The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 1 October 2013

Session 4

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HEALTH AND SPORT COMMITTEE
28th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Kathleen Bessos (Scottish Government)
John Brunton (Scottish Government)
Annette Bruton (Social Care and Social Work Improvement Scotland)
Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
Dr Denise Coia (Healthcare Improvement Scotland)
Paul Edie (Social Care and Social Work Improvement Scotland)
Maureen Falconer (Information Commissioner's Office)
Stuart Foubister (Scottish Government)
Jane MacPherson (Scottish Government)
Jim Martin (Scottish Public Services Ombudsman)
Paul McFadden (Scottish Public Services Ombudsman)
Alex Neil (Cabinet Secretary for Health and Wellbeing)
John Paterson (Scottish Government)
Robbie Pearson (Healthcare Improvement Scotland)
Shona Robison (Minister for Commonwealth Games and Sport)
Claire Sweeney (Audit Scotland)
Alison Taylor (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 5

Scottish Parliament

Health and Sport Committee

Tuesday 1 October 2013

[The Convener *opened the meeting at 09:34*]

Subordinate Legislation

Glasgow Commonwealth Games (Trading and Advertising) (Scotland) Regulations 2013 [Draft]

The Convener (Duncan McNeil): Good morning. I welcome members and the public to the 28th meeting of the Health and Sport Committee in 2013. As usual, I remind all of those present to switch off all mobile phones, BlackBerrys and other wireless devices that may interfere with our sound system. Members of the public may have noticed that some members and officials are using iPads and other tablet devices instead of hard copies of their papers.

We have received apologies from Richard Simpson. We welcome Malcolm Chisholm as the Labour Party substitute.

The first item on the agenda today is subordinate legislation. We have one affirmative instrument to consider. As usual, we will take evidence from the minister before we move to formal debate. I welcome Shona Robison, the Minister for Commonwealth Games and Sport, and her officials, who are Jane MacPherson, policy executive; and Stuart Foubister, divisional solicitor. I invite the minister to make her opening statement.

The Minister for Commonwealth Games and Sport (Shona Robison): Good morning. I thank the convener for inviting me to speak about these draft regulations, which I have laid for Parliament's approval.

The Glasgow 2014 Commonwealth games will be the largest multisport event that Scotland has ever hosted, providing a fantastic opportunity to showcase Scotland internationally.

The Government is required by the Commonwealth Games Federation host city contract to introduce legislation necessary to prohibit ambush marketing and eliminate unauthorised street trading in the vicinity of games locations. I am committed to meeting those terms and, in doing so, want to create a backdrop that will be fit to present Scotland's celebration of the games to the world. That includes not only the fields of play but the extended games locations, where it is important to create a celebratory look and feel. These regulations will ensure safe and secure routes allowing the free flow of spectators, while safeguarding sponsors' brand association rights.

I am grateful for the help of the Glasgow 2014 organising committee, Police Scotland and the host local authorities, which have helped to shape the draft regulations and informed the development of the event zones and the necessary periods of restrictions. By regulating advertising, the Government will ensure that the revenue that is generated through sponsorship is protected. It is important that companies that sponsor the games and which have paid for their association rights retain the exclusive right to associate their brands with the games.

Street traders wishing to trade in the vicinity of games locations will also need to be authorised unless one of the exemptions applies. Controlling outdoor trading will be key in ensuring the safety and free flow of spectators and traffic to and from games venues.

Experienced local authority officers will carry out the enforcement. A light-touch approach will be taken to minor infringements. However, persistent and more serious offences could be reported for prosecution through the criminal courts.

When we created the regulations, we sought to be proportionate and to create conditions whereby existing businesses are subject to minimum disruption while we ensure that the requirements of the host city contract are met. The consultation responses highlighted that it is important that businesses are well informed about what they can and cannot do. Communication will therefore be assured through a number of activities which include the publication of a plain English guide that will translate the regulations into an easy-to-follow format. This is in addition to leaflet drops to traders currently licensed to trade within the games locations.

I recommend that the committee support the regulations and recommend to Parliament that it should vote to approve them.

The Convener: I thank the minister for that statement. Do members have any questions?

Rhoda Grant (Highlands and Islands) (Lab): I would like clarification on one point. How will this affect street traders who operate in these areas at the moment, selling food or whatever? Will they need to pay for a new licence or will their existing rights be preserved?

Shona Robison: Does Stuart Foubister want to respond?

Stuart Foubister (Scottish Government): They will need to pay for a new licence.

Rhoda Grant: Will they then receive compensation? If they have to apply for a new licence, that means that they are prohibited from their normal ability to go about their business. What will happen if they are not able to purchase that new licence? Will they be compensated in some way for the removal of their business during the period of the games?

Stuart Foubister: No, they would not be compensated.

Shona Robison: The fee is £70.

Stuart Foubister: The fee is not to exceed £70, so there will be some discretion for the organising committee.

Shona Robison: That is obviously to cover the cost of administering the system.

Rhoda Grant: If someone who is currently trading is not guaranteed a licence, they might lose their livelihood for the duration of the games, with devastating impact. I do not have examples, but it might be that newspaper vendors and the like would not make £70 during the period—or at least that might be a huge proportion of their profits.

Shona Robison: There is a list of exempt categories, which include newspaper sales. If someone is currently trading from a fixed business, such as a cafe that has outside tables, they will not be affected. Newspapers are exempt, as I said, because they are not a product that could be associated with the games—they are just newspapers. I think that I am right in saying that periodicals are treated slightly differently.

Stuart Foubister: That is correct.

Rhoda Grant: Does that mean that people selling *The Big Issue* would be treated differently?

Shona Robison: Charities are not exempt, but they will not have to pay the fee—is that correct?

Stuart Foubister: Yes.

Shona Robison: Although the individual would have to apply for authorisation, because they would be selling something, they would not have to pay the £70 fee.

Rhoda Grant: Have existing traders in the area been consulted about and made aware of the arrangements?

Shona Robison: Yes, they have been. The consultation responses were fairly positive—of course questions were asked. There has been quite a high level of engagement, and meetings have been held with local traders, to try to ensure that everyone understands what is required and that the content of the regulations is communicated in plain English.

Rhoda Grant: Are people reasonably relaxed about the regulations?

Shona Robison: Yes. No respondent questioned the need for regulations and responses were broadly positive. There were questions about the technical detail and how that might affect people. At the events that I mentioned, people were able to have their questions answered.

Bob Doris (Glasgow) (SNP): The committee considered the Glasgow Commonwealth Games Bill. Ambush marketing can undermine the sponsorship and partnership deals that are vital to the financial underpinning of the games business plan.

For the sake of clarity, are you saying that a regular trader in one of the event zones in Glasgow will have their licence not revoked altogether but temporarily suspended during the period of the games? If so, for how long will the temporary suspension apply? Of course, the trader could pay the £70 fee and trade throughout the games, when there will be dramatically increased footfall in their area.

Shona Robison: The prohibited times are set out in schedule 2 to the draft regulations and are different for each venue. For example, the prohibited time for the Hampden park precinct is from 23 July to 3 August, which is absolutely the period of the games, and the prohibited time for Ibrox stadium is 25 to 27 July, because that is when the stadium will be used as a venue. The period will not be the whole duration of the games for every venue, given that some venues will be used only for part of the 11 days of the games.

Bob Doris: And when the prohibited period has elapsed, a regular street trader may continue with their business.

Shona Robison: That is absolutely right. They can go back to normal trading.

Bob Doris: Thank you. I wanted to tease out the context, because I imagine that people who sell goods during the games will see a significant increase in visitors to the area. There is a huge opportunity for local retailers.

Shona Robison: Of course, the regulations will not affect people who operate from permanent locations, such as shops and—I am not sure how to describe them; should I say “fixed venues”?

Stuart Foubister: We are talking about people who operate within buildings.

Shona Robison: Yes. Obviously the regulations will not affect those people. There are restrictions on advertising for those businesses but not on trading.

Nanette Milne (North East Scotland) (Con): Just out of interest, did you consider what happened in the Olympic games? Were any comparisons to be drawn from that? Have you followed suit?

09:45

Shona Robison: Yes. The set of arrangements is very similar. At the Olympics, there were around 894 cases of ambush marketing in which, essentially, warnings were given. In the main, people were unaware that they were infringing or breaking the rules. People were not intent on doing that; rather, they misunderstood. That shows that there is an issue that must be addressed. We have learned quite a few lessons from the Olympics in that regard, and we structured the regulations in accordance with lessons that were learned from them.

The Convener: I do not want to prolong the discussion too much, but it would be interesting to know how the street traders were consulted. My impression, which may be totally wrong, is that street traders are not in any organised groups. Based on experience elsewhere, such as in Manchester or London, how many licences are expected to be given out? When will they be available for those who wish to participate in street trading?

Shona Robison: I will hand that question over to Jane MacPherson. An informal consultation meeting with traders was held back in January. They were contacted through various means of communication. Most traders have a point of communication.

The Convener: How many turned up?

Shona Robison: Does Jane MacPherson want to add some detail?

Jane MacPherson (Scottish Government): Yes. It was a very good point that engaging with that group is very difficult. We have sent to a number of traders to try to get them to come and talk to us about the regulations. One trader turned up at the meeting.

The Convener: One?

Jane MacPherson: That was not hugely representative. The trader was fairly relaxed about the regulations and just wanted to ensure that the guidance would be clear about what they were and were not allowed to do.

We also tried to include trading organisations in the formal consultation so that we could get them to have a look at the content of the regulations. That has been quite difficult, but the organising committee in particular will do quite a lot of work to engage with traders on the ground to ensure that they know about the regulations. That will involve going along to football matches and sporting events in venues that will be used during the Commonwealth games, for example, to ensure that people are aware of the regulations and know about the authorisation process that they need to go through.

On the number of licences, the organising committee is very clear that it wants to minimise the effect on habitual traders in particular so, where possible, it will issue as many authorisations as it can while ensuring that those businesses are not unduly affected. Obviously, there will be some limitations, particularly from a safety point of view, to ensure the flow of spectators as they go to venues.

It will be for the organising committee to determine the number of licences. It has not done that yet, so I cannot give the committee a figure, but it will try to minimise the impact on traders. Once the regulations—I hope—go through Parliament, the organising committee will start the authorisation process straight away. Traders will be able to apply for authorisation for a few months. I think that they will know whether they have been successful in spring next year. Details will then be given about how they can go ahead and trade.

The Convener: As committee members have no more questions, we will move to item 2, which is the formal debate on the draft Glasgow Commonwealth Games (Trading and Advertising) (Scotland) Regulations 2013, on which we have just taken evidence. I invite the minister to move motion S4M-07761.

Motion moved,

That the Health and Sport Committee recommends that the Glasgow Commonwealth Games (Trading and Advertising) (Scotland) Regulations 2013 [draft] be approved.—[*Shona Robison*.]

Bob Doris: I do not want to unduly extend a debate that may not be necessary, but the fact that only one trader turned up at the meeting that was mentioned does not surprise me in light of how difficult I know it is to reach that group.

My understanding is that, in normal circumstances, each local authority would grant licences and review and monitor them across its area. The debate is an opportunity for me to put on the record that I am keen to know what the relationship is between the local authority and the organising committee. The local authority has a direct responsibility to ensure that it is in regular contact with street traders throughout Glasgow and other local authorities to ensure that those who ply their trade are fully licensed and comply with the regulations. There should already be a direct connection between the local authority and street vendors. I hope that the local authority, as a

games partner, will take on a role in working effectively with street traders. It seems to be the obvious vehicle. The local authority should be doing that already, irrespective of the Commonwealth games.

Shona Robison: That is a fair point. The local authorities are key, not least because they will have the enforcement officers. Their local knowledge will be very important. We will certainly feed back the fact that, particularly when it comes to communicating requirements and ensuring that street traders understand them and are communicated with well, the local authority's role will be important.

Motion agreed to,

That the Health and Sport Committee recommends that the Glasgow Commonwealth Games (Trading and Advertising) (Scotland) Regulations 2013 [draft] be approved.

The Convener: I thank the minister and the officials and suspend the meeting briefly while we make arrangements for our next panel.

09:51

Meeting suspended.

09:57

On resuming—

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

The Convener: Agenda item 3 is our last evidence session on the Public Bodies (Joint Working) (Scotland) Bill at stage 1. We will have a round-table discussion with what I could loosely call regulatory, scrutiny and complaints bodies. As is usual with a round-table session, I will introduce myself and ask everyone to do likewise, although there are many well-kent faces around the table. Many of you have been here before, but it is useful to have that information for the record. I am the convener of the Health and Sport Committee and the MSP for Greenock and Inverclyde.

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

Claire Sweeney (Audit Scotland): I am from Audit Scotland.

Annette Bruton (Social Care and Social Work Improvement Scotland): I am from the Care Inspectorate.

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

Paul Edie (Social Care and Social Work Improvement Scotland): I am from the Care Inspectorate.

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

Dr Denise Coia (Healthcare Improvement Scotland): I am the chair of Healthcare Improvement Scotland.

Rhoda Grant: I am a Highlands and Islands MSP.

Jim Martin (Scottish Public Services Ombudsman): I am the Scottish Public Services Ombudsman.

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

Robbie Pearson (Healthcare Improvement Scotland): I am director of scrutiny and assurance at Healthcare Improvement Scotland.

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

Maureen Falconer (Information Commissioner's Office): I am from the Information Commissioner's Office.

Mark McDonald (Aberdeen Donside) (SNP): I am the MSP for Aberdeen Donside.

Paul McFadden (Scottish Public Services Ombudsman): I am from the office of the Scottish Public Services Ombudsman.

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

The Convener: I thank all our guests for that. Richard Lyle will open up the discussion with the first question. As always, we will give our witnesses preference over the politicians around the table. We want to listen to what you have to say today—it makes a change from having to listen to politicians. We will see if we can keep to that.

10:00

Richard Lyle: I welcome all the panel members. I will begin with the subject of public involvement. The committee has heard extensive evidence about the involvement of key stakeholders such as the third sector and different professional groups. However, the committee has heard less about public involvement. Last week, our witnesses stressed the importance of including the public, patients and carers. How should the bill involve the public, and is it clear about the involvement of the public?

Maureen Falconer: One of the issues that we have with the bill relates to the models that are used. I am thinking specifically about how the public will exercise their rights under the Data Protection Act 1998 should they either wish to make a subject access request or have an issue with the information that is recorded about them. Of the two models of public involvement, we would go for the body corporate model as opposed to the delegation model because we see the latter as being quite confusing for members of the public who want to engage with the organisations concerned regarding the delivery of services.

Annette Bruton: From a regulatory point of view, we believe that hearing the public voice as part of the evidence for our inspections is really important, and there are a couple of areas in the bill that might help to increase public participation in the inspection process. One of those is the principle of person centredness. We involve laypeople in our inspections, and we take more than 3,000 complaints a year from members of the public specifically about services, which we investigate. That already gives the public a voice. The protection of people's human rights is also fundamental to the bill, and the public could either come to us with complaints or raise such matters as part of the work that they do in inspections to ensure that those rights are being upheld. We think that there is some potential for us to increase public participation in our inspection regime.

Claire Sweeney: Audit Scotland has long advocated users and carers being at the heart of the way in which services are delivered, and what is coming through strongly is the important role that local professionals such as general practitioners and social work staff play in shaping how services develop over time. However, it is less clear how the public will be involved and, as the bill develops, we are keen to hear more about how their voice will be heard, as it is very important that it is at the heart of service delivery.

Dr Coia: I echo what has been said. The Scottish health council, which is part of our organisation, is responsible for delivering the Scottish Government's national person-centred health and care programme, which will extend out through community services. We also have a statutory duty of user focus and feel that, in addition to what the bill provides, we already have the framework in place for that.

Robbie Pearson: The Scottish health council already has a participation standard that is mandatory for national health service boards. We assess NHS boards against that standard in terms of how they engage with the public and service users. In addition, local authorities have the national community engagement framework standard. We have an opportunity to align the Scottish health council's participation standard and local authorities' community engagement framework standard. That would give us an indication of how we could join up and arrive at a common language about engagement with communities and individuals.

Jim Martin: Structures can be very easy for administrators to find their way around. The issue that I have is that, whichever structure is in place, it must be easy for the ordinary person to access and get around. When we look at structures, the first thing that we should look at is not how they will be administered but how accessible they will be.

Secondly, when people are in that system—one that is easy for them to access—there must be a simple and standardised way for them to raise any issues that emerge. The question was about involvement, and there is a difference between involvement and access. If people are genuinely to be involved in the care and the healthcare that they receive, they must have a simple, standardised and effective means by which they can engage.

Richard Lyle: Those were interesting answers. I have a follow-up question: does the bill comply with the Christie vision of services that are designed with and for people and communities?

The Convener: Do the witnesses think that the bill will make things better? Is it designed around

the needs of service users? Is it accountable to those people?

Annette Bruton: As we said in our submission, we believe that that is what the bill's principles seek to do, so it has the potential to do that.

The Convener: Does anybody want to be more enthusiastic? I do not intend that to sound too sarcastic, because I think that what has been said reflects a lot of the evidence that we have already heard. Many MSPs, including members of this committee, are ambitious to make the bill work because what is already in place could be better for service users and others. However, there is much more work to do, between the bill and delivery. Does Robbie Pearson want to come in?

Robbie Pearson: Yes, I just want to develop that. It is about how we engage not just with service users but at a locality level. There is a real opportunity through the bill and locality planning for communities to be more closely engaged than they have been hitherto.

Paul Edie: As Annette Bruton said, the bill's principles are right. One of the biggest obstacles to getting better outcomes for service users is entrenched organisationalism. Anything that we can do to break down the barriers is to be welcomed. Across the Scottish body politic in general, there is consensus on that. Politicians will perhaps disagree about the emphasis in how that is done, but the general direction of travel is to be welcomed. What we are all about is trying to get better outcomes for frail and vulnerable people.

The Convener: How do we change the culture?

Claire Sweeney: That is the point that I was going to make. There have been lots of attempts to resolve some of the challenges around the lack of integration of health and social care services. We welcome the approach that puts the user at the heart of the changes, which is important. In theory, the bill is about trying to get round artificial divisions between services. There is a real appetite for that to be taken forward at a local level, and we are certainly starting to see signs of the development of partnership work in a much more serious way than we have ever seen in Scotland.

Dr Coia: Just to build on that, one of the great opportunities in the bill is the commissioning powers that it will give health and social care partnerships. The commissioning powers will be partly based on standards. Apart from having both health and social care standards, it is important that we have standards and outcomes that are about what people genuinely think about the services that are being delivered. To build on Robbie Pearson's point, it is about asking people in a locality what they think about the services. I think that we will be able to answer the question in the next couple of years, if commissioners adhere to the standards that have been set and have person-centred outcomes.

Mark McDonald: On the public interface, Mr Martin said that there needs to be standardisation, which leads us on to issues around the complaints system. NHS Dumfries and Galloway told us that it felt that there was no urgent need for a standardised complaints procedure. However, the ombudsman's submission states that

"the areas of health and social care contain competing legislative complaints processes and, without legislative change, there are barriers to these processes working together."

Perhaps Mr Martin could comment first, but I would also be interested to hear other views on the urgency of the standardisation of complaints. How do you envisage the complaints procedure working in a standardised way? To whom would complaints be directed? Would there be a hierarchy within which complaints could be escalated? That happens now, albeit that we have different hierarchies. My question is really this: what is the urgency and what would the ideal complaints procedure look like?

The Convener: I think that that question is directed to you, Mr Martin.

Mark McDonald: Initially.

Jim Martin: It sounds like it.

I ask you to look outside this room for a second. A parallel development is happening in which the Government is trying to bring the social work complaints procedure more into line with what is happening in other parts of the public service. The word "service" is an important one. The question for me is whether, with integration, we are creating a service or finding a means by which we are delivering services. In my view, the public look at this as a service, so the case for standardisation is clear in the public mind: if we do this, it has to be about that.

At the moment, there are many different routes on the complaints side. For example, I am restricted in what I can look at in social work, but if the Government reforms go through in the way in which they look as if they will, I may have more powers to look at social work issues. I have different powers in relation to what I can look at in social work and health. In health, I can look at clinical decision making, but in social work I cannot look at the professional judgments of social workers. We might have a holistic approach to delivering services to ordinary people, but we make it extremely difficult for people to find their way through the system when things go wrong.

I understand that the procedure in Highland, where services have been brought together, is that

the opening portal for complaints is through the health system, and thereafter people are signposted to either local authority complaints or health complaints. To make a mess of the English language, I note that that is non-joined-upness. If we want to get the system to join up, we have to ensure that it is as easy as possible for people, when things go wrong, to get holistic solutions to the holistic problems that they face. The need for standardisation is there.

I do not think that the social work provisions will change at the same pace; they might lag a year or maybe two behind the bill. If we are really being public and patient centred, we should look at the system from the perspective of the client and the customer on the way in. Do they see one service or a multiplicity of services? What do we want them to see? Can we arrange things so that, when something goes wrong, it is as simple as possible for them to get things fixed as quickly as possible?

The Convener: Does anyone else want to comment?

Annette Bruton: I absolutely agree with everything that Jim Martin has just said. However, I want to make sure that we protect the level of complaints handling that the public currently enjoy. When we carry out our complaints investigations, we do so on behalf of the complainants and we try to work out with them what they are complaining about and how we can help them to resolve the issue.

Last year, we looked at more than 3,000 complaints. Notwithstanding all the things that Jim Martin said—we come up against barriers too, because we cannot go any further than the social care environment—the advantage for people of the current complaints system in social care is that, when we carry out a complaint investigation for them, it prompts an inspection. If someone comes to us and complains about the care that their mother is receiving in a care home, we can not only investigate the complaint but, depending on its seriousness, immediately go ahead and inspect the home.

It is not simply a case of having a coherent, joined-up complaints system that is systemically different from what we have now. We need to be able to use complaints to get immediate solutions to people's problems.

The Convener: You must concede that the number of people round the table is a physical representation of the complexity of the system. In many cases, it is difficult even for elected representatives, with the resources and help that we can get and our experience of casework, to get families through the system, so how much more difficult must it be for others? We have two inspection agencies—Healthcare Improvement Scotland and the Care Inspectorate—and we have all these people round the table. We want seamless services so that, irrespective of where someone is on their journey, they can expect the same quality of care. It seems obvious that we should have a system with one entry point to ensure that people are picked up and supported.

Mark McDonald has another question.

10:15

Mark McDonald: My question is on the scope for standardisation. The bill will not cover all social care and health services—it focuses on adult social care and health services, although obviously there is scope for expansion, depending on the use of ministerial powers. How do you envisage the standardisation approach? Do you see the bill as an opportunity to standardise complaints procedure across the board, even though we perhaps do not have integration across the board? We could end up with a complicated picture if one part of the complaints process is standardised, but individual complaints procedures remain for the rest of the system.

Jim Martin: I refer the committee to the work that was done by Lorne Crerar and then by Douglas Sinclair. As I think I have said to the committee before, one of the most frustrating things that I find about the Parliament is that the pace that we go at between taking a decision for change and implementing the change sometimes seems very slow. Lorne Crerar was asked to start his work on standardisation and scrutiny in 2007. We are now in 2013 and we have just begun to implement standardisation across local authorities, housing associations and other bodies. If we are serious about integration, all aspects of integration should be looked at, which should include complaints. It is a matter of some urgency. I would not want a system to be put in place and then have a lag on the complaints side that causes people to become frustrated with the system and begin to lose confidence in it. I urge people to think carefully about that.

Annette Bruton makes a good point about the way in which we handle complaints. The bodies that are represented around this table have greater scope for joint investigations on some aspects. Bodies such as HIS and others have greater scope to use the information that we have in our databases to inform their inspections.

The Convener: We are on the same channel, and we share that frustration. It is 18 months since the committee made what I think were decent recommendations on HIS and the Care Inspectorate working together, and we raised all the issues that have been raised today. We share that frustration with slow progress. Do we have

around the table the same scenario that exists on the ground, which is that everybody is for change and working together until it impacts on them? We need to take pretty difficult decisions within organisations to break down those barriers. Is the cultural resistance that we perceive on the ground at the point of delivery reflected right the way up? Are we not all guilty of that?

Dr Coia: I do not think that we are culturally resistant. We have a huge opportunity in the integration bill. The Care Inspectorate and Healthcare Improvement Scotland have begun pilots on integrated scrutiny, which have been successful. Also, I do not think that we have issues about feeding in complaints. As organisations, we have started meeting regularly with the Scottish Public Services Ombudsman to look at the pattern of complaints in different areas.

Annette Bruton made the point that the issue is not reluctance to join complaints systems together; it is how we ensure that we provide absolutely the best service when somebody complains. I think that she was saying that the Care Inspectorate's process for dealing with complaints is to look at them properly and work out what is actually wrong. The same system exists in the Scottish Public Services Ombudsman in relation to clinical care. The public ombudsman's office can do huge in-depth deep dives into what is really happening clinically. Our challenge is to join the two together. I totally agree with you on that, and we would love to join them together but, when we do that, give us a chance to have some pilots to ensure that we do not lose any of the specialist expertise. I would say that it is not a cultural issue.

The Convener: The frustration expressed by Jim Martin and by ourselves is shared by the cabinet secretary. That is why we have the legislation, as Claire Sweeney said. Malcolm Chisholm, who is here today, previously attempted to encourage that change over a long period of time. The legislation has been brought about by frustration at not having been able to change the landscape and focus on people who are using the services. That is why we are here. What is Claire Sweeney's view on that?

Claire Sweeney: The scale of the challenge becomes clear to us through local audit work looking at how public resources are being spent across Scotland. It is a huge cultural change for people at all levels and there is a need for really strong, clear, local leadership and a shared vision, and for clarity about how resources will be used and to what end. Most important, the thing that has been missing in the past is focus on the impact, on the difference that it is actually making to people, and clarity about what the intended change is supposed to be. Those things will help to move us forward, but the scale of the challenge is significant.

We have talked about complaints, but there is a raft of other issues around workforce, skills, whether the resources are in the right places, and giving people time to think differently. For example, GPs are important, but do they really have time and do they really have space to contribute to a challenging agenda that involves working in a different way? There are lots of issues to unpick.

The Convener: Does anyone else want to respond to that? Does silence indicate agreement?

Robbie Pearson: I am certainly in agreement. A crucial element is ensuring that, when we talk about health and social care integration, we bring together elements such as GPs in local communities. The increasing engagement of GPs in this agenda will be a marker of success in the future, whereas it has not been so robust with the community health partnerships.

Rhoda Grant: We have spoken about complaints, and I note that Audit Scotland's evidence also mentioned the fact that it was not clear that the different bodies making up the new corporate body would have different audit procedures in place. We also heard previously that there are different statutory procedures in place for such things as staff governance between health and local government. I wonder how a new body gets over that, because we have heard in detail about how messy complaints can be. Once you get into staff governance, audit and the like, how can you ensure that the new body is workable? That is one of the concerns that has been brought to us.

Claire Sweeney: Audit Scotland's submission raised technical issues and broader issues that we would want to see addressed going forward. There are technical issues around how the body corporate would work in practice, with questions such as whether there would need to be a set of accounts, whether auditors would have to be assigned to the new bodies, and other technical details underpinning how the body corporate process might look.

Highland is up and running with the lead agency approach, so we are already tackling the challenges around the financial audit process for that model, and there has been a lot of useful learning from that approach. One of the bigger issues that we flagged up in our response is that the new organisations will be responsible for a significant amount of resource across the local area, and there are also issues of local power balance, the capacity to provide strong, local leadership, and the technical skills needed to

support that arrangement. We want to see those issues addressed.

Dr Coia: I want to raise the issue of clinical governance in the new bodies corporate. In Healthcare Improvement Scotland, we currently assure clinical governance throughout the NHS. As far as the body corporate is concerned, it is important to have arrangements around both clinical governance and care governance in order to deliver the quality and safety of services in clinical terms. We are now beginning to have discussions about clinical governance within the body corporate.

Malcolm Chisholm: Claire Sweeney's contribution, and her paper, raise two of the central issues: governance arrangements and resources. I suppose that the question of how resources will be determined is a straightforward one. We might wish to discuss that in more detail in a moment.

The discussion around governance raises wider issues. In the first evidence session, quite a lot of people were wondering what the relationship was, within the body corporate model, between the chief officer and the health boards and local authorities. There is still a lack of clarity on that. Audit Scotland says:

"It is essential that there is more clarity about how the Chief Officer will report into the NHS board and into the Local Authority,"

and its report makes various other comments on the matter. I do not know whether people have a view on that, or whether the bill needs to be tightened up in that regard. To quite a lot of people, it is not entirely clear what that relationship is. There is a shifting of power towards the chief officer, but it is not clear how complete that is.

Another angle came from the Information Commissioner's Office. Its submission states:

"section 21 places responsibility and liability squarely on the person to whom functions are delegated".

That is presumably the chief officer in the body corporate model. However, the ICO submission goes on to say:

"it is assumed that the Health Board and Local Authority will be joint data controllers".

Even on the issue of responsibility for information, it is not entirely clear to me whether it is the host bodies from which power is delegated or whether it is the chief officer and the board to whom power is delegated.

The last point on governance is about exactly who will be involved on the board. We had long discussions in the previous two evidence sessions about the involvement of the public on the board. Audit Scotland has said that the role of health and care professionals is unclear. There seems to be a lack of clarity about the governance issue; I do not know whether people think that it should just be left to local arrangements. It seems that there needs to be more clarity on that nationally, as some aspects have significant legal implications.

Claire Sweeney: I refer to our submission, which set out some of our concerns about that lack of clarity and the need to be clearer in future. We know from previous work that we have carried out around community health partnerships, for instance, that clear accountability and a clear sharing of resources are a very powerful combination. The potential is there, but the question is how it can be taken forward in a practical sense, and that will be interesting to see as the bill develops.

Maureen Falconer: From the perspective of the Information Commissioner's Office, the issue is about who is a legal entity. When it comes to pointing the finger of accountability on behalf of data subjects, the body corporate is easier for us, in a way, as it is a legal entity, and that is what we would pursue for some kind of redress, or to determine whether there had been a breach of a nature that was serious enough to impose a civil monetary penalty. That penalty would come from the legal entity, which is the body corporate.

Things become much more difficult, as Audit Scotland rightly says, in respect of joint data controllers. Part of the lead agency model addresses the question where we would point the finger of accountability in the event of a breach. If the breach was significant enough for a civil monetary penalty to be imposed, from whose budget would that have to come? If we have a joint data controller relationship, we have to tease out all those details very carefully in any joint data controller agreement.

That is why I said at the outset that the body corporate model is the easier one from our perspective—and also from the public's perspective, I think. When people are engaging with a service, they point to that service as being the person from whom they will seek redress. If the board then says, "We are giving you the service, but it is not really us. You will have to go somewhere else because we are joint data controllers and that bit of the service is actually provided by another data controller," everything becomes very messy.

10:30

Rhoda Grant: That is interesting, but one of the concerns is that, if we are to make the system work, we will have to set up a body—an entity on its own—and then reproduce all the functions of the two parent bodies such as audit, staff governance, clinical judgment and so on. How

much would that cost and how much would it remove from the services that we are trying to provide? The bill is designed to provide better services to those on the ground, but what if we spend much of the existing budgets on setting up a new service? Will it need to be funded by central Government? Will it need to be a body in its own right? How does that work and what costs will be attached?

Maureen Falconer: I am afraid that I do not have an answer to that. My perspective comes from the Data Protection Act and thinking about individuals and their rights under that act. What I am advocating will not necessarily be the best thing for costs to the Scottish Government. I could not answer that question.

The Convener: I suppose that it takes us to another question arising from previous evidence about how the organisations here fit in with the health board, the local authority, or three local authorities, the body corporate, or the community health partnerships. How do you all fit in to that? Is it a structure or structures? How does it all fit together with budgets going here and there? Who is accountable? How are the additional ministerial powers to be used if we do not understand the body corporate structure and what we should expect from it? How will we know when it is appropriate that the minister should intervene?

Claire Sweeney: Audit Scotland will clearly take a close interest in any area of the public sector that is going through a time of significant change. Resources are involved and we will be interested in how public money is being used, not least because the risks at that time are greater and significant.

There are two issues for Audit Scotland. The first is the technical arrangements around the finances. We have already touched on those and referred to them in our response to the committee. To understand what they will look like in practice, we need to understand a bit more about how those local arrangements will work in practice. It is very hard to say at this stage whether financial auditors ought to be appointed. To go back to the model being used in Highland, arrangements are already in place there. As I mentioned, lots of lessons have been learned from going through that process and those lessons are transferable to a body corporate arrangement in some cases.

Secondly, we also have a broader interest in how the inspectorate approach is working for that integrated system and, more generally, how good value from all the public sector resource is being achieved through that change. We are keeping a close eye on that and will continue to do so as some of the technical issues become resolved. Work is under way to address some of those challenges.

Dr Coia: Healthcare Improvement Scotland's perspective is that, if we start with an older person who ends up in accident and emergency, we are interested in what they are interested in and in quality assuring the pathway that gets them from primary care, through social care, into an accident and emergency department.

We get too bound up with structures. We can set outcomes and standards for each stage of that journey so that the person can look back and reflect on whether they had a good or bad experience. In our joint inspections, we are going out and looking at those pathways to see whether they are working. A pathway will take a patient from primary care into strict nursing, through the body corporate, which I hope will have a great opportunity to provide intermediate care in the community, which would be a step up from having to use an accident and emergency department.

If we set the right standards, measure the right outcomes and ask people how the pathway experience was for them, that is what we and the Care Inspectorate quality assure. We will not be quality assuring the structures that are in place.

Annette Bruton: To build on the point that Dr Coia has just made, the new inspections that we are developing will be able to be carried out irrespective of the structure and will follow outcomes for people.

We have been able to demonstrate over the past seven or eight years how we do that with child protection and children's services where, irrespective of the structure inside a local authority or, indeed, the community planning partnership, we have been able to examine the outcomes and impact on children and young people. In our triennial report, we have recently been able to reflect on where that partnership working has got better.

To support Denise Coia's point, if we work back from the outcomes, inspection can probably be flexible enough to deal with the structures that are deemed to be necessary locally.

Bob Doris: It is almost as if we had discussed how to provide a seamless link, because I have been sitting patiently waiting to ask about the inspection process.

Sometimes, the Care Inspectorate can move quickly. Before the committee's inquiry into care for older people ended, Nicola Sturgeon, who was then the responsible cabinet secretary, moved to improve the inspection regime for the sector. Sometimes, things can move quickly and effectively. It is important to put that on the record.

I am interested in care pathways. I know that there has been joint working between the Care Inspectorate and Healthcare Improvement

Scotland. How close are we to having one inspection regime? We are talking about integration, so rather than the Care Inspectorate or Healthcare Improvement Scotland going out, can we not just have the relevant inspector—I am not fussed what the organisation is called, to be frank—going out alone with a joint assessment tool and doing the inspection?

I hope that that is where we are going, so some comments on that would be useful, but I should stick to the details of the bill. I notice—I will read from the notes—that

"The policy memorandum to the Bill outlines that the Care Inspectorate and HIS will be required to 'scrutinise strategic plans for quality and standards, and to ensure the plan will effectively achieve the objectives of the integration plan and the nationally agreed outcomes.'"

That is a widening role and an important check and balance within the system for the strategic plans.

I would welcome comments from Healthcare Improvement Scotland and the Care Inspectorate about how ready their organisations are to do that. How close are we are to having a single accountable officer for those inspection bodies—rather than both organisations doing it—doing the job so that the service and the inspection side are integrated?

Annette Bruton: I am certain that Robbie Pearson will also want to come in on that question.

If we look solely at older people's services, we would say that we are making really good progress. As far as those who are being inspected and, more important, those who receive the services are concerned, it does not matter whose logo is on the report; they will get a single report that will pull together expertise from Healthcare Improvement Scotland and the Care Inspectorate that will comment on, and provide assurance about, the care pathway.

The landscape is a little bit more complicated than that, however; in terms of children's services, Healthcare Improvement Scotland will be involved to some extent, but so will Education Scotland. We face in different directions for different stakeholder groups, so we need to think about the landscape for protecting all vulnerable people, including through housing support and criminal justice. The work that we have done on children's services has demonstrated that those who receive inspections and those who benefit from them see it as a single inspection methodology and do not distinguish between inspectors.

Robbie Pearson may want to comment on the progress that we are jointly making on older people's services.

Robbie Pearson: There is a real appetite and opportunity to do something imaginative in the joining-up of scrutiny. It would be difficult for us, through scrutiny, to make demands about integration in service delivery but not to demonstrate integration ourselves.

We have already undertaken three pilots—in West Lothian, Inverclyde and Perth and Kinross—which have been excellent opportunities to demonstrate joined-up working between HIS and the Care Inspectorate.

However, we also need to respect the different skills and expertise that each body brings. Healthcare Improvement Scotland will bring certain specialist expertise, as will the Care Inspectorate in relation to social work input, for instance. Notwithstanding that, our inspections are now looking at the journey of patients. In one inspection, for example, we looked at the case records for about 90 older people, of which about 20 were identified as including areas for further follow-up.

Such inspections provide a real opportunity to show that we are looking at the pathways of care, the things that precipitate hospital admission and the things that prevent discharge from acute hospital settings. As we take that forward, the bigger opportunity for us will be to link that to a broader and more comprehensive assessment about the quality and safety of NHS care within individual systems, in the context of what we are doing with the Care Inspectorate.

The Convener: Did those pilots include residential acute settings as well as community settings? What did the pilots examine?

Robbie Pearson: The pilots looked very much at community-based services. Obviously, we have a separate inspection regime for acute hospital settings, but the issues that we identify within acute settings, including the things that bring people into hospital through accident and emergency departments or the things that prevent discharge, have resonance with our wider inspections with the Care Inspectorate.

The Convener: When will that information be available?

Robbie Pearson: Do you mean information on the joint inspections?

The Convener: Yes.

Robbie Pearson: We will share the key messages from that in due course. We will not publish reports on the three pilots, but we will learn from them how to apply the methodology.

Dr Coia: I add that we should remember what both our organisations need to do in addition to straightforward inspections. In looking at care

pathways, it is important for conditions such as asthma or diabetes that the right treatments and facilities are available. The evidence that Healthcare Improvement Scotland uses for that comes from the SIGN—Scottish intercollegiate guidelines network—guidelines and a wide range of standards that we produce. In the same way, the Care Inspectorate has specialist expertise in children's inspections, with links across to education.

It is nonsense to talk only about the structures, but it is important that we do not, in terms of standards and outcomes, lose specialist expertise when we combine the inspections and complete the circle. I agree that it is nonsense for the public that institutions are inspected by different people from different organisations doing different things. When we go out to inspect, there should be one group of people doing one thing.

Claire Sweeney: It is also worth mentioning that there are processes whereby inspection agencies come together to share knowledge about their local area, to think about the risks and to consider what those mean for inspections. Post Crerar, a process was established to draw those issues together in a place-based focus, I guess. That is a slightly different cut of the same issue.

Bob Doris: I accept that the important thing is that the public have an identified individual who is responsible for the inspection and to whom they can go for information. We also need to keep the expertise behind the scenes, in whatever way that is done most efficiently. However, no one has made specific reference—I do not know whether this omission means that you are supportive of the proposal—to providing quality assurance of the strategic plan for integration. Can we get something on the record about that?

Also, given that the bill is not simply about health and social care integration but about public bodies' joint working, there is scope to include a range of services that are provided by local authorities and health boards—older people's care, children's services and housing—in partnership working in the years ahead. Therefore, are there other agencies that should in the future provide quality assurance for the strategic plan? It is getting ahead of ourselves slightly, but as well as hearing about the importance of your input in signing off such strategic plans, I would be interested to hear whether you anticipate that any other bodies might have an overview of plans in the future?

10:45

Annette Bruton: That is a very important point and we missed it out. The Care Inspectorate has certainly been discussing with Healthcare Improvement Scotland what we could bring to strategic commissioning, which we think will be a key part of the plan. Obviously, Audit Scotland will be interested in strategic commissioning from a governance point of view, but we believe that jointly, we could bring quite a lot of assurance and, indeed, could undertake follow-up action if necessary.

We can look at whether the intelligence that is being used to commission services strategically is having an impact on the front-line services that we inspect. In other words, a strategic commissioning plan may seem like the right plan for an area, but we can test that by examining the services that people receive and working back from that.

We believe that we have, collectively, a lot to offer on that aspect of the bill, but I can see that Audit Scotland would also want to have a view. We work jointly with Audit Scotland on a number of strategic inspections when we might want to have a view about leadership and governance, as well as a view on the quality of people's care outcomes. It is a very important point.

The Convener: Is there anything to stop you from carrying out that assurance now? I think that the HIS submission mentioned sufficient powers or additional powers.

Robbie Pearson: Certainly, there is nothing that cuts across our being able to do that at the moment; the work that we are already testing out with the Care Inspectorate demonstrates that. We would encourage the inclusion of a reference to scrutiny on the face of the bill, through an amendment. We should be working within our existing relationships, not letting structures get in the way, and we should push on with assurance, which is what everybody wants.

The Convener: To go back to cultural change and what makes it happen, we have just heard from Robbie Pearson that there is really nothing to stop us—we have sufficient powers to carry out that cultural change. I suppose the obvious question is, "Why aren't we getting on with it?" What is going to drive that cultural change? Will it be the legislation itself? Will it be the ministerial powers? Will it be the shifting of budgets? Will the more focused human rights agenda that is at the heart of the matter help to change the culture?

Dr Coia: I will base my answer on my experience, because I am very old.

The Convener: Not at all.

Dr Coia: I have been through this before. I have worked in integrated teams; as you know, psychiatrists have long had integration with community mental health teams. For me, it boils down to leadership. It is about setting the right space. Once you have that and the principles, it is

about leadership at local level because it is people and leadership that drive change. The bill gives us a very good framework, within which we have sufficient powers in which to operate.

The Convener: Do service users have sufficient powers, in terms of their enforceable rights, to change the culture to one with a person-centred focus? That is a change that everyone believes should happen.

Dr Coia: It absolutely part of our job in the Care Inspectorate and HIS to be working for the public. We should be held to account for how we involve the public in our quality assurance of services, including how the new community health and care partnerships are involving the public. It is very much part of our role to answer that question.

Annette Bruton: Our involving people group met last week; it was keen that I say to the committee that one way to hold people to account is to listen equally to the voices of service users and of those who provide the services. The group believes that holding the people who run services to account for the outcomes is how to get integration.

Malcolm Chisholm: I agree with what has been said—cultural change rather than structural change is the thing. However, I still think that the resource issue will be key to this and there is not really that much in the bill about that. There is scope for great variation in terms of what money is put in and how it is put in.

I know that Audit Scotland had serious concerns about the arrangement, in terms of how budgets would be determined. Do the witnesses have any views on that? Most of the witnesses have been content to leave that to local discretion, but one or two have said that there should be more central determination of budgets because otherwise there will be enormous variation. The key issue that people have flagged up—how acute budgets will be involved—will be left to the discretion of health boards. I am interested to hear comments on the resource question.

Claire Sweeney: It is difficult to say how the audit process would follow the money because it is not clear yet how the body corporate—our model—will work in practice. In previous audit reports that we have presented to the Public Audit Committee we have been clear that sharing of resources is very powerful, but there is a need to be clear about what is devolved, who is responsible for what and where the focus will be. We would not comment on the extent to which that should be prescribed, but there is a need for real clarity about what is involved in that sharing of resources and how it will be accounted for. It will be interesting to follow that through the strategic commissioning arrangements and to consider the impact that that shift makes over time. It is a challenge. We are considering services for older people and we can see the scale of the challenge in terms of how resources across both systems are used. It is very difficult.

Richard Lyle: A question about VAT arose at a meeting that I attended yesterday. Does Audit Scotland have any views on how VAT will be tackled with merging budgets and so on?

Claire Sweeney: That is another issue that we have raised in our submission and which needs clarification. What type of body is the body corporate? That has to be decided. There are different VAT arrangements for the NHS and local government, so we need to understand what type of body it will be. Once that is established, the VAT arrangements should be clear.

That goes for several different technical issues. There are different arrangements, for example, for the finances and the accounts for health and social care services. That all needs to be much clearer so that we understand what arrangements and legislation apply and when.

The Convener: Has Audit Scotland been involved in that process? Other issues that have been raised include pension implications, and we have a note from the Finance Committee—it is really for the Cabinet Secretary for Finance, Employment and Sustainable Growth—about the equal pay, pension and VAT risks. Has Audit Scotland done any work on those matters?

Claire Sweeney: There are several strands of work that touch on that process and a lot of local financial audit work deals with those issues, so they have been addressed in the audited accounts and the annual reports for the local bodies. We produce overview reports for the NHS and the local authorities each year, and some of those pressures and risks recur. We have flagged them up over several years and we have been involved in discussions about how they could be resolved.

The Convener: To link that directly to this legislation, has any correlation been made—

Claire Sweeney: We are keeping a close eye on how those discussions evolve, but we have flagged up the risks around the need to be clear about which type of body corporate it might be. There are implications; there is a raft of issues that need to be resolved.

The Convener: Is all that on the record?

Claire Sweeney: Yes, it is—through submissions to the committees and discussions with the Scottish Government.

Nanette Milne: We have heard a lot this morning about the need for good local leadership. I was lucky enough to be in Inverness last week

and in West Lothian yesterday where, in their different models, there is good leadership and great enthusiasm, and everyone seems to work well together. What about areas where there is not good leadership at the moment? We know that different organisations are at different stages of this journey towards integration. Will the bill help in the areas where there is no leadership?

The Convener: Is there any response? There are no takers.

Rhoda Grant: My question is for Maureen Falconer; it is about information sharing. Last week, we heard—from the British Medical Association, I think—concerns about the single shared assessment being shared only in paper form. The view was expressed that if services are to be integrated, information technology needs to be integrated into how information is shared. That is a big challenge, given that we are talking about a body corporate, two different organisations and data protection, especially in a highly sensitive area such as health. Have you had any thoughts about how that could be done?

Maureen Falconer: With great difficulty. It is a challenge now; it will not be the case only when we have whatever body ends up being set up as a result of the bill.

Within the NHS, there is a problem in that the different systems cannot speak to one another. The situation is the same in the local authorities—many use the same systems, but not all do—and in education. The different systems cannot talk to one another. Until we have the panacea of central procurement that sends down from on high a system that can be implemented in the public sector across the board—I do not think that will ever happen—the ability of organisations to talk to one another will always be a problem.

We are contacted more and more about information sharing in the public sector. It is a question of getting it right and setting things out in a protocol. It is about understanding what we are sharing, why we are sharing it and with whom we are sharing it. It is about accountability and responsibility. Once the information is there, who is the data controller for it? There are many questions, but they are not new questions.

Around the public sector, there are good examples of good information-sharing protocols having been used successfully, which allows information to be shared and services to be delivered properly and on time. Equally, there are bad examples. The difficulty is that, for understandable reasons, the health service tends to be extremely protective of its information. That does not mean that information cannot be shared; at issue is how people go about that.

Paper is no better and no worse than electronic processing. If you look at our website, you will find that many of the breaches that occur relate to information on paper going astray or something untoward happening to it. That is less common with electronic versions, although there are issues with electronic processing, too.

It is a matter of understanding what you want to do and of having a system that allows you to do that. When new structures come on stream, people often think about getting new systems. There is a cost involved with that. An issue that we have is that people will say, "We have the very system for you," which they sell on the basis that it is an all-singing, all-dancing system with buttons and bells on it, but when someone tries to use it, it turns out that it does not do what it was supposed to do. In that respect, as we mentioned in our submission, we think that a privacy impact assessment should be carried out, so that people can raise issues to do with privacy, and can look at where infringements of privacy could be possible and how they might be mitigated in some way.

For us, it was a disappointment that a privacy impact assessment was not done alongside the bill, because the policy development to which it relates would be perfect for a privacy impact assessment that highlighted all the privacy concerns, including those about information sharing, which is fundamental to what is proposed. Integration will not happen unless there is information sharing; our fervent hope is that, at some point, a privacy impact assessment will be done that will look at information sharing in particular, as well as issues to do with the data controller and where responsibilities lie.

The Convener: We have covered a number of issues, as we expected to do. We said that we were here to listen—I suppose that there was a bit of tokenism at the end.

We will welcome your on-going observations and input, as people who are interested in and affected by the process. Thank you very much for all the time that you have given us and for your written evidence.

11:00

Meeting suspended.

11:05
On resuming—

Subordinate Legislation

National Health Service (Cross-Border Health Care) (Scotland) Regulations 2013 [Draft]

The Convener: Item 4 is consideration of another draft instrument that is subject to the affirmative procedure. We will take evidence from the Cabinet Secretary for Health and Wellbeing and his officials before we have the formal debate on the regulations. I welcome the cabinet secretary, Alex Neil, and his Scottish Government officials, who are John Brunton, European cross-border healthcare policy manager; and John Paterson, divisional solicitor.

Cabinet secretary, I invite you to make opening remarks.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Thank you, convener. Until quite recently—a decade or so ago—there was little discussion about patient mobility at European level. The United Kingdom and some other member states that have similar health systems argued that European Union treaty law applied only to insurance-based health systems.

However, in 2006 the European Court of Justice delivered its judgment in the Watts case, which concerned an English national health service patient who required hip replacement surgery. She had travelled to France to have the procedure and subsequently sought to recover the cost of the treatment from her primary care trust. The court found that, under the freedom to provide services articles in the Treaty on the Functioning of the European Union, patients have the right to obtain healthcare services, including private healthcare, in another European economic area country and be reimbursed on their return home. The patient pays for the treatment up front and has a right to claim reimbursement up to the amount that the same or equivalent treatment would have cost had it been provided by the state at home—the NHS, in Scotland. Where the home cost is lower, the actual amount is all that is reimbursed.

In July 2008, the European Commission published the draft directive on the application of patients' rights in cross-border healthcare, to codify case law and provide a legal framework for cross-border activity. The directive was agreed by the European Parliament in February 2011 and became European law in April of that year.

The 2013 regulations transpose the directive into Scottish legislation where necessary. They provide a legal basis for the NHS to introduce prior authorisation arrangements for expensive specialist treatment, and they limit the amount of reimbursement to what the treatment would have cost the NHS in Scotland if it had been provided here.

An important point is that the home state retains responsibility for deciding what healthcare it will fund on a cross-border basis. The directive is not a way for people to gain entitlement to treatments that would not normally be available at home. If I may put it simply, if you are not entitled to it here, you cannot get it there.

A key theme of the directive is the emphasis that is placed on national and local health bodies in making information on rights and entitlements publicly available and easily accessible. The intention is to establish a network of national contact points throughout the EU to facilitate the exchange of information on healthcare quality, safety, availability and accessibility, which will help patients to make informed choices on the treatment that they seek and where it is provided.

There will be national contact points in each of the four UK countries, which will be linked to each other and to national contact points in other member states. The appropriate location for Scotland's national contact point is within NHS inform—the information arm of NHS 24. The 2013 regulations designate NHS 24 as the provider of that function.

The NHS in Scotland provides first-class care, with quality and safety at the heart of all that it does, and there are short waiting times for the vast majority of services. Therefore, I do not expect that a large number of Scottish patients will wish to use the European health provisions to travel overseas for treatment that is, for the most part, readily available at home. It is estimated that currently fewer than 50 Scots do that in a 12-month period. However, like all EU citizens, Scots have the right to access healthcare in other European countries, and we must have legislation in place to allow them to exercise that right if they so wish.

The directive applies to patients from other parts of Europe who wish to receive treatment in Scotland. However, there has been little, if any, such activity to date. NHS boards have a duty to identify and record such activity and will continue to do so.

It should be noted that medical priority applies to all patients, regardless of their country of origin. There is no specific requirement on NHS boards to accept patients for planned healthcare if that would be to the detriment of our own patients with similar health needs.

The regulations provide a stable foundation for patients to exercise their European healthcare

rights and for NHS Scotland to handle cross-border healthcare applications, and they meet our European obligation. I am happy to answer any questions.

Richard Lyle: I welcome your comments and agree that we have one of the best health services in the world. This is quite exciting subordinate legislation. As you said, the majority of EU citizens receive healthcare via the healthcare system in the member state in which they live. You said that they must have prior approval before they go elsewhere. Many ad hoc judgments were being made in the courts, on the basis of different health systems, so the development of an EU directive was seen as necessary. The directive clarifies and simplifies the rules; facilitates freedom of movement; provides EU citizens with better information on their rights; ensures that cross-border healthcare is safe and of high quality; and promotes co-operation.

If, like me, you have a European health insurance card, you can access EU healthcare. Do you agree that this policy dispels the myth that, if and when Scotland becomes independent next year, people who live in Scotland will not be able to go to England for healthcare?

Alex Neil: Absolutely. That is a myth, because every country already has cross-border arrangements, which do not apply just in the situation that we are talking about. For example, we have had patients transferred to Sweden for specialist care, and other countries, including England, send patients to Scotland for specialist care. Glasgow Southern general hospital is a good example of a hospital that has an international reputation for dealing with certain types of head injury. I agree totally with you.

Gil Paterson: I have two quick questions for information. Is the cost of an individual's travel taken into account? If a waiting time applies—that is fairly normal in every country—does someone who presents here or someone from here who presents in another country jump the queue, or are they just slotted into the system?

Alex Neil: If care was planned, the individual would be slotted into the system. If the situation was urgent, they would be given priority, because an urgent case would be given priority in Scotland. The case that I cited of somebody who was treated in Sweden in the past three years was very urgent. A hospital there had to be ready to accommodate that person.

The approach to travelling costs would be similar to the means-tested approach to claiming travelling expenses in Scotland. Travelling costs for planned care would be subject to an up-front agreement between the patient or their representative and the health board. For unplanned care, people would not be entitled to accommodation costs, but they could be entitled to travel costs on the basis of the scheme for travel costs in Scotland. In the Highlands and in Western Isles NHS Board's budget, for example, travel costs are a not insignificant feature.

11:15

Aileen McLeod: Could NHS Scotland refuse to reimburse patients who received treatment in another European economic area country?

Alex Neil: It could, if it had been planned care and the patient had not received prior authorisation from the health service in Scotland. We are not obliged to pay in all circumstances.

Broadly speaking, there are two circumstances in which this is relevant. The first is if someone who is travelling in the European economic area—which of course includes countries such as Norway that are not in the EU—has a genuine emergency and requires emergency treatment. Quite frankly, I do not see us refusing to pay for treatment in such cases. On the other hand, if someone thinks that they will have to wait too long for a particular procedure in Scotland and clearly abuses the system by trying to jump the queue and get it done in Germany or wherever, we will normally refuse to pay for the treatment.

Aileen McLeod: In what circumstances is prior authorisation necessary?

Alex Neil: Under the new treatment time guarantee, we always ensure that people have the ability to get the treatment anywhere in Scotland, which means that if they cannot get it within the 12-week period in their own health board, they will be offered alternatives. For example, if they need an orthopaedic or heart procedure and cannot get it in their health board within the 12 weeks, they might be offered the services of, say, the Golden Jubilee national hospital. If a procedure can be done within a reasonable time only outside of Scotland, we will normally allow that to happen. The first option would be to offer treatment south of the border rather than in a foreign country, but it would depend on the procedure and where the specialty existed.

Aileen McLeod: When can prior authorisation be refused?

Alex Neil: If the criteria are not met. There is a list of specialist procedures that people are entitled to. However, those procedures are very expensive so, unless there is some very good reason, we will not allow or agree on a prior basis for someone to have it done elsewhere, especially if there is spare capacity in Scotland and it is available within a reasonable time period.

Aileen McLeod: Given the importance of the provisions in the directive, are there any plans to make people aware of its contents? You have said that fewer than 50 Scots have taken advantage of cross-border healthcare in the past 12 months, but all Scots have a right to do this if they so wish.

Alex Neil: I am not planning to run a television advertising campaign but, at the same time and in the appropriate circumstances, patients have a right to know what options are available to them. This is one of the options that, in certain circumstances, are available. Obviously, a lot of this is co-ordinated through NHS National Services Scotland.

Bob Doris: Most of what I was going to ask about has been clarified in the response to Aileen McLeod's questions. There might be a slight overlap in this question but, just to be clear, would prior approval for anyone normally resident in Scotland to go outwith Scotland and get healthcare somewhere else in the European economic area be given on the basis of clinical priority? What if you knew that you could get your hip replaced within 12 weeks but you thought that you would just go to Spain and get the treatment, say, six weeks ahead of everyone else in the queue? Have assurances been built into the system to ensure that, as you said, there is no such queue jumping?

Alex Neil: Unless there are other very extenuating circumstances, that is a very good example of a case where someone would not get prior agreement to get the operation externally. There is an approval process and, as the lead agency for the health service in Scotland, NSS has overall responsibility for this area of activity and would not give prior approval under such circumstances.

Bob Doris: That is helpful. I have to say that I cannot really think of an example in which someone would speculatively seek healthcare in another country, given that, to get their money back, they would have to get prior approval based on clinical need and priority before they took their journey—unless, of course, emergency healthcare were required.

Would people coming to Scotland from elsewhere in the European economic area for healthcare have to make an up-front payment to the Scottish NHS or whoever it might be? I have heard anecdotally that it can be quite difficult to reclaim costs from others using the Scottish NHS who do not necessarily have that entitlement. They are of course entitled to be treated if they need treatment, but I am talking about the cross-border transfer of cash to repay the Scottish NHS for the costs incurred.

Alex Neil: It would absolutely be an up-front payment. However, I want to draw a distinction with regard to those coming to Scotland for treatment, who are, as I have stated, very few and far between. Some of the press coverage on this issue, particularly south of the border, has centred on people coming from outwith the European economic area, and that is where the difficulty in recouping some of the costs has arisen.

Bob Doris: That is very helpful. I had read similar press reports, and it is good that you had the chance to clarify the issue this morning. I have no further questions.

Nanette Milne: Do we know where the other UK nations are with regard to adopting these regulations?

Alex Neil: I am not sure what stage they are at, but they all have to adopt them. The policy has, in fact, been adopted for a number of years now; as required by new EU law, we are simply transposing into legislation and putting on a more permanent footing what had been interim arrangements in Scotland. However, we can check exactly where the other three nations are and inform the committee.

Nanette Milne: It would be interesting to know.

The Convener: The regulations cover planned procedures that, as my deputy convener explained, an individual might be able to access earlier elsewhere or which might not be available in this country and for which it might therefore prove easier to travel. However, you also mentioned emergency procedures. How will the regulations impact on such care in Spain or anywhere else, as Bob Doris described it, outwith Scotland? Do the current arrangements not apply? If, say, someone goes to Benidorm and has a stroke, what happens now and what will happen after this legislation comes into force?

John Brunton (Scottish Government): That person will use their European health insurance card.

The Convener: So the regulations do not change that.

John Brunton: No. The cross-border stuff relates to planned treatment.

The Convener: But the cabinet secretary mentioned emergency treatment.

Alex Neil: That is where your EHIC comes in.

The Convener: So the regulations affect only planned treatment, not emergency treatment.

Alex Neil: If someone who was not from Scotland was involved in a road traffic accident in Scotland, we would treat them right away and then sort out the finances. I do not want to give the

impression that the first thing we would do is ask for their credit card.

The Convener: But we are expected to take out insurance when travelling outside Scotland.

Alex Neil: That is right.

The Convener: In fact, there is a problem with people not taking out insurance. How would they be affected? What about the add-on costs?

Alex Neil: If you go abroad without insurance and you need emergency treatment, you are liable for the cost of that treatment.

The Convener: So, just to have some fun at Richard Lyle's expense, does that mean that I will need to get holiday insurance to go to England and Wales in future?

Alex Neil: It will depend on the arrangements, but—

The Convener: I do not want to turn this into a comedy, but I thought that the question was worth asking.

Alex Neil: I would take insurance out anyway, convener.

The Convener: We will accept that, cabinet secretary.

Gil Paterson: We had a family accident when we were abroad two years ago. There was a head injury, but we just presented our card and it was all taken care of. If you carry your card, you will be fine.

The Convener: I am glad that you had that experience, Gil, but there are regular reports that it is not as simple as that for people. I was just seeking clarification that the regulations cover mainly planned treatment.

Alex Neil: Absolutely.

The Convener: Do members have any other questions?

Richard Lyle: Convener, my EHIC expires on 8 August 2015. I have never taken out insurance for going to Europe—I have just taken my card with me.

The Convener: Well, Richard, you heard the cabinet secretary's advice. He is a friend of yours.

Richard Lyle: I always take the cabinet secretary's advice.

The Convener: You should get insurance even if you are just going to England and Wales. Anyway, we must press on.

We now move to the formal debate on the regulations on which we have just taken evidence. I invite the cabinet secretary to move motion S4M-07760.

Motion moved,

That the Health and Sport Committee recommends that the National Health Service (Cross-Border Health Care) (Scotland) Regulations 2013 [draft] be approved.—[*Alex Neil.*]

The Convener: Do members have anything to say? Richard, this is the debate, not the question-and-answer session.

Richard Lyle: The debate is on whether the regulations should be passed, and I believe that this is one of the most exciting pieces of legislation in the two and a half years I have been at the Parliament. It makes it clear that people can go abroad; supports freedom of movement and patient choice; and provides every EU citizen with better information on their rights. It is an excellent piece of legislation, and I support it.

Gil Paterson: I just heard my colleague get excited about subordinate legislation. I think that he needs to see the doctor. [*Laughter*.]

Bob Doris: I am not sure how you follow that, convener—and the answer is that you probably should not.

The debate provides an opportunity to raise a wider issue about Scottish or UK citizens visiting other European countries without their EHIC and the internal procedures in certain countries. In some countries, if you do not show your card at the point of accessing accident and emergency or hospital care, you are quite often expected to pay up front. Although the Scottish NHS has accounting procedures by which it can reimburse those costs, things can be made quite difficult not by the Scottish NHS but by the internal accounting procedures of other European Union countries. I am not sure that I would deem the regulations exciting, but I certainly think that they are important and that there is still work to be done at European rather than Scottish level to ensure that the accounting procedures under which Scottish citizens are reimbursed for healthcare received elsewhere in the European economic area are expedited. I know from constituency cases that it can take a number of years for people to be reimbursed. Given the context of the debate, I thought it appropriate to put that on the record.

The Convener: As no one else wishes to take part in the debate, I invite the cabinet secretary to sum up.

Alex Neil: I am happy to take the debate as read. This is something that we have to do under European legislation and, as committee members have made clear, it will benefit both our citizens and the citizens of Europe.

Motion agreed to,

That the Health and Sport Committee recommends that the National Health Service (Cross-Border Health Care) (Scotland) Regulations 2013 [draft] be approved.

The Convener: I briefly suspend the meeting for a changeover of officials.

11:27

Meeting suspended.

11:29

On resuming—

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

The Convener: Our final agenda item is an evidence-taking session with the Cabinet Secretary for Health and Wellbeing on the Public Bodies (Joint Working) (Scotland) Bill at stage 1. The cabinet secretary has been joined by the following Scottish Government officials: Kathleen Bessos, deputy director, and Alison Taylor, team leader, both from the directorate for health and social care integration. John Paterson stays with us from the previous session.

I invite the cabinet secretary to make an opening statement.

Alex Neil: Thank you for the opportunity to discuss the Public Bodies (Joint Working) (Scotland) Bill. I will take a few minutes to say a word or two about the bill.

First, in terms of the overview, as the committee is aware, the bill provides the framework for the integration of health and social care and sits alongside the Social Care (Self-directed Support) (Scotland) Act 2013 and other key policies to deliver the Scottish Government's personalisation agenda. The bill promotes person-centred planning and delivery to ensure joined-up, seamless health and social care services, with the aim of improving outcomes for service users, carers and their families. We will do that by legislating for national health and wellbeing outcomes that will underpin the requirement for health boards and local authorities to plan effectively together to deliver quality, sustainable care services for their constituent populations.

Importantly, the bill aims to bring together the substantial resources of health and social care to deliver joined-up, effective and efficient services that meet the increasing number of people with longer-term and often complex needs, many of whom are older. We are all aware of the Audit Scotland criticism on the failure of community health partnerships, which is why the bill focuses on bringing together the accountability of statutory partners, health boards and local authorities to jointly deliver better outcomes for patients, service users and carers. For too long, health boards and local authorities have ended up in a cycle of cost shunting. The bill requires health boards and local authorities to, first, establish integrated arrangements through partnership working; and secondly, to provide for two models: delegation to a body corporate, established as a joint board, or delegation to each other as a lead agency. The health boards and local authorities will be required to delegate functions and budgets to the

integrated partnership; as a minimum, those will be adult primary care and community care; adult social care; and aspects of acute hospital services.

Secondary legislation will set out functions that integrated partnerships will be able to include, such as housing or children's services, where there is local agreement to do so. Indeed, there are areas across Scotland, such as West Lothian and Highland, where that is already working well. Each partnership will be required to establish locality planning arrangements, which will provide a forum for local professional leadership of service planning and will encompass an assets-based approach, building on local knowledge and best practice to meet the needs of the local population. The integrated partnership will be required to prepare and implement a strategic commissioning plan, which will use the totality of resources available across health and social care to plan for the health and social care needs of local populations. Importantly, professionals, service users, GPs and the third and independent sectors will be embedded in the process as key stakeholders in shaping the redesign of services.

Alongside the Social Care (Self-directed Support) (Scotland) Act 2013 and the Children and Young People (Scotland) Bill, the Public Bodies (Joint Working) (Scotland) Bill is part of the Government's broader agenda to deliver public services that better meet the needs of people and communities. The bill provides the legislative framework for partnership working at both a strategic and a local level, involving professionals, service users and partners. The planning and delivery principles in the bill encapsulate the principles of Christie, putting the person at the centre of service planning and delivery, and requiring a focus on prevention and anticipatory care planning.

The Health and Sport Committee has not only taken evidence from a range of stakeholders this month, but has heard during its inquiry into integration that there is wide support for the bill's principles. For some who are already progressing well with shadow integrated arrangements, the bill might seem unnecessary. However, I think that we are all in agreement that not enough progress has been made under the existing permissive legislation. We have not started from a blank sheet of paper, because many areas across Scotland are already working in partnership to deliver integrated services. Furthermore, we have considered the evidence from across the UK and we are mindful of applying that in a Scottish context. However, I am clear that in order to achieve consistency of progress, it is necessary to set out a legislative framework that will deliver the necessary changes to meet future demands on services.

I believe that the bill strikes the right balance in setting the framework integration, making the necessary requirements on health boards and local authorities to deliver effective integration of health and social care and providing the flexibility to develop arrangements that best suit local circumstances. I welcome the opportunity to clarify the bill further.

The Convener: Thank you, cabinet secretary. Gil Paterson will ask the first question.

Gil Paterson: It is safe to say that the oral and written evidence that the committee has received so far shows that there is unanimity across the sector that integration is a good thing that people would like to see happen. Officials may correct me, but I do not think that a single submission has said that integration would be a bad thing. However, there are some ifs, buts and maybes. It has been suggested that the reason for failures in the past has been a lack of good leadership—that seems to be one of the key factors—and that there is a need for cultural change. Given that we are hearing from everybody who is involved that integration would be welcome and should happen, why is there a need for legislation? Why not just let it happen?

Alex Neil: Many attempts have been made to make it happen. It has happened in one or two areas—West Lothian is the most notable example—but without statutory underpinning it has not happened. In one or two areas there is still, frankly, resistance to the proposals. We cannot deliver the quality of care that we require to deliver to our adult population—in particular, the disabled population and older people—without the full integration of adult health and social care services.

Our strong view, which is based on the evidence of the past 10 or 20 years, is that integration will not happen without statutory underpinning. We hope that statutory underpinning will not only make it happen on the ground throughout Scotland, but help to change the culture in health boards and local authorities so that people see the need to put the person—the end user, the patient—at the centre of everything that we do and to give overriding consideration to their needs rather than the needs of either a health board or a local authority.

Gil Paterson: I am grateful for your answer, but it leads to another question. If people are saying that the problems were due to a lack of leadership, where is the provision for good leadership? Or is that an excuse and are people protecting their empires?

Alex Neil: Leadership is part of the equation. It is part of the jigsaw of making it happen, and we are providing leadership at the national level through the bill. I have spoken to Iain Gray, a

former minister with responsibility for social justice, and he told me that he regrets the fact that he did not underpin the plans that he had at that time with legislation. Without the legislation it will not work, but the leadership tends to pull the other way because of the vested interests of local authorities and health boards. The bill will ensure that the leadership must pull with integration in both the health boards and the local authorities. In the body corporate model or the lead agency model, the leadership comes from the chief accounting officer or the lead agency. Therefore, the bill will ensure good leadership at the national level as well as at the local level.

Kathleen Bessos (Scottish Government): We have made it clear from the beginning that legislation in itself will not change the mindsets of the practitioners on the ground and create the leadership. Alongside the legislative work, we are undertaking a significant piece of work on strategic workforce development; I can say a little more about that, if you would like. For us, strategic workforce development plus the work to support locality development and strategic commissioning is where all this will land—or not land—appropriately. The strategic workforce development group will produce, probably by the end of October, a framework for action that will cover the issues that the member has raised around the support for organisational development; the support for the joint boards regarding culture, language and communications; and the support that chief officers will need to provide the strategic leadership that will be required in a complex situation.

We will say something about management development, education and training for professionals and about our on-going work to develop commissioning skills to create a proper commissioning framework. We are going to do a whole load of work. The financial memorandum identified resource that we will make available to partnerships to support their transition into a new working environment.

Alex Neil: I will just add a point about the areas where integration is already happening, such as Highland. A few months ago, I was up in the Royal northern infirmary in Inverness, where people who previously worked with the health board now work with the local authority in an integrated setting. Some of them admitted that they were a bit sceptical, but they now say that it really is the right way to go. I have found many examples of that where integration is already working on the ground.

Gil Paterson: To be honest, I am not entirely sure that leadership is the real question. There are some real good people, but they have not engaged.

Alex Neil: I think that it varies between different areas.

Gil Paterson: In business or in local or national Government, there are always vested interests. I do not think that we can ever take vested interests out of the equation—that is just the way that it is. People protect their budgets and their own wee areas, or big areas for that matter. Do you agree that, in effect, the bill will mean that the vested interests will get much wider and will encapsulate a much greater area? The sphere of influence and vested interest will encapsulate most of the population. Perhaps I should not say that, but that is what I see in the bill and it is my interpretation of what you are trying to achieve.

Alex Neil: We certainly want to ensure that everyone has a vested interest in delivering what will be the national outcomes. It is clear that, whether we are talking about strategic commissioning, budgetary procedures, how the constitution of the bodies is established or reporting mechanisms, we are trying to ensure that everybody's vested interest is in providing the best possible service to the end user.

The Convener: We know that you are having discussions with the Convention of Scottish Local Authorities. You might want to bring us up to date on those discussions but, to summarise—I am not saying that this is how it is, but it is how I view it—COSLA says that you are taking wide powers without our knowing how you would use those powers and the circumstances in which you would use them. COSLA's fear is that you are taking all these powers, but there are no rules of engagement.

In addition, there is a question about how you can be impartial in the process. The Cabinet Secretary for Health and Wellbeing is there to protect, sustain and promote the health service. COSLA perceives an imbalance that it is crucial to resolve as we go forward. Do you agree or disagree with those issues about where the power lies and your role in the process? In what circumstances would the powers be used? Do we need clear rules of engagement?

Alex Neil: The first thing to say is that, although I am called the Cabinet Secretary for Health and Wellbeing, I am also the cabinet secretary responsible for adult social care, so it is just not the case that there is a conflict of interest, because I already have responsibility for adult social care. I exercise those responsibilities today and my predecessors exercised the same responsibilities.

Secondly, COSLA has expressed concern that it believes that there is a need for tighter definition of what we mean by the term "social care" in the bill. The concern is that the way in which the bill is

drafted could be interpreted to mean that I have the power not just over social care, but over a whole gamut of local authority services. We have been working at political and official level and we have agreed that we will lodge amendments at stage 2. Those amendments, jointly agreed between COSLA and us, will I think absolutely allay any fears that I am trying to widen my powers. I am absolutely sure that my Cabinet colleagues would not want that to happen, anyway. The bill, with those amendments, will make it definitively clear what is meant by the powers in relation to social care and that they do not cover much wider areas of local authority responsibility.

11:45

Thirdly, on rules of engagement, a lot will be followed up in secondary legislation and guidance, but fundamentally the point of the bill is that it should provide a national framework and binding principles—for example, strategic commissioning and the national outcomes—and define the different models in principle that are available to deliver them. We have been very clear about that and have agreed right up front with COSLA and others on it from day 1. It has always been agreed that, beyond that, we want to leave as much discretion as makes sense to local areas to make their own detailed arrangements, and for the bill not to be overly prescriptive. That is a sensible way to go.

I sat through the last 20 minutes of the previous panel's discussion. Some of the issues that were mentioned will be covered in secondary legislation for various reasons that we will no doubt discuss in more detail later. It does not make sense to put some of those things in the bill; it makes more sense to put them in either secondary legislation or guidance.

The Convener: I am sure that you understand that, in the evidence that we have taken, people have been all on board, as Gil Paterson said.

Alex Neil: Yes.

The Convener: Indeed, the committee is on board, but a specific example is the contention about the shifting budget. The evidence that we have heard is that we can put everything in place, legislate and enable. However, according to COSLA in particular, if we do not shift the budget from the acute sector into the community, the approach will not work. I think that your position on whether you could deliver substantial money would be tested at that point, given that what was wanted was a top cut of money from the health service into the community. That is a difficult call for the Cabinet Secretary for Health and Wellbeing.

Alex Neil: There cannot be a simplistic percentage cut in the acute budget that is then redirected. That is not the right way to plan ahead.

The strategic commissioning role of the partnership is absolutely crucial. We already agree with COSLA that, where there is an acute budget related to the partnership's responsibilities, how much is spent on acute care in relation to the overall responsibilities of the partnership will be very transparent. The partnership will then have the ability to influence the acute care budget.

I will get Kathleen Bessos to talk about this in a bit more detail, but let me give an example. In my estimation, one area in which we can substantially reduce the number of unnecessary hospitalisations is the long-term condition of chronic obstructive pulmonary disease. We hospitalise many people who would not need to be hospitalised, or hospitalised as often, if the proper support were available in the community. Because of the rate of hospitalisation, the budgets for dealing with those people are covered in the acute budget. We want to move some of that into the community. The strategic commissioning plan—it would be a plan—would say that, over a period of years and in agreement with the acute providers, resources will be shifted into the community in a planned way so that within three or four years' time, say, many more people who suffer from COPD will be treated in the community rather than in the acute setting, and the money will effectively follow the patient in those circumstances.

The Convener: So you agree with COSLA and others that one of the key aspects is to shift the flow of people and budgets from the acute sector into the community.

Alex Neil: That is one of the things that we want to achieve, because we know that people are being hospitalised far too often. If the resources were available in the community, those people would not need to be hospitalised. Let us look at the economics of that. On average, it costs £4,600 a week to keep somebody in an acute hospital in Scotland and around £300 a week to treat a person at home. For those with serious chronic conditions, the average is probably nearer £800 or £900. It makes economic sense to treat people at home, but the really important point is that, where that has been done, patients' health outcomes have substantially improved. That is particularly true for older people. One of the worst things that we can do is to hospitalise them unnecessarily. We are all at one on that.

I am not sure whether Kathleen Bessos would like to spell out the budgetary aspects of that—she can perhaps do so later.

Nanette Milne: Some of us were in West Lothian yesterday. The question is one of

widening the integration agenda. It is clear that they are working on adult health and social care, but they were also talking about how important housing and children's services are. How does that tie in with what COSLA is saying to you about restricting integration?

Alex Neil: We are talking about the core of the joint board. The voting membership of the joint board in each local authority area that has the body corporate model will be made up of equal representation between the health board and the local authority. If the board decides that it wants to co-opt non-voting members on to the board, it will have the right to do so. There will be a host of infrastructure around the board and that is where services such as housing will be heavily involved—housing has a particularly important role to play in locality planning. The secondary legislation and the guidance will spell that out in more detail.

Malcolm Chisholm: What Kathleen Bessos said about the wider agenda is very important. All the witnesses have said that structural change in itself cannot deliver what is required. Most witnesses, with the exception of the Chartered Institute of Public Finance and Accountancy, have gone along in general terms with what is in the bill.

What interests me is the detail and there are two areas where I seek clarity. We have already started talking about one of them—acute budgets. In your opening statement on the bill, cabinet secretary, you spoke about aspects of acute hospital services and you gave the example of COPD. First, there is the question of who will decide. I presume that, in terms of what you propose, it is up to—in fact, I do not know. Will the health board decide, or will it be the partnership? Who decides?

The more fundamental question is, how much of the acute budget is to be shifted? Is it money to pay for reprovisioning in the community, or is it a much larger block of the acute budget? You are probably aware of NHS Lothian's concern that it sounds as though you might be taking a much larger block of the acute budget. You would then be getting a position in which the body corporate commissions from the acute sector. That is where the return of language such as "commissioner-provider" or even "purchaser-provider" has come in. It is important to know in detail how the proposals will work. How much money is being transferred and what is the relationship between the body corporate and the rest of the health service?

Alex Neil: I will get Kathleen Bessos to explain the exact mechanics of how things will work. It is important for people to understand the detail of those mechanics.

I will not be reallocating anything. It will be an entirely local decision and it will be driven by the joint board—by the body corporate or by the lead agency in the Highlands. It will not be me making the decisions; there will be 32 decision-making bodies across the country that will be making the decisions.

Malcolm Chisholm: I understand that—but some people have expressed concern about that.

Alex Neil: A key point of this whole exercise is substantially to increase acute care in the community. If we were not going to give the joint boards some responsibility for the acute budget, that would defeat that particular purpose of the integration agenda.

We should not think in terms of a precise percentage of the acute budget, and I will tell you why. If you pick an acute hospital—say, Perth royal infirmary—and compare it with the Glasgow Southern general, you will find that the Southern general has a much wider remit than just the local authority area that it is serving. Perth royal infirmary does serve people outside the Perth area, but Glasgow Southern general is a teaching hospital with a range of other responsibilities. If we just said that a percentage of the acute budget should be transferred in the same way across the country, the impact of that would be extremely different in different areas, because of the different roles played by some of the bigger hospitals in particular. That is why it has to be a local decision, dependent on the configuration of acute services in each area.

Kathleen Bessos will explain the budgetary process and how we deal with the acute plan, which starts with the unprecedented transparency of the acute budget.

Kathleen Bessos: That is right. The important thing is that we stick with the principle that the resources that are associated with the functions that are delegated to the joint board go with the functions. That is the important point, and that can be clearly articulated. The key question then becomes which aspects of acute resources lend themselves to being used in a different way. Clearly, there are services such as neurosurgery that do not lend themselves to being redesigned to support an improved pathway of care, particularly for older people.

As the cabinet secretary said, we have been working closely with the chief executives of the NHS boards to unpick the complexities—how do you land this thing so as to give enough influence to change how acute budgets are used, without introducing either incredible amounts of bureaucracy or complete chaos and confusion, with the potential for the acute service not to be

able to plan coherently across their patch because they cover more than one local authority area?

We think that we have got a position that has been agreed with COSLA and with NHS boards on what that model looks like, so we are saying that the strategic commissioning plan must describe the money that is in scope. Within that commissioning plan there will be decisions taken by the partnership board, in discussion with the health board, the council and others, about the timeframe around which changes to acute services will happen. Those resources will then be realigned and redeployed as the commissioning plan is operationalised.

For example, in community acute hospitals it is likely that all of that budget will go with the functions and be in the integrated pot, so that that resource can be used flexibly on a daily basis. However, redesigning and realigning some aspects of acute service needs to sit within the context of the agreed commissioning plan, the timescale over which the change will happen, and complete transparency about what resource is available to be redeployed.

Clearly, it is not the whole of the acute budget, but we think that we have a model. The deputy director for health finance in the Scottish Government has already asked partnerships to give an early indication of what percentage of resources would be in scope, and I am sure that once she has a comprehensive picture she would not be unhappy to share the generality of that, given that the partners are in the early days of working through the amount. However, there is a significant amount in scope.

Malcolm Chisholm: It would be helpful if some of that detail could be provided to the committee and made available more generally. It has become one of the main points of interest in the discussions and I know that there is concern about it in some health boards, so I could probably ask lots of follow-up questions. One basic question might be whether the decision about how much money is in scope is a decision of the body corporate or a decision of the health board. There is lots of scope for tension between those two and I suppose that the general point, as everybody knows, is that even in shifting the balance of care, because of demography, it is not as if acute budgets can be decreased in absolute terms. There are so many questions around that.

Alex Neil: The key tool is the strategic commissioning plan. Let us take COPD as an example, and let us say that it is for Edinburgh, Malcolm Chisholm's area, because the health board and the council have signed up to the scenario. Part of the strategic commissioning plan is to treat far more COPD patients—a percentage might be specified—in the community. To provide that service will require not just GPs, but acute consultants to work in the community. The pace at which it is done, the resource allocation and the way in which it is done should all be part of the strategic commissioning plan, which must be drawn up by the joint board—obviously, Edinburgh is a body corporate model—in wide consultation with not only the health board and the local authority but a range of other bodies. The requirement for a consultation group on the strategic commissioning plan is in the bill. It is not a case of a unilateral decision being made. Everything must be done in consultation with the key stakeholders and then, once the plan is agreed, everybody is signed up to it.

12:00

Alison Taylor (Scottish Government): To pick up on a technical detail, the bill sets out that the original agreement between the health board and the local authority, which the bill describes as the integration plan, sets out the functions and the method of calculation for payments to go with the functions in the integrated arrangement. Therefore, at the overarching level—the level of the framework about which the cabinet secretary has been talking—the health board and the local authority will have that initial discussion within the parameters of what must go in, which will be in regulations. Then, once we get into the mechanics of working out how to improve outcomes, it is exactly as the cabinet secretary said: the determination comes into the strategic planning process.

Malcolm Chisholm: That is fine for the management of a particular condition such as COPD, but when it comes to the more general question of shifting the balance of care and reducing emergency admissions, it becomes a bit more difficult. It would be helpful to have some more detail on that.

The second matter on which there has been much discussion is the precise governance arrangements, particularly the position of the chief officer of a body corporate. Again, I am drawing on what the people in my area are saying. The City of Edinburgh Council and NHS Lothian are both saying that there is a view that the balance has shifted more than was intended towards the chief officer, that, in fact, far more responsibility and decision-making power will be located there and that, in some ways, there will be a weaker relationship with local authorities and health boards than was intended in the consultation document.

I would welcome any views on that. Have you had discussions with various health boards and local authorities about it?

Alex Neil: I will be clear. The chief officer will be appointed by the joint board. He or she will report to it. That person will not be able to make unilateral decisions; they will be answerable to the joint board. They have to be employed by the local authority or the health board for a host of other reasons.

However, that is not to say that somebody who is not currently employed by the health board or the local authority could not be the chief officer. It could be that such a person applies for the job, but it would then need to be decided who their employer was. That is a technical issue.

The first thing to stress is that the chief officer will be responsible to and report to the board. They will not be unaccountable. The second thing to stress is that, on a strategic level, they will report simultaneously to the chief executives of the health board and the local authority.

Clear lines are laid out for the role, powers and job description of the chief officer. Some of the fears are perhaps based on misconceptions rather than being real, because it is clear to us that what the officer does will be very much under the board's control.

Malcolm Chisholm: The view has been expressed that the policy intention has not been translated into the wording of the bill. We will have to consider that at stage 2.

Alex Neil: We will do that.

Kathleen Bessos: That is right. We have a human resources technical working group considering the matter. The comment has been made—and we have registered it—that the chief officer will be accountable to the joint board for developing and delivering the strategic plan. However, they will have an operational line to the two chief executives for the operational discharge of that responsibility. We will do further work to clarify that, because it is a legitimate point.

Alex Neil: We are considering whether we need to lodge an amendment at stage 2 so that there is no dubiety on the issue.

The Convener: That was an interesting exchange. I have a wee parochial comment on it. I am concerned about the answers about the flow of acute budgets coming from non-specialist hospitals and worry about the sustainability of local hospitals that provide acute services. It seems that that will be the focus of drawing some of the budget out. I might be wrong, but I note the concern.

Richard Lyle: I say again that I welcome the intentions and objectives of the bill. Yesterday, I was fortunate enough to be part of a delegation that visited West Lothian, and I was impressed with what is being done there, including in the local hospital. I take on board the comments that you made about that.

You mentioned that you want disabled people to be involved. Later yesterday afternoon, we had another visit and we were asked how involved disabled people will be. You talked about who will be on the boards and said that there will be voting rights for the councils and health boards, but which independent people will we have on the boards? Will the bill state who will be on them? In response to a question that I was asked yesterday, I said that it might be that 100 organisations want to be on the board, but we cannot have that number at the top table. How do you intend to specify or decide who should be at the top table?

Alex Neil: There is a specification that, for example, there should be a representative from the staff side and a representative of the public, but there is a wider question about the accountability of the bodies. We have a piece of work going on to look specifically at how we can enhance the accountability of not just the health service in general, but the integration joint boards in the future. We do not think that we need to do more on that in the bill, as we believe that we have all the powers that we need. If we need to do anything by way of secondary legislation, we will do it. However, as I said, we are looking at the wider issue of accountability to ensure that there is genuine public accountability.

I would have thought that the fact that half of each board will be made up of elected councillors will, in itself, enhance accountability. The other half will comprise representatives of the health boards, and we are looking specifically at how we can enhance their accountability. As you know, we have trialled direct elections to health boards and some other ways of improving accountability, and I hope to make a statement sometime soon—before Christmas—on general issues of improving accountability.

The absolute guarantee is that we need to make sure that all the key stakeholders—the public, the end users, the third sector and the independent sector—are involved. The bill states throughout that they have to be involved—not just consulted, but involved—at both partnership level and, more important, the local level, because that is where a lot of the key decisions that will concern end users will be made.

Richard Lyle: I welcome that comment as I believe that they should be involved.

When I was asked this question yesterday, I could not answer it. Why did we change the name of the bill to the Public Bodies (Joint Working) (Scotland) Bill? I think that COSLA got a bit upset and thought that you and other cabinet secretaries

were going to grab extra powers from everywhere else. Why did we change the name of the bill?

Alex Neil: I point out that it is not an enabling bill of the kind that has been introduced in previous periods of history by other regimes.

This is where the lawyers come in, including the Parliament's lawyers. What initiated the change to the title is that, under the bill, what used to be called the Common Services Agency will now be able to provide services much more widely and not just to the health service in Scotland. The fact that it will be able to provide services across the entire public sector will be good for public sector efficiency and cost effectiveness and will improve the delivery of services. However, because we included that provision in the bill, its original title was no longer legally competent, so we had to amend it. I fully accept that it is not the sexiest bill title in the world, but the important thing is the bill's substance, rather than its title.

Richard Lyle: My last question is on VAT, which you will have heard me ask earlier. Different arrangements for VAT apply to local government and NHS boards. Do you have any concerns about that? What work is being done to ensure that no extra VAT will be paid once the bill is passed?

Alex Neil: We are in a state of advanced negotiations with HM Revenue & Customs on that very issue. Although I cannot forecast exactly what the outcome will be, I am reasonably confident that we will hopefully end up in a position where there will be no VAT implications in terms of additional expenditure arising from these measures.

Of course, in 2016 we will have powers over HMRC so we can rectify any outstanding matters after that.

Richard Lyle: I certainly agree with that comment.

The Convener: I think that Bob Doris has a supplementary question on that.

Bob Doris: Mr Lyle used the expression "top table", and I think that the cabinet secretary gave a hint about this in an earlier answer when he mentioned locality planning. Is there any information available on who would sit at the table—let us call it a wider strategic table rather than a top table—to sign off strategic plans? There has been almost an expectation that various other bodies might sit at that table—I will not list them, because any that I miss out will take it as a slight that they are not considered as strategically important as the others. Who might sit at that wider strategic table and who will have voting rights?

More important, can you say a bit more about the locality plans that joint boards will be under a statutory obligation to produce? The expression "top table" motivated my supplementary question because I see this bill as being a community planning initiative as much as a top-down initiative. Therefore, it would be helpful to hear a little more about the importance of locality planning. Perhaps that is an area where other stakeholders from the front line could be involved.

Alex Neil: As I said earlier, the key thing is the strategic commissioning plan, which will determine exactly what each board will do. That is one area in the bill where we have been quite prescriptive both about the consultation group that must be set up and about the people who need to be involved in the development of the strategic commissioning plan. Clearly, I would like the process to be as much bottom-up as it is top-down because the strategic commissioning plan should be largely determined by the adult health and social care needs of the community.

Perhaps, without going into inordinate detail, Alison Taylor can give you a flavour of how we believe that the locality planning mechanism would typically work and who would be involved in that.

Alison Taylor: As you can see from the bill, we have not set out a prescriptive process on locality planning. That is in direct response to what we were told by stakeholders and partners, particularly those who were already doing something like locality planning well. It would be difficult to find two examples that are particularly similar, as there is huge local variation in how locality planning works, who exactly is around the table—that can depend on the balance of local need—how often they meet and what sorts of decisions they look at. The onus was very much on us to encourage the development of local innovation and not to be prescriptive.

The bill provides various powers to set out the range of people who need to be involved in strategic planning and who need to be consulted. Again, I do not think that ministers are minded to be particularly prescriptive about the numbers of people who would be involved or that sort of thing, because those are matters that the evidence tells us work better when they are agreed locally. In locality planning, I think that there needs to be a very strong role for local clinical professionals. From memory, we can see some good examples of that in NHS Grampian and there is an interesting model at work in Nairn. A lot can be learned from those places, and that is where our attention should go.

Bob Doris: Will there be guidance on local engagement?

Alison Taylor: Yes, absolutely. I apologise, as I should have said that.

Bob Doris: Regarding the wider strategic plan, although other bodies are not mentioned on the face of the bill, I understand that the bill is not restrictive. There is nothing to stop joint boards co-opting other partners on to the board, perhaps without voting rights, for example.

Alex Neil: I think that a good comparison can be made with the process for going for planning permission to build a new building. There are statutory consultees, who absolutely must be consulted, but developers must also show that they have consulted the wider community. The process will be similar. There will be statutory consultees, but that is the de minimis position.

12:15

Bob Doris: Will there be best practice guidance on that?

Alex Neil: Yes, there absolutely will.

Kathleen Bessos: There is guidance about strategic commissioning, from which we are learning a lot of lessons. We will produce guidance on the bill that builds on what we have learned.

We have sent out the "All Hands on Deck" report, which describes the key principles of locality planning, and we have asked partnerships to look at the report and consider, with support from the joint improvement team, how it fits their local circumstances. Partnerships can use it as a template as they start to work things through. In January we will get some feedback about putting the report's guidance into practice, which we will use as we develop proper guidance, on which we will consult.

Bob Doris: That is helpful, thank you.

Rhoda Grant: In evidence, we have heard concern about matters such as governance, finance, audit, staffing and sharing information—the list goes on and on. How can such issues be satisfactorily resolved?

Alex Neil: That was a long list. I think that some concerns are misplaced. For example, I am sure that we will reach agreement with COSLA on amendments at stage 2 that are needed to address its concerns about governance. It was never our intention to give me wide-ranging powers over local authorities beyond what is intended in the bill.

On funding, we have had a good discussion on the budget process this morning and we will provide an additional briefing on the mechanics of it and the flow of budget decisions. The key point is that there will be an integrated budget. We will no longer have the ridiculous position whereby for each hospital patient there is a dog fight between the health board and the local authority about who will pay when the person is discharged, which means that we end up with delayed discharge. There are a range of issues such as that one.

When the system is fully operational, I think that there will be much more efficient and efficacious use of public funding. A good example of that will be a reduction in unnecessary hospitalisations. If we can do that, there will be much better patient outcomes, and treating people at home instead of spending so much money on keeping them unnecessarily in the acute setting in hospital will free up resources that can be used to improve the quality of care more generally.

We have listened and are listening carefully to what people are saying. We have any number of groups. There is the bill advisory group, on which all the key bodies are represented. We have a ministerial steering group, which I chair. We have an implementation group and eight working parties on all of this—just for starters. The one thing that we have done on this bill is consult, and we continue to consult widely. When we get the committee's stage 1 report, we will take any recommendations very seriously, as we always do.

Rhoda Grant: I will be more specific, because I think that you have already made those points. There are different criteria for audit in local government and in health—there are internal and external audit processes and the like. What will the body corporate's audit function be, and how will it carry it out? What will it need to put in place?

Alex Neil: Audit Scotland is part of a group that is looking at the bill, so there is active involvement from Audit Scotland on the issues that might need to be consulted on. The audit trail will need to be clear, so that we know what happens after the money goes into the new organisations. We need to know how the money is being spent and whether it is being spent on the right things, what the approval mechanisms are and so on. The audit process is part of that. Alison Taylor will explain the mechanics of how that will happen.

Alison Taylor: We have an overarching integrated resources advisory group, which is looking at all aspects of the finance and accounting procedure that relates to what we are proposing under the reforms. Sub-groups are looking at specific topics, such as audit.

As has been raised by committee members, we have heard concerns since the bill was published that we need to be clearer on aspects such as audit, which we have taken on board very seriously. The expert groups, including Audit Scotland, have been looking at those questions. With our legal colleagues, we are considering

whether any amendment to the bill might be necessary. Obviously, that will come forth in due course if it is decided that that is the best way in which to achieve clarity. Quite aside from that, there will be very detailed guidance on all these matters, an early draft of which we will share with a very large group of professionals and stakeholders at the end of this week.

We recognise that the answers to the concerns need to be clear and clearly stated. We have the work in place to get that into the parliamentary process.

Rhoda Grant: Does the same apply to staffing? We have heard evidence that there are different legal requirements for interaction with staffing and training. How will that work in a body corporate that is made up of two legal entities?

Alex Neil: I will get Alison Taylor to answer some of the detail, but let me just begin with the principle, which is that the body corporate itself will not be employing people. Obviously, that may change through time, but what we envisage is that, to start with, the people who work directly for the body corporate, such as the chief accounting officer, will be seconded from the local authority or the health board. The reason for that is that, as you will know, employment law is very complicated and it could raise a lot of issues that would make the whole integration process unnecessarily complicated. Therefore, the wisest thing to do at this stage is what we are doing, which is to work on the basis that people will technically be employees of the local authority or the health board, not of the body corporate.

Rhoda Grant: But that will surely require more work. If someone is seconded to the body corporate but kept on the local authority payroll, who will do their local authority work when they are doing the new job? Do you understand what I am driving at? There is a cost involved that is not covered in the bill, and there is no additional funding for it.

Alex Neil: In terms of the joint accounting officer, his or her salary and associated costs will obviously be met out of the integrated budget.

Kathleen Bessos: It will be jointly paid for by the board and the council.

Alex Neil: Obviously, bodies can make their own arrangements, but if the local authority or health board seconds somebody to the body corporate, it will do what it does whenever it seconds anyone, which is to make the necessary arrangements for somebody else to do the job that the person was doing, if it still needs to be done. That is normal procedure.

Rhoda Grant: That would surely mean additional costs for covering for backroom staff, which would take away money from front-line services.

Alex Neil: No. The person being seconded will do a job that will have previously been done by the local authority. It will be the same job, but it will be done under the aegis of the joint board.

Rhoda Grant: Let me just pursue this. For example, an HR officer who works for the local authority may be seconded to the new body. They will have done work for more than one department when they were part of the local authority. That work will surely need to be covered by somebody else, which will mean an additional cost.

Alex Neil: To be honest, I think that, to start with, that kind of central service will still be provided by the local authority and the health board, because the people working under the aegis of the body corporate will still, as I said earlier, be employed by the health board or the local authority.

Rhoda Grant: Okay. To take the example that you gave earlier of acute clinicians going out to work in the community, could somebody work in the community beside a social worker or care worker and have a different chain of command, line of management, personnel officer and pay structure?

Alex Neil: The chain of command for the job that they do will be with the body corporate. Obviously, there is a wide range of pay structures and pay scales within health boards and local authorities, let alone between them, so that will just continue.

Rhoda Grant: So they will remain their employees. Who will the body then employ?

Kathleen Bessos: It will not have to employ anybody. It will not be an employing body at that point. The people delivering the services will still be employed by the council or the NHS board. They will not have changed their employers and there will be no requirement to do so.

Rhoda Grant: Who, then, will give directions for what happens? How will a body share resources, put a budget together and then get people to work across sectors if they are still in their silos? How does this work? I am getting more and more confused by the answers.

Alex Neil: This concerns the legalities.

John Paterson (Scottish Government): For somebody in the local authority who provides social work services, the line management is through the local authority and ultimately to the chief executive. The chief executive directs that they follow direction from the chief officer in the chief officer's role as operational director. They are

then required to follow that direction from the chief officer as operational director.

Rhoda Grant: If they are still paid by the local authority, why does the body corporate need a budget? If all the costs are undertaken, why do we need audit? If the body corporate only directs how services happen on the ground, why does it need a budget at all?

Alex Neil: It is a question of control over the resource.

Kathleen Bessos: It needs to direct how that resource will be deployed by the people in the local authority and the NHS. The chief officer has the overall budget, and on the back of the strategic commissioning plan there will be changes required over a period of time. The chief officer, on behalf of the joint board, will direct those services to be delivered in a way that complies with the strategic plan.

John Paterson's point is that this bill enables the chief officer to give directions to the health board and the local authority to ensure that the staff employed fulfil that requirement. It is all tied up legally.

The Convener: I suppose that this gets to the difference between the body corporate model and—

Kathleen Bessos: —and the lead agency.

The Convener: The lead agency model in your area, Rhoda, does not require that transfer of employment.

What is the downside in terms of co-location of people? Does it drive the cultural agenda forward? Will it be able to achieve the results that you have witnessed and testified to in the Highlands?

Alex Neil: Some folk were at West Lothian yesterday, where it is already done and works very effectively. It is done very effectively on the lead agency model in the Highlands. Even in areas that have not had formal partnership agreements in the past, such as parts of Fife, it is done. For example, there is co-location in Queen Margaret hospital in Dunfermline between social workers and health professionals who all work as one team. It is done in Grampian.

The Convener: You should curb your enthusiasm or any minute now you will be scrapping this legislation.

Rhoda Grant: I want to get to the bottom of this. If, for example, you shift the balance of care from acute to care in the community and the body corporate decides that it does not need a consultant in an acute hospital but that it needs five or 10 more care workers for the cost of a consultant, does it tell the NHS to terminate that contract or not fill the contract as it would normally have done? Does it then go to the council and tell it to employ maybe five more workers? Is that how it would work?

Alison Taylor: There will be guidance about the directions that need to go to the health board and the local authority from the body corporate. That will be developed in good time. We would not envisage that they would be at that level of granularity. We would expect to see an expression in the strategic plan of a shift in investment and activity from one bit of the system to another.

The other important point is that the joint board is composed of members of the health board and the local authority. The chief officer has a strategic role in relation to the joint board, and an operational role in relation to the health board and the local authority. The key to all of this is that people work and plan together across the totality of available resource. Yes, there will have to be a discussion about how to deploy resources to best effect locally, as there is now. There are places which, for example, have quite significantly shifted their consultant geriatric input from hospital to community.

Rhoda Grant: The body corporate will not have the powers to direct. It may make up a strategic plan, but it has no way to fulfil that plan.

Alison Taylor: It has powers to direct delivery on the back of the strategic plan.

Rhoda Grant: The accounting officer answers to the chief executive. Surely the chief executive can say, "No, we're not going to do this."

12:30

Alison Taylor: The chief officer will be accountable to the joint board for the functions that are delegated to that board to strategically plan the delivery of services. The chief officer will have a day-to-day role. That is built on models that are more or less in place—it is similar but not exactly the same. On the operational side—in the day-to-day role in the delivery of services—the chief officer will have a close relationship with the two chief executives.

John Paterson: I talked about directing, which is separate from exercising the power of direction. A power of direction ultimately allows a direction to be given to tell someone that they must do something. In the way in which organisations operate normally, a formal direction does not require to be given on everything that is done. Normally, people are asked to do things and they do those things. It is only when conflict happens and a requirement arises for a formal direction to be given that one is given.

Rhoda Grant: You seem to be trying to legislate for good will. If the good will existed, integration

would be happening, as in the Lothian and Highland areas. The bill will push people down a street. Unless somebody is empowered to take the lead when consensus does not exist, you are trying to legislate for good will.

Alex Neil: The body corporate and the chief officer are empowered. Everybody needs to work on the basis of good will and trying to take people with them, but the body corporate has the ultimate power to do what is necessary to deliver an integrated service. The powers of direction to deal with a recalcitrant health board or local authority are vested in the body corporate. That has been missing and is why we have failed on integration for many years.

Nanette Milne: Given the available time, perhaps some of my questions could get written responses rather than answers now. Someone has told us that the term "public services" would be more appropriate than "public bodies" in the bill's title, given what we are trying to achieve. Do you have a comment on that?

Alex Neil: I do not see the advantage in changing the bill's title at this stage. What matters is the bill's substance, rather than its title. However, I agree that it is always desirable to have a sexier title if that is at all possible.

Nanette Milne: It was the independent sector that made the comment.

I totally agree about the involvement, particularly at the locality level, of clinical health professionals. I lived through the GP frustration and disillusionment with CHPs.

It is crucial to involve GPs and other professionals. You said that they must be embedded. How will you enthuse them about that?

Alex Neil: A lot of enthusiasm is out there, because people realise that we are serious this time. We are going to do this—there will be a law—and people will have no other option, so integration will have to be done.

Two mistakes were made with the CHPs. One was that they were made sub-committees of health boards. The other was that integration was not a statutory requirement; it is only now becoming a statutory requirement. That is why the disillusionment set in.

Every medical professional—such as doctors, nurses and particularly community nurses—whom I have met has been utterly signed up to integration. We will make absolutely sure in guidance that, at the locality level and the partnership level, all the key people—the stakeholders who need to be involved and not just consulted—are involved.

Nanette Milne: The CHPs were not local enough—they lost the locality. That is terribly important.

Alex Neil: That is right.

Nanette Milne: A lot of concern has been expressed that no complaints system is spelled out. Will you give detail—not necessarily now—on that? In particular, the disabled groups that we met yesterday said that, as have a number of other people. That is a concern given the different complaint routes—it is a bit like what Rhoda Grant has said about other issues.

Alex Neil: We have a stream of work on exactly the issue of establishing a complaints procedure that is fit for purpose. Obviously, local authorities and health boards have different complaints procedures. We are working on that, but we certainly do not anticipate needing a big change in primary legislation to do it. I mentioned that we have eight working parties. We have a stream of work specifically on complaints, which will, I hope, report by, roughly, the turn of the year.

Kathleen Bessos: Yes, it will have reported by the end of this year.

Nanette Milne: My other questions probably should be given a written response. One is about the options that are being considered in relation to pension funding, including the costs.

Alex Neil: Again, that is a wee bit of a red herring, in that the bodies corporate will not employ people and therefore will not be directly involved in pension issues. Obviously, however, over time, they might employ people, so there is an issue. If in future years somebody transfers their employment to a body corporate and their pension fund is in deficit, we have to ensure that we do not inherit a share of the deficit, which is historical. A technical amendment to the bill is probably required to deal with that. However, beyond that, we do not see a big issue with pensions, for the simple reason that the bodies corporate will not actually employ anybody.

Nanette Milne: The point was in connection with what is set out in the financial memorandum—at paragraph 116, to be exact.

Alex Neil: I think that the Finance Committee drew that issue to the committee's attention, but it is well in hand.

Nanette Milne: Okay. Another issue from the same source is whether any additional funding is to be provided in the event of a successful equal pay claim.

Alex Neil: No, because it is nothing to do with us. If there is an equal pay claim in the local authority, whoever works for the local authority will be part of that settlement. If there are equal pay

claims outstanding in health boards, the same thing will happen. We are not employing anybody. It is the employer who has to settle with the employee on equal pay.

Nanette Milne: Almost finally, do we have costs for the provision of funding for delivering Healthcare Improvement Scotland inspections under the integrated model?

Alex Neil: At the moment, the Care Inspectorate and Healthcare Improvement Scotland can with my permission carry out joint inspections. We will lodge an amendment to allow them to carry out those joint inspections without always having to come to me for permission—in fact, I think that that is already in the bill. As you probably heard earlier, the Care Inspectorate and HIS are working together on the implications of integration for the delivery of inspection services. HIS will launch a consultation fairly soon in which one of the subject areas that will be covered will be the implications of integration. Obviously, eventually, we will need a more integrated inspection regime.

Another strategic challenge is that, as we drive more and more to have people have their health and social care delivered much more at home, we need to be satisfied that we have robust systems in place for picking up any problems of abuse that there might be, particularly in relation to dementia patients, for example, who perhaps are not capable of reporting incidents themselves. I have charged officials and the agencies to look at that as a strategic issue that we need to address. Clearly, we cannot put a closed-circuit television camera in everybody's house—I hope that nobody is suggesting that we do that under the bill—but there is an issue about abuse at home. South of the border, there was a recent example in which a TV company installed a CCTV camera, and the way in which the older person, whom I think had dementia, was being so badly treated did not make for pleasant viewing. We need to develop more robust systems for ensuring that we pick up any abuse of people who are being treated at home.

Nanette Milne: Finally, we know that most partnerships, apart from Highland, appear to be going down the body corporate route, but do you have final figures on that yet?

Alex Neil: A couple of areas have explored the lead agency model but, to the best of our knowledge—we are in pretty close touch with all 32 areas—the only part of Scotland that is likely to use the lead agency model is the Highlands. That is our clear impression at the moment.

Mark McDonald: I will try to keep this brief, not least because I have a meeting to get to at 1 o'clock.

This morning, we heard from the Scottish Public Services Ombudsman and others that the complaints procedures should be standardised under the new model. We heard different evidence from NHS Dumfries and Galloway: its view was that there was no need to rush at standardisation. What is the Scottish Government's view on complaints procedures? Do you think that there would be merit in some form of standardisation?

Alex Neil: Inevitably, there has to be a clear single complaints procedure to allow people to make complaints against the body corporate or the lead agency. There is no doubt at all in my mind that people need to have clarity on the complaints process. That is the stream of work that is being done that I mentioned earlier. The SPSO is involved in the group that is undertaking that work. It will report by the turn of the year. At the appropriate time, we will share the outcome of that with the committee before we proceed. We will consult on the working party's recommendations, but my view is that the ombudsman is right about the need for a single complaints procedure for the services that will be covered. However, we will wait and see what the working party says.

Mark McDonald: The ombudsman expressed concern that work on complaints and scrutiny can sometimes drag on. He pointed to the Crerar review, which was commissioned in 2007. Some of its recommendations have still not been fully implemented. Do you intend to pursue the issue with some vigour, to ensure that there is not an unacceptable lag between implementation of the legislation and implementation of a standardised complaints procedure?

Alex Neil: I say unequivocally that there will be no dragging on my watch.

Mark McDonald: Thank you very much.

The Convener: I understand that you were not here for the whole of our earlier session, cabinet secretary. As I said to the ombudsman, we made similar recommendations about complaints, commissioning, the development of the new workforce and national care standards in January 2012. Many of those recommendations were accepted by the Government. That was 18 months ago, so there are significant questions to be answered.

Can I clarify that we do not need legislation to address the issue of national care standards or the integration of the Care Inspectorate and HIS? Is there a contradiction, in that one has statutory powers and the other does not?

Alex Neil: As far as the way forward that we have agreed is concerned, we do not see any need for additional primary legislation beyond what is in the bill. On the complaints procedure, there is already a substantive legal framework for

complaints in Scotland. We are talking about the process, rather than the statutory basis of the complaints procedure.

If there is a requirement to make any legislative changes—on complaints, for example—we believe that we have the powers to do that in secondary legislation. I think that the Public Services Reform (Scotland) Act 2010 allows us to do that. It probably gives us the powers that we need to do anything that we might want to do in secondary legislation.

The Convener: To support the ombudsman's claim, there is much that could have been done on the national care standards and outcomes—on which the committee made unanimous recommendations that were accepted by the Government—over the past 18 months. What has held us back?

Alex Neil: I do not think that we have been held back. Certain things happen at certain times. The priority has been to get the principles of the bill agreed. On complaints, we have not been sitting back doing nothing. Work has been going on on complaints over the past 18 months. Obviously, we have to try to take people with us. In this case, that means COSLA, and it is heavily involved in the complaints work that will report at the turn of the year.

12:45

The Convener: I am sorry to press you, cabinet secretary. You said earlier that we do not need the bill to deal with complaints or the national care standards. If the national care standards have not been reviewed in nearly 12 years, why has that work not been completed in the past 18 months?

Alex Neil: First, in terms of complaints, what I am saying to you is—

The Convener: We were talking about the national care standards, not necessarily complaints.

Alex Neil: Sorry—I thought that you were talking about both. On the national care standards, we looked carefully at the committee's recommendations and accepted in principle the need for review. One issue is that we need to consult the appropriate people before we announce a national review of the national care standards. Also, we wanted to be a bit further down the road with the bill and all the infrastructure around it so that, by the time that we reviewed the national care standards, people could look at that in the context of knowing the shape of the bill, which will impact on what people say about the future of the national care standards. In particular, there is an issue around the future interplay between clinical standards and the national care standards. This is the appropriate time to review the national care standards, now that people know exactly what is happening on integration.

Kathleen Bessos: In the parliamentary debate at the beginning of the process, the cabinet secretary gave a commitment to Parliament that we would ensure that the review of the care standards was carried out with our informal process for looking at outcomes. The national outcomes that we have put into the consultation must link together with the care standards. As we speak, we are going around the country asking members of the public, including older people's groups and broader groups, "This is what we're planning around care standards. What do you think about the future? Here is what we're saying about the national outcomes." We have brought the two processes together. My team and colleagues from the care standards and sponsorship branch of the Scottish Government are jointly going around the country, talking to people on the ground about the care standards and the national outcomes. We wanted to avoid totally confusing everybody about what the care standards and the national outcomes are, so we are having joint presentations, joint discussions and joint debates both with members of the public and with the professionals.

The Convener: I am pleased to hear that, but I must have missed it in my constituency. I do not know whether any other committee members have come across it. It would be interesting to hear about it.

Kathleen Bessos: We could give you a list of places where we have been. We started in Shetland and have been down to Dumfries and Galloway. We have also been to Paisley, Dundee and Aberdeen. We can give the committee information on that.

The Convener: It would be nice to hear about that work. I make a plea on behalf of the committee. We have done a lot of work in the area and have made a number of recommendations. There was an indication that the committee would be kept up to date with that work, and it would be useful if we were. I am glad to hear that we are making progress in and around the complaints work.

I know that the cabinet secretary is under pressure and that committee members have another meeting to go to, but there are some issues and questions that have not been covered today, including some of the financial issues. Would it be okay if we wrote to you to get responses on those on the record?

Alex Neil: Yes. That is no problem at all. If there is anything that the committee feels that it needs

additional information on, we will supply that—no problem.

The Convener: I thank you and your colleagues for your attendance this morning.

Meeting closed at 12:48.

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e-format first available
ISBN 978-1-78351-808-1

Revised e-format available
ISBN 978-1-78351-826-5

Printed in Scotland by APS Group Scotland