how mainstream budgets could be skewed but whether the application of the change fund helps you to identify gaps in services that require additional funding.

Catriona Renfrew: The change fund has basically helped to mitigate a series of other problems and pressures that would probably have overwhelmed the system if it was not in place. The audit report highlights some of those.

The idea that we are releasing money from acute services is continually undermined by the priority that is still given to acute service targets and acute service developments over everything else in the health service in Scotland. Our financial plan for this year, which we are just finishing, is entirely driven by waiting-time targets, the introduction of new drugs and a whole series of developments that are essentially about increasing spending on the acute sector and not increasing spending on primary care or community services. We have used the change fund to bridge that gap to at least make some investment in services to older people.

The same applies in primary care. It is helpful that the audit report picks up on the pressures on

primary care. Talking to GPs about doing more for older people in the community is not a purposeful discussion when the national contract does not generate for them any income or additional resources to do that. A real problem is that there is no new recurring money for primary care that in a visible way encourages GPs to refocus their practices to deal more with older people.

Annie Gunner Logan: I might have been invited to the meeting as the director of the Coalition of Care and Support Providers in Scotland, but in some ways the committee is getting two witnesses for the price of one. I also sit on a body called—I hope that I can get the title right—the health and social care integration third sector advisory group, which includes colleagues from a much wider group of third sector organisations. My organisation looks after those that provide commissioned and contracted services, and I have to say that they did not see a lot of the change fund.

Where the third sector managed to tap in to the change fund was through the more community and volunteer-led capacity-building types of support. As well as focusing on the formalised services that will be swapped from institutions to the community, we have been interested in increasing the proportion of older people who do not need services at all, because we felt that that work needed to be done if we were going to reshape care at all. According to the statistics, at the start of the programme something like 90 per cent of people over 65 did not use health or care services, and the key to the whole agenda is to make that number bigger rather than smaller.

In that respect, the third sector has taken forward the community connecting service, lunch clubs, befriending activities and so on that, although pretty low-level, can be used to increase the numbers of people who can be kept out of the system. The Audit Scotland report makes it pretty clear that a lot of national data is missing, and one of the missing bits is the exact spend on those kinds of activities. We reckon that somewhere between 10 and 20 per cent of the change fund was spent on that, but that is purely anecdotal evidence that has been collected from individual organisations that received the money.

There is now a burden of expectation on those projects to produce evidence of their impact. Audit Scotland is quite right to say that evidence-based practice should be used here, but those kinds of projects have what I would call a soft impact and it will be a very long time before we can figure out whether they have reduced hospital admissions. In any case, if that data is not collected, we will never find that out. As you have heard already, the change fund is non-recurring and, when it ends, so too will a lot of useful projects that are, we believe, making a strong contribution. The only way in which we can make the projects sustainable is by saving money elsewhere, and Catriona Renfrew has already suggested some of the difficulties in doing that.

If I may, convener, I would like to read a short comment from one of the organisations, which said:

"What can I say ... too little of the pot, lots of difficulties with doing 'good enough' evaluation (but at the same time, funders not telling us what is good enough, or even what they want and not really 'getting' what we are trying to do)"

because it is not formal service provision.

"It feels like huge amounts of money get agreed within the system with hardly any accountability or evaluation, whereas we have to work our socks off"

and do loads of stuff

"to justify £20,000."

That is where we are coming from on this issue.

If I can bore you for two more seconds, I feel that as a matter of protocol I should say that I wear another hat with regard to this matter.

The Convener: Oh, right. You are a busy woman.

Annie Gunner Logan: I feel obliged to say that since January I have been a non-executive director for the Scottish Government and sit on its health and wellbeing audit and risk committee. I am not speaking in that capacity this morning, but I should put that on the record.

The Convener: Thank you.

Tavish Scott (Shetland Islands) (LD): I am really interested in Catriona Renfrew's last—and, I thought, very telling—point about GPs, and I want to link it with the remark that John Walker made in his opening comments about his experience in his own area of Scotland. When Mr Walker talked about GPs, he mentioned a multidisciplinary locality team. What does that mean, and what does it do? More to the point, is the model successful and working?

John Walker: We have taken our staff on a journey of working and learning together so that they understand each other's roles across health and social care. That means that the social workers understand the issues for the charge nurse in the hospital and vice versa. We have created those teams to accelerate people's move out of hospital and to reduce the average length of delay in hospital, but they also mean that we can link with GP practices and use the data that Bill Nicoll talked about through the IRF to start a conversation—

Tavish Scott: Sorry, but what is the IRF? That is jargon.

John Walker: I beg your pardon. It is the integrated resource framework, which is a way of understanding the consumption of resources across health and social care.

GPs are very much the key because, at the end of the day, they make the decisions about where patients end up. GPs need to have confidence, along with members of the community, in the alternative service provision that we are creating. We have the confidence of some GPs, and some of them are using our rapid response service, which is a multidisciplinary team consisting of nurses, occupational therapists and social workers.

I mentioned in my opening statement that work is being done, through the development of a multidisciplinary team approach in Dundee and Angus, on the prevention of admissions further upstream. With older people who are known to all services, as soon as there are any tell-tale signs that someone is about to go into decline, the services get in there as quickly as possible. That team includes geriatricians, who are another key group. My experience is that geriatricians tend to attract people into hospitals. That multidisciplinary team approach is geriatrician led, and we are seeing real benefits in terms of reducing delayed discharge.

Tavish Scott: How long has the team been running? Is it 12 months?

John Walker: It was for just a couple of months last winter. We want to take the learning from Dundee and Angus and use it to build on our rapid response approach in Perth and Kinross. The really encouraging thing is that, because the team that has been created is linked to the community, we have a potent combination of people in a locality who are willing to discuss the way that we want to change services in that community. The confidence that we get from communities will enable us to change services and will put us in a strong position in the medium to long term.

Tavish Scott: Indeed—I can entirely understand that.

From the council's perspective, how are GPs doing on the journey that you describe? Perhaps I can get Mr Nicoll to give us Tayside NHS Board's perspective on that, too.

John Walker: I hope that we will say the same thing.

Tavish Scott: If you say the same thing, that would be helpful but, if you do not, you do not.

John Walker: Bill Nicoll and I have walked into surgeries with the integrated resource framework data and found the GPs to be very interested. The purpose is to stimulate their interest and for them to see the financial impact of their decisions. Engaging GPs is a challenge, because of their workloads. Also, because they might remit only one or two people a week from their surgery to hospital, in their world, they do not see it as a big problem. From their GP surgery, they do not see the cumulative effective on the hospital system.

We have begun our journey on creating multidisciplinary teams in highland Perthshire, and we wish to roll out the approach across Perth and Kinross. However, the critical factor is to have those teams working routinely with GP practices, so that we can use the data. We have rich data about, say, the top 10 consumers of health and social care within a GP practice area. We tend to find significant differences between the top 10 people who consume resources through unplanned admissions and the top 10 users of social care input. That is the conversation that we have begun with the GPs.

Bill Nicoll might want to explain what we have done to create an engagement structure with the GPs.

Bill Nicoll: I am perhaps a bit more optimistic about the opportunities with general practice. The work that has been done on equality in general practice work and on GP clusters coming together to work on improving pathways is a good example that links well to John Walker's description of the locality multidisciplinary teams. In my opinion, it is critical to success to have clusters of practices working together across localities. There are opportunities that I am beginning to see positively. There are opportunities in the new contractual arrangements that are emerging, subject their being agreed.

As has already been said, it is important to create time to free up GPs from the relentless slog of patients coming through the door, so that they can look outside the practice at the wider community and work positively with the resources in it. Freeing up GP capacity to do that and having locality leadership within general practice and a focus on anticipatory care planning are all part of what is happening.

We have a key information summary system that provides information to GPs on people with anticipatory care programmes, which links across the ambulance system through to acute services. That is a good way of ensuring that people with anticipatory care plans do not finish up being hospitalised unnecessarily.

10:45

Tavish Scott: Do you think that enough is happening in the current system to let you do what you need to do with GPs?

Bill Nicoll: I think that the framework is beginning to be put in place. A lot depends on agreement around the changes to the model of working within general practice and the amount of shift that there is. Without being disrespectful to my colleagues in general practice, we have practices that are in the same building but the only thing that they have in common is that we have removed the need for one of the internal walls. The position is almost as simple as that. We need to build relationships between general practices in order for them to work collectively with the wider system. There is still a bit of work to be done on that, but I think that the changes are good, positive opportunities for us to build on.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I want to pick up on Mr Mair's comments. Paragraph 28 of the Auditor General's report is about limited evidence of progress in moving money from institutional care to community care. I took Mr Mair's point that, in a way, standing still is almost progress. However, since 2004, it has been the Scottish Government's policy to move resources away from centralised service provision and institutionalised services and out into the community. The implication of what Mr Mair said is that that is not happening to any huge degree, although we are now 10 years down the line and successive Governments have had that policy. What evidence do we have that the policy's aim has been achieved?

Ranald Mair: Just to clarify, I was not saying that there had been no shift; I think I was saying that savings in one area alone would not allow you to develop community services' capacity to deliver against the demographics. I am not quite sure why I am being sympathetic to the hospitals, but there is a limit to the extent to which we will be able to close hospital wards, which is not deemed a great vote winner by most politicians. There is therefore a real challenge around whether we will be able to release resource from the hospital sector to fund the development of home care services and care homes.

Frankly, I do not regard care homes as being part of institutional care; they provide care in homely settings within the community. If we are going to develop the infrastructure of provision in communities, additional resource might need to be found to build up that infrastructure. I do not think that we can rely on the downsizing of the hospital sector to fund the level of development that will be required in the community—I do not think that there is evidence from the change fund for that. However, I am sure that my colleagues are more able to make that argument than me.

Bill Nicoll: I think that there is a timing issue. If we go back to the example of mental health, we were able to demonstrate over time a big reduction in demand for in-patient care for people with mental health problems by expanding the community base of the service. We did that on a permanent, once-and-for-all basis. We used bridging finance to pay for hospital double-running costs while that change was taking place, and we could see the evidence that the beds were no longer required in the system.

I will give an example to answer the question about where we can see a real trade-off. Staff in the Strathmore area of Perth and Kinross came to me and my colleagues to say that, on average, six patients came into their in-patient dementia assessment unit in the community hospital not for in-patient assessment but because the beds were there. The staff said that they were aware of hundreds of people with dementia in the community and they believed that they should redesign their service as a community-based team.

We supported that process. It was challenging because of concerns about the impact that it would have on the hospital. However, the staff went out into the community and are now delivering one of the best dementia care services anywhere because they are see patients where they exist most of the time, which is out there in the community. People are not arguing to reinstate the beds because they now have the best possible dementia care service, which we are looking to scale up.

My message is that there are opportunities for us to start to redeploy acute resource into the community. We should not start with the difficult process of closing beds; instead, we should first take geriatricians out into the community and have a community-facing acute sector that starts to work with the community base, with a common interest in changing the approach to or profile of the way in which people are looked after. My message is that, rather than starting out with the big-ticket issue of beds, we should start with a transition from the acute sector out to the community, so that the acute sector becomes community facing and we start to mobilise some of the resource out.

Catriona Renfrew: It is not just about beds and reshaping the current resource. The reality is that, in every one of the 10 financial years during which the statement that we need to shift the balance of and reshape care has been made more times than any of us would care to count, the driver of boards' financial planning has been acute access targets, new drugs, reduced waiting times and so on. Those things all cost money: it costs money to improve cancer services and to give patients access to more IVF, insulin pumps—the list goes on.

There has been a gap between quite legitimate political priorities—improving care and access to it in the acute setting—and the rebalancing care agenda. It is very difficult to do both in a relatively constrained financial climate. I thought that Annie Gunner Logan's comments about low-level community support perfectly illustrated the fundamental problem that the NHS has had since 1948: what is the balance between prevention and looking after the people who are already ill?

Fifteen years ago, councils funded the services that Annie Gunner Logan described. We are in a cycle: we are trying to reinvent all those services, which got cut as council budgets came under pressure and demand from more high-need older people rose, but then the change fund will change and we will disinvent them again. We need a coherent approach over time that asks what prevention really delivers and how we protect cash for it. Prevention is being squeezed across all services. For example, the keep well campaign, which provides prevention in primary care, will finish over the next two or three years.

Where I part company with Bill Nicoll slightly is that I think that the fact that around 10 per cent of Scotland's acute beds are filled with delayed discharge patients is actually quite a good place to start. It is a terrible failure for the individual older person and costs a lot of money. It is not the be-all and end-all, but focusing on that single issue and trying to resolve it is part of the route to creating some wriggle-room on resources, which is fundamental to developing the infrastructure that delivers prevention.

The Audit Scotland report highlights the lack of clarity about outcomes. We have always had the view that delayed discharge bed days should be a key outcome for older people because it has a series of consequences for patients. Yes, the number over two weeks or four weeks is important, but that is not the big driver of resources; the big driver is total bed days. Sometimes we have to focus on many hundreds of things, but if we have to focus on one thing for the next couple of years, I suspect that we should deal with the bed days problem, because, certainly in our board area, that would enable us to address some of the other things that are being discussed today.

David Williams: I think that Ms Renfrew's comment on outcomes is absolutely critical in relation to how we continue to deliver services. The emphasis on that issue in the integration proposals and in expectations over the next year is central to where we should go.

From a Glasgow perspective, I am very clear that probably too much of the social work services budget in Glasgow is spent on intensive, reactive crisis intervention provision. It is about reacting to delayed discharges and maintaining citizens at the level of service provision that they were getting when they came in. That is why I stress the importance of reablement and step-down services, for example, and creating and developing what in my department in Glasgow I term a throughput mentality.

It is right to focus on early intervention and prevention. I need to find a way to do that in Glasgow. I am quite clear about our responsibilities and our direction of travel within social work services, as part of the partnership. My responsibility is to rebalance the social work services budget so that more funding is available for early intervention and prevention.

It is clear from their letters to me that some of the elected members around the table have experience of elderly service users having lengthy waiting times for occupational therapy assessments. People who have got what is considered low-level occupational therapy need can wait for a number of months for an assessment. It stands to reason that if we can provide something for those people at an earlier stage, their circumstances are less likely to deteriorate, which means that they are unlikely to end up causing us and health greater cost when we get to them.

Annie Gunner Logan's comments about the evaluation of low-level early intervention and prevention are right. It is indefinable to a certain extent, but logic tells us that if we do not get to people who have clearly identified OT needs or other dependencies quickly enough, they will deteriorate and cost us more later.

Annie Gunner Logan: I have a couple of quick comments on hospital closures. Not for the first time, the 1980s model in mental health, with the closure of psychiatric and learning disability hospitals, has been raised. Although we were able to do that, there were three preconditions. One was the bridging finance, which we have already heard about. The second was serious investment in third sector alternatives: people who would otherwise have gone to Gogarburn or Lennox Castle were all pretty much supported by person-centred, third sector provision.

The third thing, which brings me back to Catriona Renfrew's point about delayed discharge, is that there was a strong social movement behind those hospital closures. It was seen as an absolute social scandal that people had to stay in hospital when they did not need to. Given the way in which the shiny new equipment and fabulous new hospitals are all puffed up, that sort of movement does not pertain at the moment. My sense is that it needs to: there needs to be a reorientation of the public's perception of services.

Ken Macintosh (Eastwood) (Lab): My question is very much on the same subject.

Mr Mair, you have twice had to correct expectations. In your opening statement, you said, "We're not going to empty hospitals; we're just going to stop building new ones." You then said, "We're not going to make any saving in the acute sector." Is it either an implicit or explicit assumption about the reshaping care agenda that it will save money in the acute sector?

Ranald Mair: My view would be that the process saves the additional money that we would otherwise have to spend.

We have to have investment in community provision, such as care-at-home services, community capacity development, care home provision and so on. That will reduce what would otherwise be an overwhelming demand on the acute sector. My only point has been that I simply do not think that we can rely on the acute sector making up-front savings year on year in order to fund those developments. However, taking Bill Nicoll's point, I think that shifting some of the acute sector resource into the community is a good thing.

The other big area where some progress has been made but more could be made is in palliative and end-of-life care. We should not have so many people dying in hospital and choosing to go into hospital to die. There is a conversation to be had with the public about the best place to die and about how we resource the capacity to support people to die at home or in appropriate care settings in the community and therefore take some of the burden off the hospitals.

11:00

All that I am saying is that the driver cannot come from immediate savings and immediate reductions in the numbers of beds. I hope that, if we manage to refocus care and shift the balance, there will be a reduced demand on the acute sector over the piece. However, I think that we will have to develop capacity to do that, and that that in itself might require there to be some shift. Some can come from within the existing pots.

I have been very consensus-orientated so far this morning but, obviously, the balance between local authority-delivered care and care that is delivered by the third sector and the independent sector is an area in which there could be significant savings. I have some concerns about the fact that, in some cases, the change fund has been used to protect high-cost public sector jobs, which was not its purpose. Market facilitation, diversification and choice are important as well. However, I think that we will have to target development at a community level in order to build up capacity without that being dependent on initial savings being made in the acute sector.

Ken Macintosh: I will ask others for their comments on that issue but, really, does there not need to be greater political leadership or clarity in this area?

Catriona Renfrew has identified bedblocking as an issue; Bill Nicoll identified dementia beds as an issue; and Mr Mair has just identified palliative care as an issue. However, none of those is the driver; the driver is the need to control spending. The fact is that the Auditor General said that the rise in spending is unsustainable and specifically said that there is limited evidence of progress in moving money to community-based services. She was not talking about creating new money.

From all your comments, there seems to be an implication that money will be moved from the acute sector—in particular from the hospital sector—to the community sector. Should there be greater clarity that that will not happen? That might be a long-term objective, but it is clear from what you are saying that it does not seem to be possible in the short term.

Catriona Renfrew: I struggle to agree with what Ranald Mair is saying. I do not see how, when 10 per cent of Scotland's hospital beds are filled with people who should not be in hospital, it is impossible to reduce the costs of acute care in a reasonably short space of time through reinvestment. I cannot understand the logic that lies behind the statement to the contrary.

Ken Macintosh: Just to clarify, you think that there could be a 10 per cent saving on hospital beds and it—

Catriona Renfrew: It is self-evidently the case. There is no controversy about the people in those beds. The local social work services, the health services and the consultants who are responsible for them have all agreed that they do not need to be in hospital. They are not the people whose admission we are trying to avoid or who we are trying to give anticipatory care to; they are people who are trapped in acute hospitals because other care is not available.

Putting the other care in place has hugely challenged us. In a sense, the change fund has played a bridging role—it was new money. As I said, we have reduced delayed-discharge bed days, and I think that other boards might have done so, too. However, we have not made the necessary systemic change.

I empathise with David Williams's point about waiting times. We still have a culture that says that, for older people, waiting is okay. In most of the health service, rather than having an acceptance of waiting times we have said that

people should not wait for a scan or an assessment, because the way to run an efficient system is to ensure that people get the care close to the point that they need it. However, in some local authorities, people can wait for a year for aids and adaptations. That is an acceptable norm, but it would not be acceptable for anything in the health service, because we have really hammered down waiting times.

There is a piece of the acute provision that is easily identified as being in need of being sorted, even if it is not easily solved. Acute care doctors, including geriatricians, will tell you that large numbers of patients are in acute hospitals because we do not have systems to care for them in other ways. Palliative care is one example. The number of bed days that have been consumed by people in our health board who have come into hospital to die is, again, massive.

I think that there is an opportunity to radically reshape acute care. It is not the only solution, of course, because issues around the demand, the demographics and the pressure on social care budgets are bigger than that. However, I certainly do not accept the view that acute service reductions are not part of the solution.

Political leadership is a fundamental issue. After all, hospitals are very precious to people and bed numbers have become a huge issue in Scotland; in fact, baseline bed numbers have become a bit like the numbers of policemen—or, I should say, police people—on the beat. We need clarity on this matter, and a really important message that needs to be sent out is that if we want older people to get really good community care—and we should remember that most older people do not want to be in hospital—the operation of hospitals will have to change radically.

Ken Macintosh: I can see that the other witnesses want to respond.

The Convener: I am sorry, but we just do not have time for that.

Ken Macintosh: There were two other points that I wanted to make. First of all, I might be wrong, but it sounded as if Mr Mair was making a bid for some of Mr Williams's money.

Catriona Renfrew: Mr Williams does not have any, so the effort was wasted. [*Laughter*.]

Ken Macintosh: Indeed. In her report, the Auditor General points out that, between 2002 and 2009, council spending on social care services rose by about 40 per cent to £1.33 billion but that, between 2009 and 2012, it fell to £1.26 billion. How can you make these changes and reshape care for older people when your budget is falling? Does your budget need to increase, or is there something else that you can do?

David Williams: There are probably a number of issues to address in that question.

Right at the start, Ranald Mair talked about the independent and voluntary sectors' contribution to the provision of social care to Scotland's citizens. However, I want to qualify those statements to a certain extent, because the overwhelming majority of the funding for those services comes directly from local authorities and the NHS. We should not lose sight of that fact. Indeed, approximately two thirds of Glasgow City Council social work services' budget—somewhere in the region of £300 million—is directly invested in purchasing services from the private and voluntary sectors.

Glasgow City Council's market share in relation to the provision of residential care is about 15 per cent. At any given point on any given day in the city, we purchase something of the order of 4,000 beds for older people, which is far above the national averages per head of population. We can compare that with somewhere like Manchester, for example, where about 2,000 beds are purchased at any given point.

As much of the evidence presented by Audit Scotland shows, Glasgow is an outlier in this respect. There are reasons for that, including the city's social and economic circumstances, the level of dependencies and people's need to access health and social care at an earlier age than perhaps is the case for people in other parts of the country. As a result, demand continues to be greater.

However, if we are to create the environment in which we can shift resource to develop a different culture and different service environment, we will need to address the number of people who are accessing residential and nursing care. That approach will complement some of the things that Catriona Renfrew and Ranald Mair were saying about palliative care, because the fact is that people want to die in their own homes instead of being placed in residential nursing care or hospital.

Earlier, Annie Gunner Logan talked about re-engineering public expectations of what services can provide. A pretty fundamental issue is what we—collectively as a partnership with service users, individuals and families—can deliver that is reasonable, rather than there being a continued expectation on our sector.

Mary Scanlon (Highlands and Islands) (Con): I have to say that I am finding this quite depressing. After all, it is 15 years since we first started to talk about integrated care working. I feel that I—and, indeed, the convener—have gone back to 1999 again, because we heard exactly the same comments from 1999 and 2002. It is depressing to sit here today and hear about the

promotion of integrated team working. I have got that off my chest.

Mr Nicoll and Mr Walker talked about Angus, Dundee and Perth. I am from that area and understand it well. I understand and completely accept the inequalities in Dundee, which you talked about. Given the picture that you described and the accepted inequalities, I would have expected the average number of home care hours and the spending on home care for older people in Dundee to differ significantly from those in Perth. However, the difference in average home care hours is about half an hour—the average is 7.8 in Perth and 8.4 in Dundee—and spending on home care for older people is 9.6 per cent of the total amount in Dundee and 9.3 per cent in Perth.

You emphasised to the convener the inequalities in Dundee in comparison with Perth and Kinross, which I accept. Given that, why do the allocated numbers of hours and the percentage shares of the budgets not differ more?

John Walker: A couple of factors are at play in the allocated number of hours.

As a result of the difference that we have spoken about, people live longer in Perth and Kinross. Furthermore, like David Williams in Glasgow, we have introduced reablement, which has meant that 40 per cent of our older people who come through reablement are diverted from the dependency on home care services that they would have had under our old traditional model. We have therefore completely transformed our home care services, and that has allowed people to live more independently. People are given a period of intensive home care support but, after that, many of them are on reduced hours. That has enabled us to sustain our services through a period of economic challenge.

As for the second part of the question, my explanation for our figure being lower is the reablement approach, investing in the third sector and creating a sense of wellbeing for people to live independently. It is also the case that we have reduced budgets because of the challenges that we have faced. Some of that has occurred through the use of commissioning contracts and the third and independent sectors to provide care on a greater scale than before.

Mary Scanlon: I do not have time to drill down into that as I have another two questions to ask, but I did not find that answer acceptable. We will move on.

Catriona Renfrew said that a coherent approach is needed. I am sure that you have all done your homework and looked at Audit Scotland's report. Exhibit 11 shows progress on the reshaping care for older people programme, which came out in 2010 and which forms a reasonably coherent approach. There are eight commitments, three of which have been achieved. All the witnesses are stakeholders in achieving the commitments, and I will ask about three of them.

Commitment 1 is:

"We will double the proportion of the total health and social care budget for older people that is spent on care at home over the life of this plan."

That figure has not doubled; it has reduced from 9.2 to 8.7 per cent.

Others have mentioned the change fund. Kenneth Macintosh said that there is limited evidence about more being spent on community-based services. Audit Scotland's report says:

"as yet there is no evidence that"

commitment 3

"has stimulated organisations to spend more".

I am also concerned about commitment 7, which is:

"We will ensure older people are not admitted directly to long-term institutional care from an acute hospital."

The report says that

"National data is not available"

on that.

Do you understand how difficult it is for Audit Scotland to present us with a report when the information from stakeholders is not available to allow us to audit and monitor spending? Why is the budget going down, why is there no evidence on the change fund and why is national data not available to measure older people going into institutional care?

11:15

Catriona Renfrew: I think that the answer to the first two questions is a conflation of all the issues that we have talked about, including the increased spending on acute services and the dilemma of investing in prevention and early intervention versus dealing with older people who are already at a point in the system at which institutional care is the only response.

Furthermore, if someone is in hospital now having had a significant health event and they need to go into a care home, they should be able to get into one. We should not be saying, "The policy is that you can't do that because you have to go somewhere else first." A number of health boards always challenge the proposition that no one should go from hospital to a care home. If someone has had a massive stroke and they are very disabled and will never live independently, why should we not allow them to go to a care home that is their final destination?

The answer to the first two questions—

Mary Scanlon: I appreciate that. I am just saying that the data is not there.

Catriona Renfrew: I suspect that individual councils may have the data, and I would imagine that hospitals do. I cannot be certain why that information is not available. We certainly collect data about where people are discharged to. I would have thought that hospital data would tell you how many people have gone straight from hospital to a care home.

The Convener: Before Mary Scanlon comes back in, are you saying that Greater Glasgow and Clyde NHS Board will have that information?

Catriona Renfrew: I believe that it would, because we know patients' destination on discharge from hospital. I am happy to look at that and see whether we can produce something for you.

The Convener: It is not just for us; it is also for Audit Scotland. If the information has not already been provided, I ask you to ensure that it is provided both to us and to Audit Scotland, and also to tell us why it was not provided before.

Mary Scanlon: My second question is on Government commitments. I support—

The Convener: Is your question on a different point? I want to bring in Ranald Mair.

Mary Scanlon: No. It is about the fact that the budget has not been doubled but instead has gone down.

I have heard you so often talking to colleagues about the acute sector, Ms Renfrew, and I understand all of that, but there was also a commitment on health and social care. Was that a lesser commitment or one that was easy to ditch? A commitment was made, I imagine with cross-party support, to double the proportion that is spent on health and social care, but you are saying that, as the acute sector needs the money, it cannot happen.

Catriona Renfrew: I do not think that that is what I was trying to express. I was trying to express that there are also a series of commitments, some of them made in legislation, on things such as waiting times, which require major investment.

I suspect that one of the challenges is that there are a series of commitments that are made in policy terms that, in a time of constrained finance, are difficult to honour across the piece. From our financial planning point of view, there has been significant investment in acute services to meet commitments that have been made in processes other than reshaping care for older people.

The Convener: We could also direct questions about that to the accountable officer in the Scottish Government.

Mary Scanlon: Yes.

The Convener: I bring in Ranald Mair.

Ranald Mair: I agree with what Catriona Renfrew said about the idea that nobody would be discharged from hospital to a care home. That idea was frankly nonsensical. I understand where it came from and the idea that people should go from hospital back to the place whence they came, but to send people home to fail in order to then access the resource that they need would be appalling.

We need correct assessment of who can be subject to reablement and supported to go back home and who, frankly, will need long-term care. We need to be able to do that through multidisciplinary assessment in the hospital context and to get it right. People should not be going into care homes if they have the potential to go back home, but nor should they go back home if it is clear that they need long-term care. It was therefore not a good target, in my view.

We certainly need more investment in home care. Yesterday, we saw the start of the implementation of self-directed support, and we want to give people more choice and more control over the care options to which they have access. When we drill down into the figures that Mary Scanlon talked about, we see that, even within the spend, a small number of people are having higher amounts of input of home care, but overall a reduced number of people are having care at home.

If the goal is to maintain people with support, and particularly to have earlier intervention to support people, we are not investing in the right areas. It is clear that, in some areas, there are tensions with the in-house provision. The fact that 97 per cent of Glasgow's home care, including all the reablement care, is delivered by its arm's-length in-house body may or may not give the citizens of Glasgow choice or the best use of public moneys, but that is a political decision. There are issues around whether we could spend the home care pot more efficiently, but we probably have to simply ensure that the pot increases. I think that that is the point that you are drawing attention to.

Mary Scanlon: Finally, let us look at exhibit 6 on page 21 of the report and the "Care Homes", "Homecare" and "Other" sectors. From 2009-10, the budget has been falling, and I understand that the trend is still downwards in those three social care sectors. Exhibit 1 shows that, between 2010 and 2035, the population of people aged 65 or over will increase, starting from a range of 13.6

per cent in Glasgow to 22.2 per cent in Dumfries and Galloway.

Therefore, the trends are a falling budget and an increase of around 20 per cent in the population of people aged 65 or over that, it is fair to say, will lead to an increase in demand for services. How will we meet that increased demand with a decreased supply of money?

Annie Gunner Logan: You have hit the nail on the head. We would not necessarily equate the fall in spend with a fall in volume. Something else has been happening in care-at-home services that colleagues are, I think, well aware of. Prices for care-at-home provision have been driven down to the point at which the provision of care at home for older people outside direct delivery by local authorities is inching its way towards a minimum wage occupation for which people are not paid for travelling from one customer to the next, 15-minute care visits are being commissioned and are on the increase, and so on.

When we look at the cost and volume of home care, we need to keep our eye firmly on quality, because if we do not provide a good quality of care, that will be another driver for increased acute care demand. Therefore, there is more to the figures than may meet the eye.

David Williams: I think that that is right—there is an issue.

I suppose that, in some respects, there is also an issue with the assumptions, particularly about the first commitment in exhibit 11, to

"double the proportion of the total health and social care budget for older people that is spent on care at home over the life of this plan."

What we have talked about relates to the point about hitting the nail on the head that Annie Gunner Logan made: we need to be able to ensure that the money that is available to us is used as efficiently and effectively as it can be.

We have referred to reablement. That has demonstrated unequivocally that people are receiving home care for shorter lengths of time than has historically been the case, and that has been sustained. In essence, that will mean that that spend will not necessarily increase but will reduce. There is a very clear case to argue about how we do things differently that will substantially address the points that Mary Scanlon has made about reducing public funds and increasing demand.

The Convener: I am not familiar with reablement. Could you perhaps send us a short written briefing on exactly what it is and what it does?

You said that one of the challenges is to use resources efficiently and effectively and to get the best value. Are you able to meet the needs of the elderly, and of other sectors of the population in Glasgow who need care services, to acceptable standards within existing budgets?

David Williams: At this moment in time, I am confident that we have been meeting people's needs to the best of our abilities within the resources—

The Convener: Sorry—what does "to the best of our abilities" mean?

David Williams: I have a fixed amount of money available to me as the director of social work—

The Convener: Forgive me, but I asked whether you are able to meet the needs of all those people to acceptable standards rather than whether you are able to do what you can within the budget.

David Williams: I indicated earlier in the session that it is unacceptable that people wait for lengthy periods of time—for example, for OT assessments. That situation has existed for a very long time in Glasgow, and I need to change it. There are elements of what we are doing that need to be improved.

The Convener: Can that be done within existing budgets, or is more money required? The question is not just about what you do in Glasgow. Is more money required to provide the level of services that is needed by the elderly and others in the population who need care?

David Williams: I will not say that we would not need more money. That argument is being played out elsewhere in political terms, and the effects have clearly impacted on my social work services budget in the past few years in particular. We would always be able to direct the money more effectively and efficiently if it were available.

Catriona Renfrew: Perhaps I can help David Williams on that point. We work with six local authorities, and they all have substantial pressures on their social work budgets, even if they are not all overspent. There is clearly more demand for social care—not just for adults but for children—than there is cash in fixed budgets to deliver it.

Our concern is that, in moving to the new partnerships from April 2015, we will, if we cannot reach agreement with councils about a realistic level of funding, immediately run into problems with the ability of those partnerships to meet their obligations. Councils in our area—and, I suspect, in other parts of Scotland—would accept that they are not able to put the money into or are overspent on social care budgets, and that they are not able to put in the necessary money to meet demand.

Part of the issue that we have touched on—I do not want us to lose sight of this, because it is picked up in the audit report—is workforce costs. I agree with Annie Gunner Logan that there are real risks around quality. What we have done with the national care homes contract has driven down or contained price potentially at the cost of quality care—particularly for people with dementia—and certainly at the cost of getting a dedicated, committed and career-shaped workforce. The same is true in other services.

Part of our perfect storm is that we are not paying a lot of the workers who deliver the care a reasonable living wage—in fact, we are not paying the living wage, as the audit report says. I would avoid the race to the bottom in which we say that the council-provided services are expensive. They are more expensive largely because the employees have the type of package for pensions, sick pay and benefits that should be the minimum rather than some sort of aspiration. We need to be careful about the race to squeeze workforce costs at the expense of quality.

Mary Scanlon: I have a question on that point. I have just listened to everyone talking about the need to ensure that people get the right quality of care, and the need to watch the money. I am probably more familiar with the situation in Dundee and Angus than in Glasgow, but I am aware that someone will pay 80 per cent more per person per week to fund a place in a council home than they will pay for a place in the independent sector. Put simply, we could have three people in a council home or five in the independent sector.

The Care Inspectorate says that the quality standards in both sectors are the same. I take Catriona Renfrew's point but, given that the Care Inspectorate says that the quality standards are the same in both sectors, how can you justify £800—sometimes more than £1,000—a week for a council placement while the cost is £500-ish in the independent and third sectors that Annie Gunner Logan mentioned?

11:30

John Walker: I cannot speak on behalf of Dundee or Angus. I work for Perth and Kinross Council.

Mary Scanlon: You can speak on behalf of your council.

John Walker: I am not familiar with that market, but I know that the difference in Perthshire is not as marked as the difference that you indicated.

Mary Scanlon: The difference in Dundee is 80 per cent.

John Walker: At the end of the day, it comes down to choice because it is the people who are moving into the homes and their loved ones who ultimately make the decision on how the market works. In Perthshire, we are overendowed with capacity as regards older people's homes and, quite frankly, some of our operators are struggling because of that. There are about 54 care homes across Perthshire; we operate three care homes as a council. We operate within that market and we have had to adjust to those market pressures as well. That is just some of the background to explain where we are in Perth and Kinross.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I want to tease out one or two more of the issues around delayed discharge. I have heard quite a number of very helpful comments; I just want to get your further thoughts on delayed discharge. The Auditor General noted in her report that the problem seems to have improved since 2007—the figure is almost half the size now—but people aged 75 or over still have more than 300,000 unnecessary days in hospital. There is clearly a huge cost attached to that.

I have heard some of the ideas for improving that figure—David Williams mentioned the step-down process, for example, and Bill Nicoll mentioned an improved discharge pathway. Will we ever get the delayed discharge figure down to zero? Is that a realistic proposition? What are the barriers to getting that figure down further and where are the opportunities for us to gain from this? If we got that figure down to zero, I presume that we would not save all that money because the cost of that care would be transferred into the community as a result. What are the barriers to improving the delayed discharge figures and where are the biggest opportunities for gain?

Ranald Mair: David Williams put the emphasis on step-down care—on how we get people out of hospital more quickly—which is important. However, it is important that we try to avoid people going into hospital in the first place, because their discharge will not be delayed if they are not in hospital. Alternatives to hospital are important; for example, there is step-up provision or non-hospital-based care, which may still be under the oversight of a geriatrician or GP. Care in other settings—in somebody's home with intensive home care, or in a care home—is an important part of improving delayed discharge.

As we know, hospital admission is often triggered by something that does not necessarily require the high-end clinical input of a hospital. That is not why the bulk of older people go into hospital. They go in for things that, in clinical terms, are relatively straightforward and could be addressed either in their homes or in other settings. I want to bring us back to the part of the equation that is not about what we do once somebody is in hospital. We need to start by

ensuring that somebody does not go into hospital unless they absolutely need the clinical inputs that they can get only from a hospital.

Bill Nicoll: I absolutely agree with Ranald Mair's point. As has been said many a time, hospitals are dangerous places for frail, vulnerable older people. We should not be admitting anyone who does not need to be there to an acute hospital. However, with regard to results of the day care surveys that have been carried out, I think that in North Lanarkshire recently it was indicated that something in the region of 25 per cent of people at any one time perhaps did not need to be in hospital—either because they were fit for discharge or because it was deemed that their admission was avoidable.

Delayed discharge is something of a national scandal that we need to address and the figures for delayed discharge need to get as close to zero as we can manage. We are committed to trying to achieve that and I know that some areas are getting close to that goal. The cabinet secretary mentioned that West Lothian was perhaps closer to it than most areas. I do not know the facts of that, but it has to be an achievable goal for us because delayed discharge is something of a scandal.

Our experience shows that improving the pathways for discharge is critical, as is the avoidance of admission and the flow. For example, we made great inroads early doors with our change fund initiatives in Perth and Kinross. We found that, in some areas, notwithstanding the work on reablement, there was a need for much smaller packages of home care to sustain people beyond the reablement phase but that was not necessarily always available in rural areas. Some providers find it difficult to provide a small package of care to somebody up in Rannoch or wherever for the same cost as elsewhere. We continue to learn and add to what we are doing. To resolve that situation in Perth and Kinross, we have been working on using geographic information system data to map out areas. We have providers operating in particular areas and providing every package of care that is required in them, including very small packages. That is what we should aim for.

Reductions in home care per person over time are a good thing, because they mean that people are being reabled and sustained for longer. My colleagues have made points about the reducing proportion of such care. Some of the measures that we use are perhaps wrong. We used to see intensive home care packages as a strong measure, but that is no longer the case. We would not necessarily subscribe to the idea that 10-plus hours of home care per week is a measure of effectiveness in providing the right level of home care. We want to ensure that people can live with as little dependence on care as possible. However, we have to meet some of the geographical or rural challenges. I imagine that there are similar challenges in some parts of cities.

We need to ensure that we have flow, so that people can move quickly right the way through the process. Every time that we fix one bit, we cannot afford to have another blockage somewhere else in the process, otherwise things back right up and we have the same problem that we started with. We have found that and we are now starting to fix it.

David Williams: We face a challenge from April next year when we move to the two-week timeframe. Clearly, it will be impossible to complete an assessment of an older person's community care needs within two weeks—the process takes longer than that. The question that that raises is: why have a target at all? Why not move to a point at which we strive to get people out of hospital on the day that they are deemed fit for discharge? Catriona Renfrew has alluded to the potential release of resource that could come as a consequence of that, which could then contribute in some way towards the alternative provision. Because of some people's circumstances, not everybody can go home but, through interim provision in the form of step-down or intermediate care, we could deal significantly with delayed discharge. However, that requires will from local authorities and health boards and the practitioners in those sectors, and politically, to enable change so that people think, "I'm fit for discharge today and, actually, this is the day I want to leave hospital."

Willie Coffey: Are people admitted to hospital without a discharge plan, so that we do not know when they will come back out? Is that the norm?

Catriona Renfrew: You have hit exactly on the key issue. The way to meet the two-week target is to start assessing people when they are admitted to hospital. I often have a bet with my acute front-door colleagues that, if I sat in accident and emergency, I could probably pick out 90 per cent of the people there who will need a social care assessment. That is because the drivers for the need for a social care assessment are not exactly difficult to see in a patient. They are a fairly classic group of patients as they enter hospital.

You have hit the nail on the head. The problem with delayed discharge is that it has become an accepted norm. One issue that we have with our acute hospitals is that they do not drive hard enough to get delayed discharge patients out. It has become the norm that older patients all wait two or three weeks and that none of them goes home on the day that they are ready for discharge. That cultural issue must be addressed.

One of our drives is to get our staff to refer patients the minute that there is a possibility that they will require social care. The assessment therefore starts long before patients are ready for discharge and they are discharged into an appropriate, concluded place because their assessment takes place when they are recovering in hospital instead of starting once they have recovered. That seems to be fairly simple. I have to say that I get frustrated because it seems so difficult to do.

John Walker: We have been planning discharge as soon as people come into hospital. To provide some context, roughly 500-odd people come in to Perth royal infirmary as unplanned admissions every month. That has not varied over the past few years, but what has grown exponentially is the number of people who come on to the delayed discharge pathway—the increase has been in the over-80 age group. We have reduced delayed discharges by 33 per cent over the past few years and we are confident that—given the investment that the council is making separately from the change fund—if the change fund were to continue alongside the council investment, we would meet the two-week target.

My colleague Catriona Renfrew is right to say that we need to avoid people coming into hospital. We are trying to develop the expertise in the community to deal with complexity in the community. Once we do that, we reduce the demand for beds, which opens up opportunities to use health economics to assess how much resource that releases.

As a result of the information that we have from the integrated resource framework, we know what the average consumption is per capita in different parts of Perthshire. Although I use this as an example, it does not indicate that there is a race to the bottom. There are four localities in Perthshire; if the three other localities were to consume the same as the region that has the lowest per capita consumption, we would save a sum in the region of £4.5 million. However, that £4.5 million is tied up in buildings and in staff, so the challenge is to explore the economics and look at the opportunities that exist through our commissioning plans to unlock the investment that is tied up. I think that that answers your original question.

Willie Coffey: I am mindful that we are the Public Audit Committee, not the Health and Sport Committee, so we are always interested in the flow of money, the costs and so on. I have done a quick calculation that indicates that delayed discharge could be costing us up to £150 million a year or thereabouts. If the Public Audit Committee gets the problem solved as best we can, where does the financial benefit go? Is it spread into the community to provide the care service? I presume that we will save a portion of that money if we solve the problem, or will we not?

Catriona Renfrew: We will—absolutely. The debate will be about whether we are allowed to close hospital beds, because that is how cost is saved, and whether we are allowed to do that in an economic way, which may mean closing beds in a large part of a hospital rather than two beds in each hospital. Releasing the money depends in part on being allowed to change hospital services, which is always a challenge. The second issue is what other pressures there are on the acute sector and what other demands there are for new investment in the acute sector. The third point is that, in our view, the funding should go into community care services. We mean that broadly; it should go into primary care, NHS community care and social care. Our view is that that is what the integration joint boards will do in the future. The funding would be allocated to their budget on an agreed basis, so that they could look at that as part of their plan.

You have probably heard a number of comments about the risk that changing the change fund creates. One thing that needs to change is that the fund needs to become core funding for the new integration joint boards rather than a separate plan or a separate stream of money with a separate set of checks; it needs to be seen as part of the opening core budget that partnerships have to try to solve some of these problems.

Willie Coffey: That is very helpful. Thank you.

The Convener: Mr Williams talked about assessment, and Catriona Renfrew mentioned that assessment should start when people go into hospital. Is it a requirement that a care plan is produced for someone in a hospital setting or in the community who needs services from social care?

David Williams: Yes. It should be produced at the conclusion of an assessment.

11:45

The Convener: Should the individual be given a copy of the care plan?

David Williams: The point was made earlier, with regard to the implementation of self-directed support that started yesterday, that the expectation is that the care plan will have a clear level of co-production with the service user and their advocate.

The Convener: My experience over a number of years in dealing with different local authorities is that the production of the care plan is not done timeously or as a given, and that very often the care plan is not provided unless the individual or

their family requests it. I can cite a number of constituents' current experience in that regard. However, I do not assume that that is a particular problem in Renfrewshire. I think that it is a general issue. I know that there are resource implications and that staff are burdened, but if there is a legal requirement to provide a care plan, why are local authorities not providing the plan to the individual when the assessment is done?

David Williams: I would expect individuals to be involved in the development of the care plan and for them to have a copy of it.

The Convener: Okay. I can make further inquiries. Thank you.

James Dornan (Glasgow Cathcart) (SNP): I will ask David Williams a question and then put a question to the rest of the panel. We have had quite a lot of discussion about early intervention. You mentioned it, Mr Williams, and I think that Annie Gunner Logan talked about the impact that low-level services could have on the wellbeing of elderly people. How will charging up to £15 a day for day care services encourage people to take up those services? Will that charge not have a knock-on effect? For example, a day care service in my constituency is talking about closing because it does not think that its clients can afford to pay that charge.

David Williams: There is a need for consistency in Glasgow City Council's approach to the contributions that adults make to the social care services that they receive. For a number of years, the council, along with many other councils, has had a charging policy for non-residential services. Our authority has been implementing the personalisation direction of travel for social policy over the past three years among the under-65 adult age group for people with learning disabilities, people with mental health issues and people with physical disabilities. We have applied a charge for the receipt of services to them. The Social Care (Self-directed Support) (Scotland) Act 2013 required the council to include older people in our personalisation programme. To ensure that we were not discriminating against people whom we have asked for a contribution for services for the past three years, we have had to apply a contribution expectation, too, to older people receiving our community-based services. It is about consistency and ensuring fairness and equality across the board.

The Convener: Yes, but neither this discussion nor the Audit Scotland report is about the specific charging policies of any one council, so I am not going to go down that route.

James Dornan: No, but it is about the wellbeing of elderly people. It has already been mentioned that day care services have an impact on the wellbeing of elderly people.

The Convener: Sorry, James—

James Dornan: The charge is putting people off going to the day care services. Mr Williams, the civil service advice that I have seen suggests that SDS has nothing to do with Glasgow City Council's decision to charge £15 a day for day care services.

The Convener: This is not about what Glasgow City Council does; it is about looking at an Audit Scotland report on the provision of services to older people across Scotland. Indeed, Glasgow City Council will not be the only local authority that is charging for day care services, so we are not going down that route. Do you want to go back to the other issue?

James Dornan: Yes. I have a question for all the panel. Catriona Renfrew said that she was concerned about the joint sharing of budgets. When I was a councillor, I was a member of a community health and care partnership. It did a lot of good work, but it came to a blockage that involved pretty much the same thing—control and money. What work is being done to redesign services for elderly people given the passage of the Public Bodies (Joint Working) (Scotland) Act 2014?

Catriona Renfrew: As members might know, we have three integrated partnerships—in Inverclyde, West Dunbartonshire and East Renfrewshire. The directors of those partnerships, who are soon to be chief officers, hold health and social care budgets for the full range of health and social care and not just adult health and social care.

We have arrived at a similar agreement with Glasgow City Council, and a process is getting under way to establish the same arrangement, which will cover all social care services and not just those for adults. The challenge will be in agreeing an opening budget for that partnership. The council will rightly challenge us on the amount of money that we put in and on transparency about that, and we will challenge the council on spending versus budget and all those issues.

I made the point that such discussions will be difficult because of the pressures that are on not just Glasgow's social care budgets but all social care budgets. It is important that the new partnerships start with a chance of success, which means sorting out the money realistically. That is not just a local issue; I am sure that it applies across Scotland. Councils across Scotland have pressures on social care budgets and a number of health boards have significant spending problems.

If we start the partnerships short-changed, they will fail. They cannot tackle the agenda of redesign and improvement and the challenges that they face without having a reasonable financial proposition at the start of the process.

James Dornan: As you said, the issue is not just for Glasgow and its surrounds. Would anybody else like to comment on work that is being done to ensure that systems are in place?

Bill Nicoll: In Tayside, agreement has still to be reached on the scope of the services in each partnership, but progress is being made on formulating the partnerships in the three areas. My colleague John Walker has just been appointed as the interim chief officer in Perth and Kinross, and we have arrangements in place for the three areas.

Putting the budgets together within the scope of agreed services is the easy bit; the challenge is to bend the spend and redirect funding when overall resources are fairly tight. Challenges will come when the host organisations that support partnerships come under pressure to make decisions about committing more resource from health to what is traditionally regarded as social care and vice versa.

I return to the importance of the integrated resource framework and of understanding that the whole resource is being committed to people's pathways of care. That brings the acute sector to the table, too. If we are to succeed, we must get agreement across the pathway and particularly on realigning resources for older people in the most effective way and on putting resources where they need to go. That is where tensions might come through.

It is important for partnerships to move from being voluntary to having a legislative and much tighter framework. The Parliament has started to make such changes happen through the new legislation. I am sure that it will make a significant difference to have one person who has overall responsibility for the budgets and who works with a partnership board and to have a single budget and a single set of commitments to improve outcomes for older people, to do whatever it takes to move the money to where the greatest need is and to reprofile the spend. That will be difficult, but I feel more confident that we are now in a position where that is more of a reality than it was in the past.

Annie Gunner Logan: At the beginning, Ranald Mair talked about who the partners are. We are starting to go down the road of partnership being about councils and NHS boards. David Williams and others have reminded us that, although they have all the money, they do not have all the assets. A lot of the assets are in the third and independent sectors and they include the older people. We should not lose sight of that.

Mary Scanlon said that we are here as stakeholders. That is relatively new for us, because the third sector has always been on the outside. Reshaping care is the first programme in which the third sector has been a partner and a stakeholder in delivery.

I am bound to say that all partners are equal, but some might be more equal than others. In that respect, I commend to the committee a couple of reports from the project that I mentioned earlier. I will send the clerk a link to them electronically. It has been quite difficult for us to make those arguments but, certainly in relation to older people, there needs to be much more consultation and participation of local groups that represent people. It is not just high-level strategic budget finagling that is going on here. We need to link the work directly back to older people's needs and views and how they want to reshape care.

James Dornan: Are you getting a sense, even at this early stage, that you are being involved in the process and that it is not going to be a case of the two big beasts fighting it out?

Annie Gunner Logan: There has been some progress around the reshaping care agenda. There are two elements. One is the involvement of the third sector in the planning structures and the strategic commissioning groups. That is quite positive and some good progress has been made there. The second bit is the involvement of the third sector in supporting older people, which is not quite the same thing. There has been some progress there, but there has been less of it. As I said, once the change fund ends, we might wave cheerio to some provision that has been established.

I make the point—just because I can—that the reshaping care partnership, which is a four-way partnership, is not being carried forward into the integration partnerships under the Public Bodies (Joint Working) (Scotland) Act 2014, which are still very much two-way partnerships. We hope that the reshaping care partnership will carry on, but it is not a legislative requirement. That is a shame.

David Williams: I do not mean this in the wrong way, but we should not lose sight of the fact that the requirement is for councils and health boards to integrate, which is different from working in partnership. The focus of attention at present, certainly in Glasgow and potentially elsewhere, is such that the majority of the effort is going into ensuring that the two bodies are able to integrate and be fit for purpose from 1 April, but, in developing the integration scheme, we have to take account of the need for partnerships. We have consistently said jointly with health that we

are not the only players who will deliver services and that there has to be proportionality around the difference between the integration of two bodies and the development of partnerships that will actually deliver the services.

Bob Doris: It is important to put on the record that the Public Bodies (Joint Working) (Scotland) Act 2014, which is core to what we are discussing, is not just about the integration of health and social care across the country. It could be about housing and other services as well.

I want to make an audit point for the future about the strategic plan and the local planning level. I was taken by what Annie Gunner Logan said about local priorities, local co-production and working with older people to determine the services that they want. All of that has to be audited and accounted for at a later date. If we come back and discuss the subject in one, two or three years' time, will strategic boards be speaking to each other about how they account for all those things? In one or two years' time, when the committee says, "Let's look at local planning" and you all account for it in different ways, will there be consistency?

Ranald Mair: Locality planning and the level of devolved decision making, including financial decision making, at locality level are one of the key elements of the 2014 act that we have to work out. I had a discussion about that in Fife, where Kirkcaldy's needs are not the same as those of St Andrews. Certain things have to be shaped at locality level.

We have a complex task. We are trying to get the required level of integration between health and councils, and we are saying that we, as third or independent sector providers, need to be full partners, as do service users. However, we must not spend all the time thinking about what that would look like at board level or in the corridors of power; rather, we need to consider what that would feel like on the ground in communities and how we would get some of the decision making down to that level.

During this transition year, we cannot just talk about locality planning as a nice idea; rather, we must focus on what it looks like. At the end of the day, if decision making and accountability for moneys are to be devolved, those must feed back into an audit trail in a different way.

12:00

Annie Gunner Logan: Bob Doris has described quite a challenging issue. The partnerships will be held to account for outcomes but, by its nature, an audit committee is very interested in cost and volume. A challenge that we will all face is how to appropriately report on outcomes in a way that will satisfy the audit requirements. I do not know what the answer to that is, but we need to face up to that issue.

Bill Nicoll: Commitment 7 in exhibit 11 talks about a lack of national data. I have been talking to ISD Scotland for some time about what measures we need in future. To return to the points about public sector integration and the wider partnership that we need to make that happen locally, the key message coming through is that we must capture activity information on a wider base.

I referred to the integrated resource framework. We need to look at that, too. The strength of the third and independent sectors in an area can be a major factor in whether communities have the necessary support, resources and resilience, and that makes a difference in how they consume higher-level resources. We need to reduce dependency. The figure cited is that, at any one time, 98 per cent of the population should be outside a formal care setting. We need to be pushing such a measure. However, we also need to quantify matters that are not going to pop up in an ISD report as national data. Perhaps committees such as this one need to find the mechanisms by which the richer vein of data that is available in local areas can be drawn out and viewed, because that will be very important in seeing how the whole area of work hangs together.

The Convener: I will follow through on that point. You talked about the need to capture information. Are consistent systems available across the country that would tell us where the service gaps are, whether needs have been met and whether services have been delivered effectively and efficiently? Can we quantify what is happening?

Bill Nicoll: I do not want to return to the elephants' graveyard of integrated health and social care systems, but we must resolve that issue. The information is out there. Questions were asked about whether data is available in local areas. It is clear to me from the briefing information that I have seen that we have such information across Tayside. Therefore, the issue is how that information finds its way up so that it is seen at national level.

We must also have systems in place so that, regardless of which parts of a service or system people are interacting with, we can capture the data and the outcome-focused approach. That has been an elephants' graveyard. When we used to have a health and social care partnership in Perth and Kinross, we had an e-care system that used single shared assessment in a single outcomes framework, and a single data platform was a powerful tool. We must resolve some of those

issues. The starting point would be to find a better way to gather that rich vein of data at a national level from the local areas. There is still room for consistent measures across the piece, but some of that must be tailored to the local issues and needs.

The Convener: It has been a long session and I am aware that people have other things to go to, but I would like finally to return to the question about the self-funding and personalisation of care and the potential transfer of resources to the individual for them to purchase the care for themselves. How is that quantified? For example, if someone in Edinburgh decides to adopt that approach, will they be provided with the same level of funding to purchase care as someone in Glasgow, Perth or Aberdeen is given? How is it being done and how will we know whether the money that is provided is sufficient for the individual to purchase the level of care that they require?

John Walker: The crucial point with SDS is the conversation with the person who needs the care support. That is about support planning and identifying the person's aspirations and their needs if they are to live independently. It is about the assets that they have, such as extended family and friends, and the community supports that we are trying to create through our integrated health and social care working. It is not about designating a cost up front. At an appropriate time in the conversation, when we find out how we can best support the person's needs, we can then bring an indicative amount into the conversation.

We were recently audited by Audit Scotland on our approach to SDS. We were a bit worried about being an outlier, because we have not raced towards a quick calculation of the monetary value of people's needs. We await the written response in June, but the feedback that we have had verbally is that our approach is quite favourable.

The Convener: In many places, unless you know the area, you would not know whether you are in one local authority area or another. I will give Glasgow City Council and Renfrewshire Council as an example, but the same could apply in East Renfrewshire Council, West Dunbartonshire Council, East Dunbartonshire Council and maybe South Lanarkshire Council. If someone lives in the approaches to Paisley along Paisley Road West towards the boundary and they are assessed by Glasgow City Council as requiring X amount of money to provide their social care but they then decide to move just a few hundred yards across the boundary into Renfrewshire, their family and support network will still be there, but could they access the same monetary support from Renfrewshire Council as they do from Glasgow City Council?

David Williams: Probably not. That relates to the level of resource that is available to local authority social work departments and how it is managed and distributed. As Catriona Renfrew highlighted—

The Convener: Can I stop you there? You say that it depends on the level of resources available to the local authority social work department.

David Williams: Yes.

The Convener: I thought that we were assessing the requirements and needs of the individual for their care plan.

David Williams: Yes.

The Convener: If someone requires a certain amount of money to deliver care under self-directed support and then moves a few hundred yards, why would the level change for them, leaving aside the local authorities?

David Williams: It is about the assessed need. You are right to concentrate and focus on the level of assessed need and the nature of the services that are provided. The individual budgets that are available are a responsibility of, and are determined by, each of the 32 local authorities. Should it be that way? I do not know, but that is the way that it is at present. The expectation is that local authorities will manage the budgets that they have available to them. My responsibility is to ensure fairness and equity of access to resource for all citizens who have broadly similar needs within Glasgow City Council's boundary. The priority that we place on that might be different from the priority in Renfrewshire, East Renfrewshire or other authority areas.

The Convener: Assuming that that is the case, say that someone in Ralston is assessed by Renfrewshire Council as requiring a certain sum of money each day to deliver care and they then contract with the local independent or private sector to purchase that care. If they move a couple of hundred yards into Glasgow, will another community care plan be produced?

David Williams: The transfer between local authorities of responsibilities relating to adults is not a straightforward matter. There are ordinary residence issues that relate to people who have responsibilities. In many cases, the responsibility remains with the original local authority if the individual moves. If there is a choice, and someone wants to have services in a different area and approaches the local authority whose area they have moved into for an assessment of their need, the local authority will undertake an assessment of that need and an outcome-based support plan. The interesting thing about self-directed support is that it affords the individual the opportunity to continue to use the provider that

they previously had, if they so choose, although the level of resource might be different.

The Convener: Exactly. That is the point. If someone moves from one authority to another, they may choose to access the same support provider, but they may be given more or less to do so by the neighbouring authority.

David Williams: They may well be, but the level of community assets and support arrangements will be different in Glasgow from what is available to people in East Renfrewshire or Renfrewshire, for instance. Therefore, people may be able to access a different type of service and support.

The Convener: No, I am talking about someone who lives in a community in which services are interchangeable. I am not talking about a person who lives in Castlemilk and a person who lives in Johnstone; I am talking about people who live in a community in which the care providers are local and probably provide services across boundary areas. Will a second assessment be done? If it is and the same assessment is made for the level of care, why could there be one level of payment in one authority and a second level of payment in another? It is almost as if we are developing a postcode lottery.

David Williams: That has always been the case in the provision of services to individuals throughout the country. The self-directed support legislation has not changed that, but individuals now have a clear indication of the level of financial resource that is available to them with which to have their needs met.

Annie Gunner Logan: I am bursting to get in, as this is my favourite subject. I have a number of points.

The first point is that there is a monitoring and evaluation plan for self-directed support that should at some point tell the committee how many people are choosing the different options under SDS. I remind the committee that there are four of those.

Secondly, the principle of the self-directed support legislation is that individuals should be able to exercise as much choice and control as they want to, regardless of whether they take the money and buy their own services. Even if they say, "I don't want to choose—just give me a service," they should still have the right to exercise choice and control over the service that they receive. That is often misunderstood.

Thirdly, the differences are not just across boundaries; they are within the same council areas. For example, a person may choose option 2 under SDS and say, "I don't want to take the money as a direct payment, but I'd like the council to spend my money on provider X." Provider X may charge £14 an hour, for argument's sake. If the person wants to choose option 1, which is a direct payment, they will not get £14 an hour; rather, they will get £11.50 or whatever it is, because councils have set completely different rates for direct payments under option 1 than they might be prepared to pay under option 2. In other words, if a person wants to exercise maximum choice and control by taking the money and buying their own care, they will not be able to buy as much of it as they would be able to under options 2 and 3. I get excited about that because my organisation attempted to amend the legislation to prevent that from happening. We did not succeed in that, but I think that that issue will come back to haunt us.

Fourthly, around this time last year, I read a number of the joint strategic commissioning plans for reshaping care for older people and was astonished at how few of them even mentioned self-directed support as a way in which older people could be drawn into the process of reshaping their own care. It was almost invisible in a number of the plans that I read.

My final point is that Audit Scotland is now involved in a performance audit of preparations for self-directed support. When that is done, it will come to the committee. I look forward to a much more comprehensive discussion of that issue, because it is very important.

The Convener: Okay. I have given Annie Gunner Logan the final word. Thank you very much for that.

The session has been long and very productive, and the discussion could have gone on for much longer. There are huge and fundamental issues, not all of which are necessarily audit responsibilities—many of them are care responsibilities. It is clear that the issue will be a challenge for everyone, irrespective of their responsibilities.

I thank the witnesses very much for their contributions and suspend the meeting for a short time.

12:15

Meeting suspended.

12:22

On resuming—

Major Capital Projects

The Convener: We move to item 3. The committee has received an update on major capital projects from the Scottish Government. Members will note that the update is in a new format, which is very detailed and quite interesting. The update lists the projects and gives some information about them. Our job is not to monitor or evaluate the progress on each individual project; it is more about process and whether there are any issues arising from that. Do members have any comments?

Mary Scanlon: I welcome the new format. Given that I drive up and down the A9 most weeks—apart from in the winter, when I get the train—I would like to highlight that the A9 has disappeared. There is no A9.

James Dornan: How did you get down to Edinburgh this week then?

Mary Scanlon: The A9 has disappeared from the major capital projects list. It has been in every such list since I joined the committee. I am aware that quite a lot of work is in progress on the A9 and that there are considerable plans to completely dual the A9, so I would welcome an update. This is the only time that the A9 has been missing from the list.

The Convener: Okay. We can write and ask about that.

Ken Macintosh: I am not sure that I welcome the new format. I am not quite sure what the point of it is, but it does not seem to monitor change.

The first part of the section—the new additional information—is a list of all the projects greater than £20 million; that is useful, although it is just a list. More important, it does not give us the information that we used to get on how the major projects have changed since the last time that they were reported on. I thought that the whole point was that we had a baseline position and we measured what is happening against that. I have been through the whole thing. The only comment that I could find that suggested any kind of change was on page 22, under "Kilmarnock Campus—Ayrshire College", where it says:

"there has been slight slippage in reaching financial close".

On page 23, under "V&A at Dundee", it says:

"The project has been subject to some slippage due to movement of the proposed site".

Those are the only mentions of change in the entire document. I do not understand. From memory, I think that the old document on the major projects told us the initial cost, the dates and any in-work changes to the projects. The new format seems to be an entirely backward step.

The document includes supposedly useful information under the heading "Contribution Made Towards Local Economic Development", but the variation in information there is incredible. Some of the entries are detailed and helpful—they list the number of jobs and apprenticeships, procurement conditions and so on—but some of them have nothing of the sort.

The level of detail does not seem to depend on the size of the project. On one of the major projects—the Edinburgh to Glasgow improvement programme, on page 15—the document gives no detail whatever of what the impact would be. That is a £742 million project and we are told that it will "deliver enhanced connectivity". There is nothing about jobs, apprenticeships or anything else.

The information is useful, but perhaps we have to evolve from this point. However, I would like to know the minimum amount of information that we expect, which can perhaps be supplemented by additional information. It strikes me as odd not to have any information, particularly on a project of that size.

It is difficult to believe what is happening in this document. I will give you an example. On page 24, under "Scottish Crime Campus", it says:

"The full business case for the project outlined that it would cost £82 million and that practical completion would be achieved in autumn 2013, prior to the agencies becoming operational in the new building by April 2014. Practical completion of the project was completed on time and on budget in autumn 2013."

That did not quite ring a bell with me, so I have just looked it up. On 14 April 2009, in a press release on the Scottish Government website about the Scottish crime campus, Kenny MacAskill said:

"The work is underway and I expect the campus to be operational by late 2011."

It also says that the campus will cost £65 million.

In another press release in March 2010, under the heading

"Full steam ahead for crime campus",

Mr MacAskill said:

"Subject to contract we expect the first agency to move into the campus in 2012 with full occupancy by mid-2013."

It opened in February 2014.

I do not understand what this document does for us.

The Convener: You raise a number of issues. On variations, it could be that there are only two projects where there are variations. However,

those are legitimate questions to ask and we can write to the Scottish Government to ask for clarification, not only on the specific items that you mentioned but on the process issues about how information will be provided. I, too, hope that the process is evolutionary and that we are trying to improve it as we go along.

12:30

Bob Doris: I will try to be brief. I think that you hit the mark perfectly, convener, because the updates report looks the way that it does because of an on-going dialogue between this committee and the Scottish Government. We have fed in a couple of times how we would like the figures to be presented. I think that you are right to say that that is an evolutionary process, which we can continue to engage in.

On whether things are on budget, I noted on page 13 of the report on the M8, M73 and M74 network improvements project that one area is under budget. I spotted another one that was under budget, too, but I cannot find where it is in the report at the moment.

Like Ken Macintosh, I am keen to know what we mean by the term "on budget". Obviously, significant things can change during the lifetime of a project. If the budget was revised in 2012 or 2013, is the project on budget compared with the new baseline? In other words, if something was significantly revised in, say, January 2013 and it was completed in January 2014, and in that one-year period it was bang on budget for the new budget from January 2013—if committee members are still following me—but there was a realignment in the budget because of earlier events, should that always be flagged up in the latest report that we have?

I think that all the information is there and that it is merely a question of how it is presented in the progress report. I am nervous about the report getting a bit unwieldy. It is about information being presented in a sensible and focused manner.

The Convener: As I suggested, we can write to the Scottish Government. We can also put on our agenda at some point a discussion with Audit Scotland to get some further analysis of how the progress report is being used.

Ken Macintosh: I will pick up on two things that Bob Doris said. I do not quite follow the information about the M8, M73 and M74 project, because it suggests that the non-profit-distributing contract has reduced in value from £415 million to £310 million. The report says:

"The total cost of the project is estimated to be £435 million".

That does not make clear to me what the total cost saving was.

That is one of the major projects, as is EGIP. I do not want to list all the major projects, but I hope that the committee will not ask the Government for comments on just the ones that I am picking out. On EGIP, the report states on page 15:

"The full business case has recently been published and outlines that the cost of the first phase of the programme is £742 million and ... The project is progressing on time and on budget."

That does not even come close to summarising what has happened to EGIP. That project has gone through many different changes. As I remember, it was a report in a previous document that was presented to this committee that flagged up to Parliament that the project had been reduced by £350 million and stripped out so that it was no longer recognisable. That showed the very important contribution that the Parliament's scrutiny of major projects makes to the spending of public money. In that case, we asked questions and turned the gaze of parliamentary scrutiny on to a huge sum of money.

Annie Gunner Logan said earlier that we ask people to jump through hoops to justify spending £20,000. However, although the EGIP project is worth £742 million, the report refers to it in only two sentences. I do not think that it is any help at all just to produce a list of projects—that is all that the report is—with no useful information that we can scrutinise. We know only that the projects are happening. That list of information will get in the way of our analysing what really matters, which is whether projects are being delivered in the way that it was said they would be delivered and are on schedule, using the same amount of money by the same vehicle, or whether they have been realigned. Those are the questions that we should be asking in a proper audit process.

Willie Coffey: My recollection is that the update reports in the past have broadly matched what we asked for at the time. This report does the same: it matches up with what we asked for. The committee does not micromanage or project manage the capital projects. If we think that we now need more and more detailed information, that is another matter. However, I think that the current update report broadly reflects what we have always asked for.

However, I suggest that what is missing is an indication of the contingency set-aside or spend. We asked at some point in the past for that to be included in the update report, because the issue came up in previous committee discussions. If members want more detail about the status of a piece of work, I would be quite happy to see that, too. However, that would mean that there would

be more and more detail for us in the update reports, which is not their purpose.

The Convener: The reply to the committee from Sir Peter Housden has a section on contingency. In our letter to the Scottish Government, I suggest that we ask for more clarification on all the broad issues as well as the specific issues that members have identified. We will also schedule a discussion with Audit Scotland about the way in which the update reports are being used.

Bob Doris: I think that Ken Macintosh makes a reasonable point in relation to the M8, M73 and M74 network improvements project. During a previous discussion on the issue, I remember raising a point that I do not think is reflected in the project updates report. As well as there being development costs for the project, there can be other costs, such as land purchase costs. I asked where such costs would be accounted for. I am not saying that such costs are the reason for the gap to which Ken Macintosh referred. I asked for such information, but it has not been presented.

By and large, I think that the report presents pretty much what we have asked for. Perhaps the committee is getting a bit more sophisticated regarding the information that it wants. The second thing that I will put on the record—

Ken Macintosh: It is not more sophisticated.

Bob Doris: Bear with me, Mr Macintosh. The second thing is to confirm whether we have all the information that has been provided, because the project updates report could be a summary update of information and other information might already be in the public domain for us to access. If we choose to dig beneath the report that we have, the question is how quickly and easily we will find further information. Do we want such information in the summary, or do we want to be able to dig beneath the summary in a focused manner?

We are back to well-known questions. If the Government gives us too much information, we ask how we are to pick out the needle in the haystack; if the Government gives us focused information, we say that we are not getting enough information. It is about getting the balance right and the committee doing things in a collegiate way with the Government.

The Convener: Okay. Is the suggested course of action agreed?

Members *indicated agreement.*

The Convener: Thank you.

12:37

Meeting continued in private until 12:53.

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