The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

FINANCE COMMITTEE

Wednesday 11 September 2013

Session 4

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FINANCE COMMITTEE
21st Meeting 2013, Session 4

CONVENER

*Kenneth Gibson (Cunninghame North) (SNP)

DEPUTY CONVENER

*John Mason (Glasgow Shettleston) (SNP)

COMMITTEE MEMBERS

*Gavin Brown (Lothian) (Con)
*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)
*Michael McMahon (Uddingston and Bellshill) (Lab)
*Jean Urquhart (Highlands and Islands) (Ind)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jean Campbell (East Dunbartonshire Council)
Frances Conlan (Scottish Government)
Nick Kenton (NHS Highland)
Paul Leak (Scottish Government)
Christine McLaughlin (Scottish Government)
Alison Taylor (Scottish Government)

CLERK TO THE COMMITTEE

James Johnston

LOCATION

Committee Room 5

Scottish Parliament

Finance Committee

Wednesday 11 September 2013

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

Public Bodies (Joint Working) (Scotland) Bill: Financial Memorandum

The Convener (Kenneth Gibson): Good morning and welcome to the 21st meeting in 2013 of the Finance Committee of the Scottish Parliament. I remind everyone to turn off their mobile phones, tablets and other electronic devices.

Our only piece of business today is an evidence-taking session as part of our scrutiny of the Public Bodies (Joint Working) (Scotland) Bill's financial memorandum. The bill is designed to establish a framework to support the integration of local authority and health board functions.

We will hear first from two witnesses who submitted written evidence to the committee and we will then put questions to the Scottish Government's bill team. I welcome Jean Campbell, from East Dunbartonshire Council, and Nick Kenton, of NHS Highland.

As we have no opening statements, we will move straight to questions. As usual, I will ask some opening questions before widening out the questioning to members of the committee. If either of our witnesses would like to respond to a question or make a point, they should indicate their wish to me or the clerk. I will focus questions on one witness, but the other can respond as well.

Paragraph 5 of Jean Campbell's submission says, with regard to the financial implications for your organisation, that

"There is no focus on the issues arising from the delegation and resources under each of the two options available which is a key area of concern".

Could you expand on that?

Jean Campbell (East Dunbartonshire Council): In reading through the financial memorandum, I felt that the focus was clearly on the transition and implementation costs that might arise from the bill. Obviously, from our perspective, we have concerns about what would go into the pot in terms of the totality of an integrated budget in relation to aspects of acute spend and how far the guidance will go in terms of being prescriptive about the funding that needs to go into the integrated pot.

The bill's premise behind integration is around effecting a shift in resources from emergency admissions to community-based alternatives. Obviously, there must be sufficient budget under the control of the single accountable officer to enable that and to effect that kind of change. There might be some risks if there is not enough in the pot, if you like, and the financial memorandum does not delve into risks that might arise in trying to deliver the agenda.

The Convener: The next paragraph says:

"A significant omission appears to be an estimate of the cost of the rising demographic of older people requiring a service ... given there are savings predicated on the way this will be delivered into the future."

Can you comment further on that and talk a wee bit more about risks, which you touched on?

Jean Campbell: The financial memorandum does not go into any great detail on estimations of costs that will come from demographic growth. Studies suggest that, by 2031, we will be looking at an increase of £2.5 billion being needed in the budget. The efficiency measures that are highlighted in the financial memorandum will go some way—although not a lot of the way—towards trying to address some of that pressure.

Obviously, a lot of the efficiencies that are built into the financial memorandum are about assumptions about delivery in terms of delayed discharge and the effectiveness of anticipatory care planning. I suppose that there are risks around how successful that will be in delivering the efficiencies that are outlined in the bill, and the extent to which that will deliver in relation to the demographic pressure that we know is out there, but which is not as evident in the financial memorandum as it could be. However, certainly, work has been done elsewhere on the issue.

The Convener: Mr Kenton, would you like to comment on what we have heard so far?

Nick Kenton (NHS Highland): It is true that the bill does not delve into the impact of demographic changes. Of course, those changes are happening irrespective of the bill or integration so, in a sense, those costs are not directly relevant to the bill, so I suggest going down the route of integration as a way of trying to mitigate the impact of demographic change rather than building such mitigation into the cost of the bill. I agree with Jean Campbell that the sort of offsets that are quoted in the financial memorandum are fairly high-level costs that try to give an overview of the bill. They also rely on releasing fixed costs from the acute sector, and there are risks around that.

The key point is that the demographic changes will happen whether the bill is passed or not, and we need to address those rather than get hung up on them as part of the scrutiny of the bill.

The Convener: In NHS Highland's submission, you say that it is reasonable to assume that the financial implications will be in line with the estimates that are made in the financial memorandum, and that the assumptions seem to be reasonable.

You also touch on an issue that the committee and the Scottish Government has wrestled with when you say:

"It is worth noting that the integration of budgets between partner bodies requires a high degree of trust and openness—and this is as much about leadership and culture as legislation."

I think that we would all agree with that. How confident are you that that will be delivered? I know that NHS Highland has some experience of the issue.

Nick Kenton: The issue of the financial implications works on two levels. The first level concerns the costs of making the transition; I think that the bill makes a reasonable attempt to quantify them. They are quantifiable, but they pale into insignificance when compared with the wider implications of sharing budgets for real. My view is that it is hard to legislate for that—it has to be done with a degree of openness and transparency that is hard to set down in legislation. We had to place trust in our counterparts in Highland Council. It is no secret that, during our first transitional year, we had some challenging negotiations in relation to the money, but we came through that and were always open and above board.

Our move to integration began in December 2010. About a dozen key people in various parts of the organisation took that forward, working with a high degree of openness and trust. Our partnership agreement is 400 pages long. That might sound like a large document, but it does not cover every eventuality. Even in the first year, we found that issues arose that were not covered by the partnership agreement. What we always said was that, if we have to have recourse to the agreement, we have failed, to some degree, because we should be able to agree things as partners without having to go to the book.

Jean Campbell: The success of the bill will lie in its effecting a culture change in how organisations work together. In terms of money, there needs to be openness and an open dialogue between partners to effect the shifts that need to happen and to ensure that there is a realism about how that can be done. Obviously, getting the key people involved will be pivotal to ensuring that.

Nick Kenton: One thing that we found in the first year was that even with that level of openness and trust, there were times when we were almost not talking the same language from an accounting point of view, because the regimes were so different. Sometimes, there were misunderstandings rather than disagreements, and we had to work through those as we went along. It was a real learning experience; we would be happy to share that experience with colleagues who are interested in learning from our model.

The Convener: I want to talk about some of the wider issues that have been discussed. NHS Highland's submission says:

"The wider financial consequences of integration are difficult to quantify but our belief is that these will be beneficial rather than a cost burden."

However, you also say that

"the bill does not seem to make provision for the potential costs of transferring ownership of assets (or long term leasing of assets)."

You also point out

"the potential efficiencies from reducing delayed discharges"—

which we have touched on already—

"reducing variation and anticipatory care plans are presumably based on 'full cost' estimates which are therefore not fully realisable unless fixed costs are reduced as a result of the changes."

Is there an opportunity to reduce those fixed costs? Could you comment more widely on those matters?

Nick Kenton: There is an opportunity to reduce fixed costs. It is very challenging, and it is a medium to long-term goal. As we always said when we went down our integration route, the first two years would be about bedding in and almost "business as usual"—that is the phrase that we used. In transferring £89 million and 1,500 staff one way and £8 million and 200 staff the other way, all the pensions, payroll and accounting treatments were transferred, too, so there was real potential for things to go wrong. Our hope is that all the resources for adult services being in one place in the health service will bring opportunities.

We touched on the demographic pressures earlier. It is not clear yet, but just to hold the line in acute spend might be a good result, given the demographic increases and pressures in the acute sector. We are not yet confident that we can take large amounts of fixed costs out of the acute sector. That is untested. We are confident, however, that having all the resources in one place can only help with that.

Property demonstrates a feature of the differences in accounting regimes. At the moment, we are delivering services from care homes that remain owned by Highland Council, but the services that we deliver from there are delivered by staff whom we now employ; they moved over from Highland Council. We would like to lease the buildings or own them, but even if Highland

Council wishes to sell them to us for £1—which it might be prepared to do—the accounting regime in the national health service will not allow that to happen easily. We are working with colleagues in the Scottish Government to find a way round that.

The transfer itself would be a cost. When an asset is owned in our NHS system, a cost or depreciation is paid on it; it is a real cost. In the local government system, it is a notional cost. There are significant differences in the accounting regimes. At the moment that is, in accounting terms, probably the biggest barrier to moving forward, although we are working closely with colleagues in the Scottish Government to resolve that.

Jean Campbell: We do not have the same experience that Nick Kenton has had in Highland, but natural efficiencies will come from integration in relation to management posts when there is co-location, for example. That makes delivery of services much more real for people, and efficiencies come from that. A lot can be done around information and communication technology systems by integrating them a lot more and by streamlining processes. It would be a lot more efficient to input information only once, for example.

The bigger costs and the shift of resource from the acute sector result in questions about whether that might eventually result in ward closures or the closure of buildings and so on, but those are probably quite a long way away—that is probably quite aspirational, given the demographic pressures and the fact that, even if we are able to free up beds, there are other areas of pressure in the health service that would quite easily suck up that resource for other purposes. Natural efficiencies could be made by way of assets, perhaps involving co-location and ICT systems, but the bigger aim around wards, hospitals and beds is probably longer term.

The Convener: I will ask one more question before I let the rest of the committee in. This question is to you, Ms Campbell, although Mr Kenton can of course comment, too. What concerns do you have in relation to potential equal-pay claims for staff who will be working more closely together?

Jean Campbell: There are provisions in the bill such that if we were to use the lead commissioning model, with rafts of staff—under the Transfer of Undertakings (Protection of Employment) Regulations—TUPEing over, there might be natural harmonisation of pay claims as teams come together. There are differences in the pay and conditions of occupational therapists, for example, so in an integrated occupational therapy team, people could see that their counterparts from either the health service or the local authority might be on more advantageous terms and conditions. As a result, there would, naturally, be pay claims around that. That issue might not arise as instantly as it would under a lead-commissioning model, but under a body-corporate model, it might well emerge as teams come together.

10:15

The Convener: Do you have any idea of the cost implications for a health board area of, say, the size of NHS Greater Glasgow and Clyde?

Jean Campbell: I could not comment on that.

The Convener: That would certainly be difficult to estimate.

NHS Highland is much further down the road with all this, so Mr Kenton obviously has more experience in this area. What is your view on the matter?

Nick Kenton: It is certainly worth pointing out that pay claims are a risk. I summarise our approach as proceeding with caution. We do not have a harmonisation policy, but if posts become vacant or if there is a redesign, we are—where we can—moving posts over to the relevant pay scale for the new employer. As I have said, however, we are proceeding with caution.

The Convener: I open the session to colleagues around the table; Malcolm Chisholm will be the first to ask questions.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I agree with Nick Kenton that integration can mitigate the effects of demographic change, but I suppose that that will happen only if it works properly and shifts the balance of care in a way that structural change on its own will not.

However, even assuming that it does shift the balance of care, I have to say that I do not really agree with you that demography is irrelevant, because the whole implication of the financial memorandum is that quite large savings can be delivered by reducing delayed discharge, by putting in place anticipatory care plans and by "reducing variation". You might want to comment on what is involved in reducing variation, but we would all agree that reducing delayed discharge and anticipatory care plans are good things. However, because of demography, there is no way that they will produce those savings, which means that in that sense the financial memorandum is highly misleading.

Nick Kenton: Perhaps I did not previously express myself as I meant to. My point in response to Jean Campbell's comment—that demographics need to be included as a cost of the bill—was that those costs will happen whether or not the bill is passed and that the issue is

therefore not directly relevant to the costs of the bill. However, it is—as I think you have suggested—a relevant part of the context and we need to be aware of it. Indeed, for me, it is one of the issues in support of the bill.

Malcolm Chisholm: Do you agree with that, Ms Campbell?

Jean Campbell: The context of that comment is our view that in seeking to predicate efficiency savings on the basis of the bill, it is relevant to consider the extent of demographic growth in order to see the extent to which integration would deal with certain issues. There needs to be more consideration of how we meet the pressures that will be caused by demographic growth. Although integration will go some way towards addressing that, it would have been helpful had the financial memorandum set out the extent of the issue that we are going to be dealing with over the next 20 years, if we are indeed going to be predicating efficiency savings on that basis.

Malcolm Chisholm: Obviously you fully understand that, but the problem is that many local authority submissions about the bill assume that significant resources can be released from acute budgets to pay for the development of services in the community. If people think that that is going to be possible, they are being misled because of the demography issue. It might be more possible in some parts of Scotland than in others; it certainly will not be possible in NHS Lothian, given our demography.

I suppose that this question is more for Nick Kenton, given his health experience. To what extent would NHS Highland be able to release money from acute budgets to shift the balance of care?

Nick Kenton: That is our aim, but at the moment we do not have a timescale. As I said, the change is a medium to long-term issue. We are looking to keep the ship steady for two years before we try to do anything clever, as it were. I do not have a glib answer to your question, but we certainly want to do what you suggest and we think that it is more likely to happen if all the resources are in one place than if there are organisational divisions between the resources.

Malcolm Chisholm: I was also puzzled by the comment in the financial memorandum that quite a lot of the savings are going to come from "reducing variation". After all, variation can be a good or a bad thing. It might be a bad thing because it shows that the service is inefficient, or it might be a good thing because it shows that the service is better. I am interested to hear your comments about making savings by reducing variation.

Nick Kenton: We should be looking at variation across the whole NHS and local government, and not just in the context of integration. We in Highland certainly need to focus on that issue. You are absolutely right to suggest that sometimes variation can be completely appropriate, but we need to understand the issue, bring it to light and challenge it.

Malcolm Chisholm: Thank you. Those are all the questions I have, for now.

John Mason (Glasgow Shettleston) (SNP): One of the things that strikes me in all of this is that we are starting with two organisations—local government and health boards—and ending up with three. On the surface, it seems that that might make things even more expensive because there will be more bureaucracy: before a pound is spent, it will have to be approved three times rather than just twice. Is that assumption wrong?

Nick Kenton: I am not sure who you are directing the question to.

John Mason: The question is for both of you.

Nick Kenton: There are only two statutory bodies in the lead-agency model, and even under the terms of the bill the situation in Highland would not need to change much. We would need a joint committee, but we already have a strategic commissioning group that involves both organisations and which actually looks fairly similar to the proposed joint committee. As I have said, the Highland model still has only two statutory bodies.

John Mason: So, you have just been transferring between yourselves without the need for a third organisation to do all that.

Nick Kenton: That is correct.

John Mason: It has been suggested that a third organisation could be set up to do all that.

Nick Kenton: I think that that is correct with regard to the other model, but that is probably a question for the Scottish Government.

John Mason: Why did you not go down that route?

Nick Kenton: When we considered which model to introduce, there was no bill; instead, our model was put together under the terms of the Community Care and Health (Scotland) Act 2002. When in 2010 we first looked at the various models, a third-party model was considered. I am not sure whether that would have required legislation, but the view was that putting in place another body would simply put more boundaries into the system instead of eliminating them.

John Mason: That is very much my point. Do you share that concern, Ms Campbell?

Jean Campbell: The key will be in what the guidance says and the level of autonomy that the body corporate will have. It seems from the bill that the body will have quite a lot of autonomy over decisions about the pots of money that are allocated to it, and that it will be able to set clear direction on allocation of resources across the landscape to meet key outcomes. However, the bodies that sit at the back—the local authority and the health board—will need to agree those outcomes and the strategic or joint strategic commissioning plan for allocating the resources.

We should also remember that each year efficiencies will be applied to our separate annual budgets. The body corporate will be a separate entity that might have quite a lot of autonomy, but people will be concerned about two separate bodies in the background having a say over the amount of money going in and where that money should go, and about the fact that the body corporate cannot be completely autonomous and cannot make decisions without having regard to those two bodies. I think that such a move will create additional bureaucracy.

John Mason: I am quite concerned by those comments. At the moment, if £10 million goes into, say, social work, social work decides how that money should be spent. In the future, however, that £10 million might be transferred to the new organisation. How hands-on will social work be with that £10 million? Will it simply hand the money over and let the new body get on with it, or will it be quite involved in decisions on how that money is spent?

Jean Campbell: The guidance will be key in setting out how that money is dealt with once it is transferred. That said, the council might transfer £10 million one year, but the next year it might have to make 3 per cent efficiencies and so might deduct 3 per cent from that £10 million, put in place a process for allocating efficiency savings or ask the body corporate to make those savings. There will need to be a dialogue between the council and the body corporate about the level of funding and the extent to which it will have a say over what happens to that funding. The guidance will make clear the level of autonomy the body will have in such decisions.

The bill suggests that the body corporate will be quite autonomous but, as the years pass, it will have to meet the efficiency pressures—or whatever else might be going on in the background—that are faced by its parent bodies. It will have to comply with those efficiencies just as happens with money that is allocated to education or sports and leisure. Everybody must contribute to the bigger agenda and the overall council and health strategies. As I said, the body corporate will be autonomous and be able to do what it likes with that £10 million, but it will have to make the efficiencies that the parent bodies must deliver on, too.

John Mason: Your council, which is relatively small, deals with Greater Glasgow and Clyde NHS Board. Will there be one joint body for Greater Glasgow and Clyde?

Jean Campbell: That has still to be determined.

John Mason: That is not determined.

Jean Campbell: It is not. Under the bill, each local authority area will have a partnership agreement, so we would expect East Dunbartonshire Council to have its own partnership agreement. However, we share hospital provision with six other local authorities.

John Mason: I presume that your council will want to ensure that the £10 million that it puts into the pot benefits its residents rather than, for example, Renfrewshire residents.

Jean Campbell: Or Glasgow residents—yes.

Nick Kenton: When Highland Council transferred the £89 million, NHS Highland had a debate with it about how much influence and control or otherwise the council would have over that funding. We debated whether we should focus on the inputs—the staff and all the transferred budgets—or the outcomes. We are in a state of flux, but we prefer to look at the outcomes and how we deliver with the £89 million rather than how many social workers have been appointed or whatever. That debate has yet to be resolved but, as we mature, I hope that we will move towards looking at the outcomes that each of the other agencies has delivered, rather than focusing on the exact amount transferred.

John Mason: I realise that neither of you is directly answerable for my next topic but I will ask the question anyway. I understand that Healthcare Improvement Scotland and the Care Inspectorate would come in and do the inspections and so on. That has the potential for duplication. Is it your understanding that both bodies would do the same thing or would they do different things?

Jean Campbell: They currently do different things—Healthcare Improvement Scotland looks at the quality of healthcare and the Care Inspectorate looks at the quality of social care delivery. However, I understand that the bodies are moving towards joint inspections.

Our child protection services have just had a joint inspection, which looked at how organisations work together to deliver jointly on outcomes. The Care Inspectorate is certainly moving towards delivering such an approach. Were that approach to continue, it would perhaps eradicate the

duplication that is out there, but that has cost implications.

John Mason: To be sceptical, that sounds as if two people are turning up to inspect something together, although that is probably better than two people turning up and inspecting it separately. Would it ultimately be better if just one person turned up and did the inspection? That would save 50 per cent.

Jean Campbell: Yes. I hope that that is the way that things will go. When the Care Inspectorate came along, it looked at the whole joint landscape of child protection delivery and how we work jointly to deliver on related outcomes. When the healthcare inspectorate comes along, I hope that it will take cognisance of that care inspection and that that will inform the level of inspection that it does. As things develop, I hope that that will come together a lot more.

John Mason: Mr Kenton, do you share the view that it will be in the longer term that inspections join up?

Nick Kenton: I am not sure that we have a formal organisational view on that, so I will speak in a personal capacity. On the one hand, joining up and integrating the inspectorate regime and the care at the same time seems to make sense; on the other, we must ensure that we do not lose expertise. For example, if the national health service is running care homes, we need to ensure that the standards applied are not the ones that apply to hospitals, as otherwise we will end up with inappropriate responses. In principle, it makes sense to join up the regimes, but we must keep an appropriate inspectorate regime for each part of the organisation.

John Mason: In your experience of bringing together two organisations—or at least of joint working—was there a big financial input from outside or did you cover that with your own resources?

10:30

Nick Kenton: We had support from the Scottish Government to the tune of about £1.5 million, of which about £900,000 was for the direct costs of transition. Because we were first in the queue, some costs have not applied to other organisations. The model that we used also had some costs for human resources support that would not necessarily apply under other models.

The rest of the support concerned differences in accounting regimes. For example, if health service staff carry their leave forward beyond the end of the financial year, the health service is required to provide for that as if the time was paid for, whereas that accounting requirement does not exist for the council. We needed help to cover some transitional changes, but that was the scale of the support.

John Mason: So you just needed to get the accountants to behave themselves.

Michael McMahon (Uddingston and Bellshill) (Lab): Like the deputy convener, I am interested in the costs of organisational development. Paragraph 53 of the financial memorandum states:

> "Support will be necessary at all levels in the new partnerships, including the establishment of new integration joint boards, or integration joint monitoring committees, through to education and training for frontline practitioners, working in new ways to support service users."

That is perhaps a statement of fact. Does the financial memorandum take into account the costs of that organisational redevelopment? What cost implications will there be for the establishment of the new bodies?

Jean Campbell: Some costs are reflected in the financial memorandum, such as those for the appointment of joint accountable officers and for the displacement of community health partnership managers—under the bill, those posts will go. However, there seems to be no reciprocal provision for the local authority side, which has management or leadership posts that will go under the new arrangements as well as management structures that are underneath them. Health and social work management teams will need to be joined up to deliver on the new agenda, but the fact that those arrangements could have redundancy and displacement costs in local authorities is not reflected.

Nick Kenton: In the Highland model, there was no new body to staff up. We have had to restructure on the back of integration, but that has been broadly cost neutral for us.

I am not aware of any new costs for training front-line staff. As I said in an earlier answer, the initial two years are business as usual for front-line staff. Although the staff involved are now paid from a different payroll and are part of a different organisation, the delivery of front-line care is pretty much the same, so I do not see that additional training is a particular issue for them in the short term.

Michael McMahon: Given that the new arrangements will apply across the whole of Scotland, have you considered how the provision in the financial memorandum will apply overall rather than just from your own perspective? The changes will apply to all health boards and local authorities, so there will be cost implications. We need to consider whether the Scottish Government has taken those cost implications into account in its planning for the financial arrangements.

Nick Kenton: I can answer only from an NHS Highland point of view, so that is probably a question for the Scottish Government officials who will appear on the next panel.

The Convener: Committee members have no further questions, so I will finish with a question to each of you, although both of you might want to respond to each question. Ms Campbell, your submission says:

"Delayed Discharges—predicated on a maximum 14 day delay in hospital—is this realistic and achievable?"

Do you believe that the target is realistic and achievable?

Jean Campbell: To establish whether the target is achievable, it would be helpful to see how successful partnerships across Scotland are in achieving the current 28-day target. Certainly, I know that our authority had no delayed discharges when there was a six-week target but, in the months leading up to the current 28-day target as well as in the initial months of having it, we had some delays against it, although we are now achieving it.

The bill identifies efficiencies from using care homes and home care rather than hospital admissions, but it does not recognise that, for example, assessment teams will need to run twice as fast to undertake assessments and get people out of hospital. From my perspective, to go from 28 to 14 days is asking a lot of the social work teams that will need to provide assessments in that timescale.

Although we in East Dunbartonshire are relatively successful in attaining the targets for delayed discharge, I am aware that performance is not consistent across Scotland. To reflect realistic expectations about that, it might be worth considering the extent to which other partnerships are achieving the current 28-day target. As that moves to 14 days, it will become more and more difficult for teams physically to get people out in those timescales.

The Convener: Mr Kenton, is the new target realistic and achievable?

Nick Kenton: This is not my direct area of expertise, but I think that we have set ourselves a target of beating that target. However, we currently have issues with delayed discharges, so we are looking at care-home and care-at-home capacity.

Now that such matters are under our direct control, it is in our gift to move resources to address the problem, whereas in the past we had to negotiate with the council on a joint response. Our system should make the target more doable, but that is not to say that it is not a challenge. I do not have the figures to hand, but I think that evidence from Torbay, where there is a similar model to the Highland model, suggests that fairly good results on delayed discharges have been achieved from the integration approach.

The Convener: My final question is to Mr Kenton, although Ms Campbell might also want to comment. Your submission states that it is important to have

"sufficient local discretion to achieve the objectives the government has set out ... However, we felt that there must be a level of flexibility ... The emphasis should be on functions and not services per se to ensure that the total resource required to deliver that function is included in the integrated pot."

Can you expand on that a wee bit?

Nick Kenton: That relates to my earlier point that we cannot legislate for everything and write everything down. Although we have a 400-page partnership agreement, it does not cover all eventualities. We need to encourage flexibility to allow partnerships to find their own local solutions.

The wording in our submission is perhaps a bit clunky, as it should have referred to "outcomes" rather than "functions"—instead of talking about "functions and not services", it should have said "outcomes and not services". Rather than get hung up on the minutiae of the budget transfer, we should talk about what outcomes a partnership wishes to see.

Jean Campbell: I agree that we need to focus on the outcomes that we want to deliver, although it is hard to get away from the practicalities of transfers, partnership agreements and all the minutiae required to make those happen. At the front line, we need to do the best for older people, who do not want to be in hospital and want good-quality care at home. To deliver those outcomes for older people, we need to look at what we need in the pot.

The Convener: Before I call this evidence session to a halt, do you want to make any further points to the committee?

Nick Kenton: No, thank you.

Jean Campbell: No.

The Convener: Thank you both very much. We really appreciate the responses that you have given to our questions.

I call a short recess until 10.45.

10:38

Meeting suspended

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10:45

On resuming—

The Convener: We continue to take evidence on the financial memorandum to the Public Bodies (Joint Working) (Scotland) Bill. I welcome our second panel of witnesses, who are from the Scottish Government: Frances Conlan, Christine McLaughlin, Paul Leak and Alison Taylor. There will be no opening statements and we will go straight into questions. The first questions will come from me, as usual—the joys of convenership—and I will then open the meeting out to other committee members.

The financial memorandum estimates potential efficiency savings of between £138 million and £157 million for health boards and local authorities from the combined effect of anticipatory care plans, reduced delayed discharge and reduced variation. However, the memorandum also notes that

"there is considerable uncertainty around these estimates".

Those uncertainties have been acknowledged by a number of people who have submitted evidence to the committee. For example, Scottish Borders partnership stated that

"much more research and a robust evidence base will be needed".

Dumfries and Galloway Council said that

"there is considerable uncertainty around the estimates in relation to projected efficiencies."

How much uncertainty do you estimate there is, and how did you arrive at the relatively narrow range of between £138 million and £157 million?

Alison Taylor (Scottish Government): I will begin with a general statement on the policy and then hand over to my colleagues, who did the calculations. Would that be best?

The Convener: Sure—I am happy with that.

Alison Taylor: On uncertainty, part of the challenge for us is that, as in all health and social care systems in developed countries, the issues at work are highly complex. There is a wealth of evidence, but that is, in itself, complex. Drawing down what potential improvements are available requires a multifaceted calculation.

Paul Leak (Scottish Government): The efficiency savings are estimated across three areas: anticipatory care plans, the reduction in delayed discharges and the reduction in variation. The range relates to the calculation for delayed discharges, for which there were two assumptions—14 days and 72 hours. That explains the difference in the range.

The basis of the calculation for variation is that we can track the expenditure for health boards by population down to partnership areas. For instance, we can track how much expenditure by Lothian NHS Board is spent across the four partnerships in Lothian. That shows that there is variation. Even though there is an average spend per head across Lothian, Tayside or wherever, there is variation in the spend per weighted head for the populations of the partnership areas.

We are indicating that, through the integration proposals, the difference in expenditure per head will be evident to the partnership and there will be a basis for scrutinising that. However, we are unsure about the processes that the partnerships will follow and the decisions that they will make in reviewing that information and in forming their allocations subsequently. That is the uncertainty in that area. It is more uncertainty about the decisions that partnerships will take than uncertainty about the figures.

The Convener: Colleagues will drill down into that, so I will resist the temptation to ask further questions on the issue.

On transitional, non-recurrent costs, the financial memorandum tells us that

"it is reasonable to assume that Health Boards and local authorities will realise opportunity costs, which will be expected to be used to support transitional arrangements."

What are those opportunity costs likely to be? I know that a table is provided but, for the *Official Report*, will you tell us a bit more about that?

Paul Leak: The method that we used to calculate the transition costs was to take the Highland example, as Mr Kenton indicated, and remove from its costs any costs that do not apply under the bill, such as children's services costs, and costs that are specific to the lead agency model, to give us a transition cost estimate for the integrated joint board or body corporate model.

In carrying out that calculation, we understood from Highland that it incurred some costs on which it did not have to expend expenditure; it covered them by reallocating resource from other budgets in its programme. We noted that as a potential opportunity for other partnerships to follow in due course, but we did not apply it to our calculations, so the estimate for transition costs in the financial memorandum makes no assumptions for opportunity costs.

The Convener: We have received written evidence from some local authorities, and a representative of East Dunbartonshire Council has given oral evidence today. In its submission, East Dunbartonshire Council says:

"There is no focus on the issues arising from the delegation of budgets and resources under each of the 2 options available which is a key area of concern and will have far reaching implications in the medium/longer term and the realism attached to releasing resources from

budgets tied into acute budgets without de-stabilising hospital provision."

Will you respond to that?

Paul Leak: From my understanding of the response that was given earlier, I think that that refers to the fact that we did not include in the bill the potential benefits of the redesign of secondary care by referring specifically to that. It could be argued that some of the potential efficiencies from reducing delayed discharges reflect that.

Alison Taylor: There has previously been helpful discussion about the difficulties associated with releasing any resource from acute spend and the need to incorporate acute spending and activity in what I would describe as the strategic planning process that we are laying out for the integrated systems. The main focus in policy terms is that we do not believe that we can deliver better outcomes for people unless we ensure a strategic planning process that reflects the entire journey of care. The assumptions that are worked in about redesign of all types of provision—primary care, community care and hospital care—depend largely on the local opportunity for improvement.

Christine McLaughlin can add more from a health perspective.

Christine McLaughlin (Scottish Government): The bill covers an overall approach in relation to scope. A number of submissions have referred to the extent to which scope is included in the financial memorandum, and the memorandum sets out the total spend on adults, although it does not specify in great detail the components of resources that will come within the scope of a plan. That work has been taken forward through the integrated resources advisory group, which I chair and which includes directors of finance from local government and health, the Association of Directors of Social Work, Audit Scotland, the Chartered Institute of Public Finance and Accountancy and other bodies. The issue is how to get the best use of the total resources; we have tried to outline that up front in the financial memorandum. This is not just about what things cost and what can be identified as tangible savings but about the wider question of making best use of the total resources available.

If members are interested, I can provide the committee with details of further work in which we have asked partnerships to give us information about the scope of resources that each partnership is looking to put into the overall scope of the plan, but that is not identified in the financial memorandum. I had the sense that that was where some of the responses were coming from; they were about quantifying the scope. I do not know whether that answers your question.

The Convener: To a degree, it does. I will continue on costs, which are fundamental to the financial memorandum. A number of people who have submitted evidence have said that the costs on health bodies are more clearly identified and addressed than the costs on local authorities are. Why is that?

Alison Taylor: That partly reflects the fact that the financial memorandum reflects the costs incurred under the bill. As the bill—if and when it is enacted—will take community health partnerships off the statute book, it will have a direct impact on management arrangements that health boards have had in place to support CHPs.

Paul Leak: We did not have the time to consult on the financial memorandum, so we took the opportunity to work informally with the ADSW and the Convention of Scottish Local Authorities to identify costs that local government might incur. We reflected all those costs in the financial memorandum.

In addition, we used the resources advisory group that we have established to advise us on the bill's resource implications. We did not share the detailed figures with the group, but we shared with it all the headings and areas of cost that we had identified, to get a broader assessment of the costs that might apply. We used Highland as the model for the transition costs, but we captured all the costs that both partners in Highland incurred, which we incorporated, with adjustments, into the financial memorandum.

The Convener: You mentioned the ADSW, which believes that management posts are more likely to be deleted than is being suggested. It therefore says:

"we think that potential redundancy and redeployment costs will be significantly larger than those contained in the FM."

Alison Taylor: As you will be aware, in the discussion with previous witnesses and in other discussions on the issue, there has been some reflection on the need to ensure that local systems have the flexibility to put in place arrangements that best suit local needs and which provide a smooth, sustainable and robust transition from current patterns of provision to a more integrated model. We have worked closely with representatives of the ADSW and other pertinent bodies in formulating the figures, as Paul Leak indicated. We have not been able to fathom in detail what such changes might amount to in a general sense, because they tend to be particular to local systems.

Paul Leak: Most of the CHP general manager posts are funded by boards, but some are part funded by boards and local authorities, so the estimate of the displacement costs in relation to

those posts addresses the costs that boards and local authorities will incur. That calculation relates just to the displacement of CHP general managers, as those posts are directly affected by the bill.

The Convener: An issue that North Ayrshire Council, which is the council for my constituency, commented on was

"Insufficient ICT developments and recurring costs".

The three local authorities in my area are coterminous with a single health board. According to North Ayrshire Council,

"within Ayrshire the three local authorities operate different social work management information systems."

That will be an even greater issue in the Greater Glasgow and Clyde area, although perhaps less so in Lanarkshire.

What has been taken into account in that regard? There is clearly a concern that the financial implications have not been given as much consideration as those local authorities think that they should have been given.

Paul Leak: We have included in the financial memorandum costs specifically for a project to improve management information to support strategic planning. Strategic planning is a key proposal in the bill. The information that we have used to support the figures in the financial memorandum is based on a project that we have had under way for a number of years, which is called the integrated resource framework. It links health and social care data at an individual client/patient level and aggregates that up to larger geographies—general practitioner practice areas, CHP boundaries or local authority districts.

Having based the figures in the financial memorandum on work that is under way, we propose to roll out that work to all partnerships in Scotland so that, by the time the bill is implemented, we will have linked health and social care management data that can be used by partnerships to inform their strategic planning. The figures that we have included in the financial memorandum are based on actual costs that are incurred at the moment, which have been scaled up.

The process does not involve a standardisation of systems. Essentially, it uses existing systems, draws the data in and presents it back to partners in a way that they can access.

11:00

The Convener: Thanks for that. That is very helpful.

Christine McLaughlin: I know that a number of responses suggested that a new IT system is needed. The experience in health over the past five years or so has certainly been very much about the convergence of systems as opposed to creating new systems, and focusing on the standardisation of clinical information as well as the data itself. The approach very much fits the wider e-health strategy of using existing systems and accepting that sometimes the answer is not a one-size-fits-all system for every part of the country.

That is the straightforward answer to why we have not included a very large, multimillion pound figure for IT systems at this point.

The Convener: Okay. Thank you.

I have a further point before I open up the discussion to the committee. On the clinical negligence and other risks indemnity scheme—CNORIS, which is an acronym that I do not think many of us were familiar with before we came to the bill—Falkirk Council notes in its submission:

"In respect of Clinical Negligence and Other Risks Insurance, the FM notes that the costs of obtaining indemnity from the market might be prohibitive but makes no mention of additional costs that might arise from extension of the scheme."

Can you talk us through your thinking in that area? What might the additional costs be?

Christine McLaughlin: CNORIS is not an insurance scheme as such; rather, it is a risk-sharing scheme that is mandatory across all NHS boards. Basically, it allows the total costs of claims in any one year to be shared on an agreed basis across all the members. Currently, it does not provide for social care functions. The reason for the scheme being in the bill is to extend its provision so that, if local authorities wished to join it for the functions that are defined in the bill, they can do so. In respect of additional costs, a premium would not be put in place; it is simply about sharing costs.

This is how I envisage the scheme working if social care functions were included. We would need to have a way of identifying the risks associated with those services to be able to attribute across all members the total costs incurred in any one year. We think that it is unlikely that there would be additional costs. In fact, the scheme was put into the NHS to try to make the best use of resources and avoid anyone having to hold reserves for any potential high-value claims. The aim was to have a smoothing effect across all the service.

Going out to market for services in health does not make a great deal of financial sense because of the potential for high-value claims in areas such as obstetrics. The proposal potentially allows social care functions to benefit from the same risk-sharing agreement. The strength in the NHS

scheme is that all boards work to very similar clinical risk management standards and procedures, and one would want to maintain that integrity for anyone who joins the scheme.

I have had discussions with people who have asked about the scheme more generally. There is nothing to prohibit anyone else from looking to set up a similar scheme for other functions, but we have focused on the functions that are within the scope of the bill.

The Convener: Thank you for that comprehensive response. I now open up the discussion to colleagues.

Malcolm Chisholm: I will start with the issue of reducing variations, in relation to which Paul Leak gave the helpful Lothian example. However, I am still struggling to see how that works. That is the largest potential efficiency, but I genuinely do not really understand it.

Paul Leak said that there would be uncertainties about the decisions taken by the partnership. To stick with his Lothian example, it is not clear to me how things would be different. There are variations among the four local authorities, but there are four different partnership boards, so I am not quite sure how the bill will change anything fundamentally in that regard.

Paul Leak: We considered very carefully the figures for the financial memorandum. We started by looking at the variation in health and social care expenditure across partnership populations. However, we were aware that some of the variation in local authority expenditure per head might be due to political decisions, so we took that out of the equation. That left us with the variation across partnership areas in health board expenditure. To stick with the Lothian example, that gave us expenditure figures per head of population for the four partnerships in Lothian, which, when they were averaged out, gave Lothian's spend per head across the whole of the Lothian population.

The premise is that, through the bill's provisions and the establishment of the partnerships, that variation will be apparent. I think that it is apparent in some boards at the moment, but it is perhaps a marginal issue. We think that the bill's provisions will give it more prominence and that there will be at least the potential for partners to scrutinise why expenditure per head in, say, Edinburgh is different from that in Midlothian. It will allow comparison of the outcomes achieved for the additional expenditure per head and conclusions to be drawn from that. We hope that in due course that would then inform partners' strategic planning decisions. What I tried to explain earlier about the uncertainty in the figures is that we are unsure about the decisions that partnerships will take when they are presented with the information. We are therefore saying that there is variation and that there are potential efficiencies but that it is up to the partners to act on that information.

Malcolm Chisholm: I will not pursue that, but I am sceptical about it. We already have separate partnership boards in Lothian, so I am not quite sure why they would not be able to act now if they wanted to.

Paul Leak: The question is whether that information—the total health and social care expenditure on adults in Midlothian, West Lothian and so on—is being reported at the moment. I am not sure that it is. At the moment, I think that all that is reported is information about the direct budgets that the CHPs manage. However, the fuller information will include figures on the use of all the services by the population, which will show quite material variation.

Malcolm Chisholm: Okay. That leads me on to my next question. You referred to the uncertainty about decisions taken by partnerships, but that also goes to the financial heart of the bill. Is that just about decisions taken by partnerships? Surely the totality of the resource that they have will be determined not by the partnership but by the council and the health board. I agree with the bill's objectives and everything that you have said about the best use of total resources and so on, but it is still not clear to me how it will work in practice.

My question is perhaps a policy one. Is the Government comfortable with allowing 32 decisions in Scotland by health boards and local authorities on how much money goes in? That will be fundamental to all that is being proposed. The particularly important decision will be about how much money goes into acute services. I do not quite see how all that is going to work in practice in an equitable way. Is there a case for having more central direction of how much goes into the integrated budget?

Paul Leak: I will answer that unless Alison Taylor wants to.

Alison Taylor: There are several points in there that we might respond to. Paul Leak will start.

Paul Leak: Alison can address policy issues afterwards.

The resource advisory group that we have established is producing professional guidance for boards and local authority finance leaders on the process for setting the initial budget and subsequent budgets. The guidance will set out all the factors that should be considered by the partners in deciding what should be in the budget. One of the factors will be any movement by the parent bodies to remove some of the variation. For example, in discussions between a partnership

and a parent body about the subsequent allocation to the partnership, the latter might argue that the parent body was allocating £50 per head less to it than to the next-door partnership while expecting it to achieve the same outcomes as that partnership. The discussion will then be around what can be amended. Therefore, the process will involve discussion between the parent body and the chief officer in the partnership about the resource that is being allocated.

Malcolm Chisholm: That will drive up costs, because no one will say to the parent body, "You're allocating us £50 more than you're allocating to the next partnership."

Paul Leak: The challenge is for the parent body to say, "We're allocating you £50 more than before. We're setting you a differential efficiency target to achieve the same outcomes."

Alison Taylor: Christine McLaughlin might want to speak about how local integrated budgets are arrived at and agreed, and about the interaction and support that we are putting in place around that with local partnerships. I go back to the discussion on variation and a point that Paul Leak made a few minutes ago about the investment that we are making in improving the provision of linked data at the local level. As he said, that will go below the partnership level as we work through the process and build on the experience of the integrated resource framework.

One of the things that we have learned from that experience, which is on-going, is that the data that comes out of that work gives local clinicians a great opportunity to look at variation between their own practices. That is absolutely not an area in which bureaucrats would wish to be involved, with one saying that one kind of variation was good and another suggesting that something was not right. Colleagues who are senior clinicians and senior medical officers have been involved in leading conversations at the local level that reflect on variation in spend activity and outcomes and what that means for local practice. Obviously, it is through primary care that we see a lot of unplanned admissions, so that transparency around activity and what is going on ought to be helpful in improving quality and outcomes, particularly for a frail elderly population.

I will hand over to Christine McLaughlin to talk about acute budgets.

Christine McLaughlin: Throughout the discussions that we have had on acute budgets, it has become evident that there are two different approaches: effort can be focused either on how much is in the pot or on the outcomes that will be delivered. We have got to the point of thinking that it is more productive to focus on the outcomes. As the committee will know, there are well-defined performance management arrangements in place for local authorities and health, so delivery of outcomes will be integral to those arrangements. We are not saying that we are leaving arrangements entirely to the discretion of local partnerships. If we do not see the outcomes that we expect to see, that would just fall within the normal management arrangements that already exist.

The point that Alison Taylor made was about transparency of information and the ability to compare and benchmark. In the Scottish Government, we anticipate a lot more investment of time and energy and a lot more focus across the NHS and local government more generally than just on this part of the spend, but there is a real benefit in having much more management information that will allow better decision making.

To put all that together, it is important to make sure that there is enough scope in here to make sure that the partnerships really work, but we would prefer to focus our efforts in that regard on the extent to which the required outcomes are delivered.

Malcolm Chisholm: My final question—

The Convener: Paul Leak wants to come back in.

Paul Leak: I just want to emphasise Christine McLaughlin's point. The main focus for hospital provision in the bill is on unplanned admissions. A significant proportion of our hospital capacity is taken up with unplanned admissions, particularly of elderly people. I do not know whether this will be done through regulations, but we will target particular specialties for partners to include within the scope of the strategic plan. A relatively small number of specialties are responsible for most of the unplanned admissions bed days for elderly people so, through the bill's provisions, we will direct partners to include those within the minimum scope of the strategy.

Malcolm Chisholm: That leads on to my final question, because the most difficult question is about the acute budgets. We had a representative of East Dunbartonshire Council here earlier, and I was struck by how many different local authorities Greater Glasgow and Clyde NHS Board has to negotiate with. It is difficult to see how that will work in practice. Your answer implies that you will give guidance or direction on which aspects of hospital budgets will have to be included.

I suppose that this goes back to the point about demographics. We all accept the objectives around late discharge and anticipatory care, but the hospital specialties that you are thinking of will still have all their beds filled because of the demographics.

The bill's approach is based on the idea of a stable elderly population, which would allow us genuinely to reduce the need for hospital beds and build up community services. However, everybody in Lothian tells me that, while they have to increase community provision, they also have to keep hospital beds—in fact, they are increasing the number of acute beds at present.

11:15

It is not clear to me whether the thinking behind the savings is right, or how, in practice, you can include acute services budgets. Are you basically saying that each health board will include a budget for acute services? In some cases, I do not see how that can be done. Are you saying that boards will put in a small amount of money to increase the amount of community provision? What will that do? As you must know, that is one of the NHS's concerns about the bill.

Glasgow is a good example. If there are a number of local authorities all trying to chip away at the health budget, and yet the board still has to run all the same hospitals—one of which is currently being rebuilt—with the same number of beds, I do not see how that will work in practice.

Paul Leak: I will address the technical points. The bill focuses on enabling parts of the NHS to use resources better across the entire spectrum of care. At present, there are artificial disconnects between community provision and acute provision within boards, and between boards and local authorities, all of which affect expenditure in each of those sectors. The bill's premise is that, by bringing those things together and focusing on them all, we can better allocate the resource.

We think that there are efficiencies to be made through that process, as we indicate in the financial memorandum. If we compare the performance of our systems with that of integrated systems in other parts of the UK—for example, the care trust in Torbay and the system in North East Lincolnshire—we can see clearly that they have much lower bed day rates than we do.

There are efficiencies to be made through reallocating resources, but that will not be sufficient to offset demographic change, and we indicate that in the financial memorandum. The bill is about using the resources that we have now more efficiently and planning strategically across all the sectors to enable better use of resource in the future.

Alison Taylor: I reiterate what Paul Leak says, which goes back to the point that I made earlier. It is not really about handing money over; it is about bringing money together to reflect the care journey of the growing population of need, which largely consists of people who are frail and in their older years but also includes other adults who have multiple and complex needs.

We are focusing in particular on the importance of a strategic planning effort across primary care, social care and the particular aspects of acute hospital care that we believe lend themselves to being redesigned in favour of prevention. The key is the bringing together rather than the handing over.

As Paul Leak says, there is of course a large unknown quantity—as has been discussed a great deal this morning—with regard to the opportunity for redirection and reprovision. However, we believe that there is evidence to suggest that such an opportunity exists.

The primary aim of the job that we were given of bringing together policy and legislation was to seek a mechanism that makes much better use of the current resource envelope. If we do not make better and more efficient use of what we have now, we will certainly not be equipped to deal with demographic change. As Paul Leak said, the financial memorandum—specifically at paragraphs 34 and 35—states that we note and are reflecting on the impact of demographic change more broadly.

Malcolm Chisholm: Surely we are bringing such aspects together now. The bill sets up a body corporate, to which resources will be handed over, but you are proposing that we move a step on from that, and have a body that is, in a certain sense, separate from health boards and local authorities.

Alison Taylor: As we reflected on how we could integrate in the broadest and most straightforward sense, it struck us that—to return to what Mr Kenton said earlier—we could follow the type of model that Highland has used. It has also been used, to good effect, in some places down south, where—to put it in the simplest terms—one body hands something to the other, which takes the lead, and the money and the functions go together in that way.

Alternatively, we reasoned that we could take a different path and bring functions and resources together by creating something in the middle of a health board and a local authority that might resemble the overlap in a Venn diagram. That is what we have sought to do, but I challenge the idea that it is separate from the health board and the local authority.

The governance arrangements that we have in mind, which we have described in the accompanying material and which we have started to outline in appropriate terms for legislation, have a clear, strong role for the health board and the local authority. The objective of the exercise is to maximise their mutual support for each other as

regards delivering services for a common population of need. We do not see that as a separate exercise.

Also, as the bill stands, the duties that are placed on that joint board relate to strategic planning. It is conceived as a central point where the health board and local authority interests must come together to plan together for the population of need, to maximum effect for the population and to maximise the potential efficiency and effectiveness of the organisations themselves.

My colleague Frances Conlan will add to that.

Frances Conlan (Scottish Government): In terms of the technical aspects of the bill, there is a strong role for the health board and the local authority in relation to strategic planning. The duties are on the body corporate, as described in the bill. However, there is a clear duty on that body corporate to fully consult the health board and the local authority to ensure that they are full partners in that strategic planning process.

Malcolm Chisholm: It is probably beyond the remit of this committee, but I merely add that both NHS Lothian and the City of Edinburgh Council think that there is a big gap between the policy memorandum and what the bill actually says. That issue needs to be ironed out in the committee process.

Michael McMahon: The witnesses have already had a heads-up on the area that I am concerned about, and it is not dissimilar to Malcolm Chisholm's point. There is an element of dancing on the head of a pin when considering whether a new integration joint board or an integration joint monitoring committee is a different institution from what already exists. However, the fact is that they are referred to in the financial memorandum as separate entities.

We have to take into account education and training when it comes to the organisational redevelopment. When the financial memorandum says that

"Support will be necessary",

I assume that that is not flags, banners and cheerleaders and that we are talking about financial support. There is a cost involved in that. We heard from Mr Kenton that Highland did not have a take on that, because it is not going to work under that system, but concerns have been raised that the cost implications of the transformation are not adequately addressed in the financial memorandum. Will you comment on that?

Paul Leak: The estimates for organisational development that are included in the financial memorandum were based on estimates by—goodness, I have forgotten the name.

Alison Taylor: It was the Scottish Social Services Council and NHS Education for Scotland.

Paul Leak: They were estimates for providing organisational development for the members of the integration joint boards. In addition, we are looking to develop the strategic planning capabilities within partnerships, and that is included in the estimate from the SSSC.

Michael McMahon: In the response that I had earlier, there was a comment on management positions being lost and redundancy costs being incurred. Have those costs been included in the financial memorandum?

Paul Leak: Yes. I do not have the reference point, but we included a provision for the potential displacement cost of CHP general managers. We have not included any other posts, as the CHP general manager posts are the posts that will be directly removed as a result of the bill.

Michael McMahon: Have numbers been discussed in relation to that and can those numbers be achieved through voluntary redundancies?

Paul Leak: We have set out three scenarios for the CHP general managers. One is that all the general managers are successful in applying for the chief officer posts in the joint boards; another is that none is successful in securing a chief officer post; and the third is a midway point, where half the general managers are successful. For each scenario, we then calculated the potential displacement costs, depending on the number of general managers who are not successful. In each case, we assumed that half of the people who were not successful would be made redundant and half would go on to a redeployment register and then subsequently be re-employed. I am just trying to find my notes on that.

Christine McLaughlin: While Paul is doing that, I will mention that we are in a fortunate position in having had a pilot of which we can take cognisance in developing the costs. However, we are aware that there was a slightly different position in Highland, partly because of the speed of implementation there.

We recognise that the various partnerships are at different stages, but some of them are already implementing what they call shadow arrangements and some have already appointed people to posts, so there are different partnerships that we can use to give us a bit more assurance—or not—about costs. Some of the partnerships have set up their shadow arrangements without additional costs being incurred, but the situation will be different in each partnership. Some might have costs because of their particular circumstances and structures, whereas others might incur insignificant costs—there is a bit of a spectrum. We would hope that

the fact that the partnerships have more time to put their arrangements in place will allow them to resolve potential issues and to work through any potential for redeployment.

Paul Leak: Paragraph 51 of the financial memorandum, on page 31 of the explanatory notes, says:

"If none of the 28 displaced Community Health Partnership"

general managers

"are successful ... the ... cost would be £3.5m incurred in 2014/15 and £1.3m"

in the two subsequent years. If half of them are successful, it would be proportionately lower—it would be

"£1.8m incurred in 2014/15 and £0.7m"

for the two years after that.

John Mason: Continuing on the same theme, I refer to a point in the NHS Highland submission that the convener quoted earlier. It states:

"It is worth noting that the integration of budgets between partner bodies requires a high degree of trust and openness - and this is as much about leadership and culture as legislation."

We had the example of Glasgow where, basically, that did not work. Do you feel that the bill will be sufficient, even if people do not get on with each other? Does it actually depend on attitudes?

Alison Taylor: None of us would make the leap to saying that legislation alone is sufficient, but our position and ministers' position is that, given the shape of population need, it is reasonable, in the light of the experience of the last several years of partnership working, to place particular emphasis at this stage on the importance of effective integrated working.

In this instance, legislation can place the importance of working effectively together on a different footing. In relation to public sector leadership, it can become something that is defined in statute as necessary, which places it in a different context. Alone, however, legislation is not enough. The financial memorandum reflects on issues such as organisational and leadership development, which are key to tackling the challenges ahead. We are not starting with a clean sheet in that regard, but there is a renewed emphasis on those issues as we reflect on developing need. It is a mixed picture.

John Mason: From what I can see at a distance, Highland seems to be a good example of where things have worked well. However, my concern is that, if we repeat the process 32 times, there might be one or two cost implications. The committee's job is to be a bit sceptical about that. If the new joint board, or whatever it is called, develops a life of its own and we effectively have three legal entities all trying to relate to one another, there are cost implications in that.

Alison Taylor: The joint board has to have some life of its own. It is meant to lead strategic planning in an integrated way, which has been set out in a fairly novel manner. However, it needs to be carefully and closely bound into a relationship with the health board and local authority. Those are the points that Frances Conlan reflected on.

You are right to say that we have seen success in Highland. There are other examples of areas that are well down the path of developing an integrated approach although, for the reasons that Mr Kenton raised, nobody at this stage is actually doing the joint board arrangement as it is described in the bill. We can learn from examples such as Edinburgh, West Lothian, West Dunbartonshire and other places that have an integrated approach in place.

Where there are challenges—we all know that there will be areas where there are specific challenges in any programme of change, particularly for something so significant—we will need to provide support and improvement support. We have established arrangements in place to help with local development as necessary and as the programme rolls out.

I am not sure whether my colleagues who have worked directly on the detail of the financial memorandum want to add any comments.

Paul Leak: No.

11:30

John Mason: I asked the representative from East Dunbartonshire Council whether, if it hands over £10 million to the joint body, that money will have to be double accounted for, because the joint body will have to scrutinise exactly what the £10 million is used for and East Dunbartonshire will also scrutinise exactly where it goes. If they do not do that, will the auditors criticise them? I fear that there might be duplication.

Alison Taylor: I recognise your concern. It is of key importance to us that, in the pursuit of improved outcomes, we do not create a whole new bureaucracy and a whole new science. I will hand over to Christine McLaughlin to reflect on how we are handling the issue.

Christine McLaughlin: The resources group is focused on the accounting impact of the arrangements, with the focus being on doing it once and being able to take an approach that we use. Hosted arrangements are in place in many services. Glasgow is a good example of such an approach being taken, because often one part of the system or one council takes the lead on a

service and provides it to others. There are some pretty tried and tested ways of ensuring that a service can be provided somewhere and that that does not result in duplication of effort, whether in accounting, bureaucracy or the administration of the people who are involved.

Our approach in the bill is to achieve transparency through the accounting process and to avoid going down the multiple accounting route or having additional bureaucracy. At this point, we do not anticipate increases in the number of staff, because staff already work in the area in CHPs and local authorities. There is nothing to suggest that there is a need to overlay anything on top of that structure. We are looking at how we can use the existing resources and infrastructure as far as possible.

John Mason: Do you anticipate that the specific problem that Highland Council identified with properties moving between the two sides will arise? How would that be dealt with?

Christine McLaughlin: We are aware of that issue, which relates to the lead agency model. There is a way of dealing with that whereby assets would be retained under local authority provision.

I am fairly confident in saying that, until now, with every issue that we have identified as an issue to be resolved, we have either resolved it or there are a couple of different options for ways in which partnerships can resolve it. Those are all probably in the category of technical issues that arise because we are working within the existing structures in local authorities and health boards. There is pretty much a way through all those issues, and we will obviously try to ensure that any solutions do not have additional financial implications.

John Mason: Is the VAT issue one that has been resolved, or is it one for which there are a few options?

Christine McLaughlin: We are close to a resolution on VAT. We have been working effectively with Her Majesty's Revenue and Customs on the issue and have had good engagement with it. We are not yet at the point of a formal decision, but the advice that we are getting on the model that we have proposed is that, on the face of it, HMRC is in agreement with our working assumptions, which would mean that there would not be an additional VAT burden.

We are clear that we are not looking to do something that creates additional opportunity on VAT, but are looking to create a VAT neutral position. All our risk mitigation is about ensuring that we deal with the issue early and have good engagement, because from the outset we have been relatively confident that there is an approach that would not increase the VAT costs to local authorities.

Gavin Brown (Lothian) (Con): I want to go through a few parts of the full financial memorandum, if I may. However, before I do so, I want to clarify something. Did Paul Leak say that there was no time to consult on the financial memorandum?

Paul Leak: I may have used the wrong terminology. Frances Conlan will expand on that.

Frances Conlan: We consulted with ADSW and COSLA and with our third sector and independent sector colleagues on some of the assumptions and estimates that we have identified and are in the financial memorandum. I suppose that Paul Leak was referring to a formal consultation that might involve a wider distribution and a wider stakeholder group.

Gavin Brown: To be clear, you spoke to some stakeholders, but there was no formal consultation. Why was there no time for a formal consultation?

Frances Conlan: It was felt that the best approach was to use existing examples around the country, as my colleagues have said. Using Highland as an example, we decided that speaking to colleagues who have already made good progress on the integration of services, such as West Lothian Council and East Dunbartonshire Council, and then speaking to specific professional groups and stakeholder groups that were involved in key areas, such as the third sector, which is a big provider of care services, would be the most efficient use of our time in identifying the estimates that are in the financial memorandum.

Gavin Brown: Forgive me for labouring the point, but did you do that because you thought that it was a better way of working or because of the pressure of time?

Frances Conlan: We felt that it was the most appropriate engagement method. In fact, we have received feedback from colleagues and stakeholders to the effect that they were receptive to that approach.

Gavin Brown: Thank you for clearing that up.

The convener raised the issue of efficiencies, and Malcolm Chisholm raised the specific point about reducing variation. I want to go through the three categories of efficiencies in a bit more detail. I feel that the financial memorandum is a bit light. It has a bit of blurb and then it produces a figure. As a member of the Finance Committee, I find it difficult to know where the figures come from and whether they are right. We are given a figure of £104 million for reducing variation, but it could have said £204 million and I would not have

known whether that was right, based on the information in the financial memorandum.

On delayed discharges, the savings are estimated to be between £22 million and £41 million per annum. What would need to happen in order to save £22 million a year? I have to say that my background in health issues is poor, but my understanding is that that would be the saving if nobody stayed in hospital for more than 14 days. Is that correct?

Paul Leak: Yes. To arrive at that figure, we took the total days that are spent in hospital following the point at which people are clinically ready to go home—we counted 14 days from that point, and basically took the subsequent days that were spent in hospital. The total delayed discharge equates to something like 80 wards across Scotland, so it represents a material level of resource. The assumption was that, if there was sufficient community capacity in community health district nursing and social care to prevent those delays, those patients could go home. However, the resource that would be released from that would need to be recycled into the provision of that community capacity.

We calculated the total resource that is used for those post-14-day delays and took away from that any fixed and semi-fixed costs, so that we were left with the direct costs that should be able to be released. We then offset from that the cost of the estimated social and health care that would need to be provided in the community. The net figure was £22 million.

Gavin Brown: How likely is it that we will get to a stage at which nobody is delayed for more than 14 days? Is that a realistic goal or is it a best-case scenario?

Paul Leak: We need to recognise that we are in a dynamic situation, as we have discussed. We have increasing demand due to demographic change, so any efficiencies that we make might just create capacity to cope with increased demand in future. Nevertheless, we need to make those efficiencies, particularly in relation to delayed discharges, as the evidence is that elderly people start to experience functional decline after three days. There is, therefore, an imperative to get people home or into a homely setting as soon as possible.

Given the scale of the issue—it is not marginal; it is a material level of resource—and the clinical and care imperative, partners should, through strategic planning, be able to reorganise the resources and create the capacity that is needed in the community. They should, if you like, be able to prioritise resources to create that capacity. Of course, the question to which we do not know the answer is whether that will simply create capacity for increased demand in future.

Gavin Brown: Obviously, such a goal is desirable and everyone wants it but, coming back to my initial question, how likely is it and how long will it take to happen?

Paul Leak: The evidence from the integrated systems in Torbay, North East Lincolnshire and the Isle of Wight shows that they do not have delayed discharges and that that is possible through the redirection of resources.

Gavin Brown: The projected £12 million saving from anticipatory care plans is based on the Nairn study. How robust is that study and how likely is it that what happened in Nairn will be replicated elsewhere?

Paul Leak: The study is robust. It was published in the *British Journal of General Practice*, is second-tier and has been peer reviewed. However, although its evidence is transferable to other partnerships in Scotland, it is contingent on having an integrated approach. Nairn fostered an integrated approach between health and social care, with locality and integrated teams working closely together and a reactive response to admissions. There is no question but that it is transferable. Indeed, a subsequent study across other settings supports our initial assessment and indicates a £16 million saving.

Gavin Brown: The third and largest category of saving is from reducing variation. Malcolm Chisholm has already asked about that, but is the £104 million in efficiency savings to be achieved through having no variation whatever in health boards? Where do we need to get to in order to realise such a saving?

Paul Leak: With a four-partnership health board, we assumed that the partnerships with more than the average level of variation would in time be able to get down to the average but there would still be variation within the partnership. The saving is not achieved by removing all variation.

Gavin Brown: You say in the financial memorandum that such differences could be

"due to differences in local democratic decisions, input costs, prevalence of unpaid care, the relative size of the voluntary sector or inefficiencies."

Are you not relying on almost all variation being down to inefficiencies?

Paul Leak: That sentence relates to variation in social care expenditure. For those reasons, we removed that from the analysis and focused on the variation in health board expenditure, controlling for the population's demographic profile and differences in need—or so-called demand-side

issues. That left historical supply-side decisions as the only explanation for variation.

Gavin Brown: Can you get some of your workings to us? As I said in my opening remarks, the £104 million seems to have been just plucked out. It might be absolutely right, but I have no way of knowing.

Paul Leak: I can prepare an explanation for you.

Gavin Brown: Finally, on the issue of VAT, which is covered in the financial memorandum but has not yet been raised, your view, at least on 28 May when the bill was introduced, was that the bill was likely to be VAT neutral. However, South Lanarkshire Council has said that VAT is "critical"—obviously it will be critical if it costs £32 million—and that the issue

"requires to be confirmed in order to inform the formation of the optimum partnership model".

ADSW has also expressed concern, asking whether the Scottish Government is going to

"fund these pressures should they occur".

Has anything happened on this matter since 28 May? Are you in a position to confirm whether the bill will be VAT neutral?

Christine McLaughlin: I think that my earlier answer stands. We are still having constructive dialogue with HMRC, but we do not yet have a formal position from it on the matter. Its verbal response to the information that we have provided is that it agrees with our logic that takes us to a VAT-neutral position, but I do not want to commit it to anything at this point, because more work still has to be carried out. However, the position is encouraging.

Gavin Brown: I will not ask you to overreach but, just to be absolutely clear, are you saying that, as it stands, HMRC's verbal position is that the bill will definitely be cost-neutral?

Christine McLaughlin: I am sorry, but that is not what I said. As Paul Leak was at the most recent meeting with HMRC, I ask him to confirm the position.

11:45

Paul Leak: The VAT issue is different for the different models. HMRC has advised us that, in its opinion, the integration joint board—the body corporate model—is not a taxable person because it does not provide services. However, the bill includes provision that, at some point in future, a body corporate might be empowered to do so. In that case, in HMRC's view, the body corporate would become a taxable person and the question of section 33 or section 41 status—in terms of the Value Added Tax Act 1994—would need to be decided on.

For the lead agency model, the matter is slightly more settled, as there is existing HMRC guidance that relates to the Department of Health in England. With HMRC, we have been developing a Scottish version of that. In fact, NHS Highland has recently had a decision on the basis of that model that has allowed it to achieve a VAT-neutral position. We will build on that to produce Scotland-wide guidance.

Gavin Brown: For the financial memorandum, your position is that it is likely that the arrangements will be cost neutral. Is that a fair description?

Paul Leak: Yes.

Christine McLaughlin: That is certainly our working assumption, if I may put it like that. Our working assumption is that the arrangements will be VAT neutral. From our discussions so far with HMRC, there has been nothing that would change our position on that.

Jean Urquhart (Highlands and Islands) (Ind): Many of my points have already been answered in responses to earlier questions, but I have a couple of questions.

Nick Kenton mentioned earlier that NHS Highland and Highland Council have a 400-page agreement. He seemed to say that, on reflection, that was probably too detailed. Given the Scottish Government's culture around looking at outcomes through single outcome agreements and so on, is there a bit of a mismatch in respect of agencies such as health boards? In what is a very complex situation, could such matters be simplified?

Also, the language of "integration joint boards" slightly conjures up the idea that we are creating another tier of governance. Having been associated a wee bit with the Highland experience in its early days, I cannot remember that being an issue, although that was perhaps because there was already joint working in other areas. The creation of a joint board seems to be an option, whereas I would have thought that we would be anxious for that not to happen.

Alison Taylor: Fortunately, as we have developed the policy underlying the bill, we have had the opportunity to reflect on evidence from elsewhere. As my colleagues have mentioned, evidence from one or two places in other parts of the United Kingdom demonstrates that there are significantly better outcomes from what we might describe in informal terms as better integrated working. We have been able to learn from those places.

A key lesson from all the evidence that we have reviewed—both from the written evidence and

from talking to and visiting people—is that there are no fixed structural models that will deliver better integration just by virtue of being imposed on an existing system. None of us would expect that, and I think that common sense and experience tell us that. However, there are characteristics of successful systems that we can pick up on, which is what we have tried to do in the policy and the bill. Four key characteristics, which we always return to in our discussions with people, are that better outcomes come from integrated systems where people plan together for their populations of need, where they bring their resources together, where they bring clinical leadership to the forefront of what they are doing and where they exhibit strong general leadership.

Regarding the detail that needs to be covered in what one might describe as the partnership agreement between the health board and the local authority, an important lesson that we have learned from other places is that the partnership agreement needs to be as detailed as it needs to be for local circumstance but it needs to be given thorough consideration. As Mr Kenton reflected, it is hard to anticipate every eventuality that might arise, but at the same time we do not want to end up with a massive new bureaucracy. We are currently investing effort in starting to look at the sort of guidance that will be beneficial to local partnerships to ensure that their partnership agreement captures sufficient information to deal with future challenges and to nail down the parameters of the partnership arrangement without being overwhelming. As Christine McLaughlin reflected, for financial matters, the fact that we have a living example in Scotland in Highland is tremendously helpful. We have quite a lot of work under way and we recognise the risks that are involved, but we need to offset those against the risk of failing to act.

On the language of "joint boards", we all recognise that there is a potential tension. The reason why I have reflected on evidence from elsewhere is because the idea of planning for the population of need and bringing resources together—not just money, although that is tremendously important, but the human resources that support service delivery—seems to be what helps to shift outcomes. There are good reasons in some areas why people might not want to use the lead agency model, so we needed to provide an alternative. In describing an integration joint board, we have attempted to describe an arrangement that knits together the health board and local authority to provide the focus for that population-based planning and bringing together of the two sets of resources for delivery.

The Convener: That has exhausted questions from committee members, but I want to ask a couple more questions before we wind up. First, what target, if any, is there for delayed discharges under the national performance framework?

Alison Taylor: Ministers have established a new target for delayed discharge this year. Local partnerships are currently working towards delays of no more than 28 days—I look to Paul Leak to confirm that—and we are moving towards a 14-day target. If Paul Leak can check the timescale, that would be helpful.

Paul Leak: I will just check.

Alison Taylor: A considerable amount of effort is being invested in trying to shift the pattern of delayed discharge, in part because there is anecdotal evidence—this would apply to any such situation—that having a target makes it easier for people to focus on the issue. There is also an opportunity for improvement. Would it be best if we wrote to the committee on that point?

The Convener: Yes. I asked the East Dunbartonshire Council representative about the issue because its submission expresses concern about how realistic the 14-day target might be for some local authorities and health boards to achieve.

Alison Taylor: Ministers have reflected quite carefully on the improvement in delayed discharge over recent years in Scotland. There has been a tremendous degree of progress.

The Convener: The financial memorandum includes a dramatic graph to illustrate that.

Alison Taylor: Yes, the graph is dramatic. Evidence from elsewhere suggests that there remains opportunity for improvement. We shall write to the committee with details of the timescales for the new targets.

The Convener: Thank you.

The point of the bill is to provide improved efficiency, better outcomes and lower costs to the taxpayer, but is the bill not a bit of a halfway house? Is it not time—I am not asking for a political answer on this—to cut the Gordian knot? For example, in Ayrshire, where we have three local authorities and a health board, the local authorities already work closely with the health board and they share among themselves functions such as payroll and council tax collection. Given that they are already coming closer, could we not be more responsive to people's needs if we had one organisation that fully merged local authorities with health boards? Could that not provide more strategic overview and reduce costs while perhaps allowing us to resurrect some of the local town councils, which people still talk about some 40 years after they were abolished, to provide locally responsive services? Could you perhaps comment on that? [*Laughter*.]

I ask you to comment from an efficiency, better outcomes and lower costs perspective rather than a political one.

Alison Taylor: Any question on public sector reform more broadly is one that we would refer to ministers.

The Convener: Somehow, I thought that that might be your answer, but I decided to take a chance anyway—it has certainly woken up Jamie Hepburn.

I thank committee members for their questions and our witnesses for their answers. That being all that we have on our agenda today, that is the end of today's meeting.

Meeting closed at 11:54.

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