The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

EQUAL OPPORTUNITIES COMMITTEE

Thursday 13 November 2014

Session 4

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EQUAL OPPORTUNITIES COMMITTEE
18th Meeting 2014, Session 4

CONVENER

*Margaret McCulloch (Central Scotland) (Lab)

DEPUTY CONVENER

*Marco Biagi (Edinburgh Central) (SNP)

COMMITTEE MEMBERS

*Christian Allard (North East Scotland) (SNP)
*John Finnie (Highlands and Islands) (Ind)
*Alex Johnstone (North East Scotland) (Con)
*John Mason (Glasgow Shettleston) (SNP)
*Siobhan McMahon (Central Scotland) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Iona Colvin (North Ayrshire Health and Social Care Partnership)
Joe McElholm (North Lanarkshire Council)
Professor Stewart Mercer (University of Glasgow)

CLERK TO THE COMMITTEE

Ruth McGill

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equal Opportunities Committee

Thursday 13 November 2014

[The Convener opened the meeting at 10:01]

Draft Budget Scrutiny 2015-16

The Convener (Margaret McCulloch): I welcome everyone to the 18th meeting in 2014 of the Equal Opportunities Committee. Will everyone please switch off their electronic devices or put them into flight mode?

I like to start with introductions. We are supported by clerking and research staff, official reporters, broadcasting services and, around the room, security.

Today's only agenda item is an evidence session on our scrutiny of the draft budget 2015-16. I welcome our panel of witnesses. When you wish to speak during the discussion, please indicate to me or the clerk on my left. There will be no opening statements but when witnesses are introducing themselves, it would be appreciated if they could give some brief background information on the role that they play within their organisation.

I will start by introducing myself. I am the committee convener. Members will now introduce themselves in turn, starting on my right, followed by the witnesses.

Marco Biagi (Edinburgh Central) (SNP): Good morning. I am the member of the Scottish Parliament for Edinburgh Central and the deputy convener of the committee.

Alex Johnstone (North East Scotland) (Con): I am a member for North East Scotland.

John Mason (Glasgow Shettleston) (SNP): I am the MSP for Glasgow Shettleston.

John Finnie (Highlands and Islands) (Ind): Madainn mhath—good morning. I am an MSP for the Highlands and Islands.

Siobhan McMahon (Central Scotland) (Lab): I am an MSP for Central Scotland.

Christian Allard (North East Scotland) (SNP): I am an MSP for North East Scotland.

Joe McElholm (North Lanarkshire Council): My role is the manager for older adult services in North Lanarkshire Council. I represent North Lanarkshire Council and NHS Lanarkshire health and social care partnership. My role is to oversee the development and day-to-day operational management of services for older people and the strategic development that looks forward to changes in the future of old people's services. However, because we are in an increasingly integrated world, that works across the full age cycle.

Iona Colvin (North Ayrshire Health and Social Care Partnership): I am director of North Ayrshire health and social care partnership and chief officer for the partnership. I have been in post for almost a year. Ayrshire and Arran NHS Board is in the shadow phase of the health and social care partnership. I am responsible for all social services, community health services and mental health services in Ayrshire and Arran as the lead partnership director.

Professor Stewart Mercer (University of Glasgow): I am professor of primary care research at the University of Glasgow. I am also newly appointed as the director of the Scottish school of primary care, which is a virtual school that promotes research into primary care. The main focus of my research is on the needs of people with multiple morbidity or multiple complex long-term conditions. We consider that across the board, among all age groups. We do so largely from a primary care angle, but there are lots of important interfaces.

John Mason: I appreciate the opportunity to ask some questions.

The whole thrust seems to be that we should try to keep older people at home as much as possible, which seems to be widely accepted—that has been touched on by a number of committees. I was surprised, however, at the statement that only 7 per cent of the funding for over-65s in the health and social care area is spent on home care. That could show that home care is cheaper, but it could also show that we are not putting enough emphasis on that area. What progress has been made in shifting the balance of care towards home-based services?

Iona Colvin: You are starting with an easy question!

We have not made as much progress as we would have wanted to make. The balance of national health service funding is overwhelmingly invested in acute and secondary services, and most of that is tied up in the big district general hospitals, particularly in areas such as Ayrshire and Arran.

We have grown some elements of care at home through the reshaping care for older people fund, but I do not think that that fund managed to influence the main stream of funding as much as it should have done. We are considering seriously how to grow the community infrastructure. That is not just about care at home; it is about district nursing, community psychiatric nursing and

building services around general practice, which is fundamental.

At the moment, in developing our strategic plans, we are very much focused on how to move money into the community so as to build and grow care at home. How do we respecify care at home, so that it can cover a broader range of tasks? We are exploring the partnership arrangements, so that we work alongside district nurses and community psychiatric nurses as well as social workers.

We have not grown home-based services as much as we need to. It has been a matter of shifting the balance of care, and a lot of the money has gone into care homes and the growth of the care home sector, rather than into care at home. In Ayrshire, we are currently preparing our strategic plans, which will very much focus on how we shift that balance.

We can pull out some efficiencies from how we manage within health and social care partnerships, because there is some duplication, and there are barriers and things that do not make sense. As we go through and integrate services, we will be able to free up some resource. The big question, however, is how we get the bigger resource freed up from within the big district general hospitals, so that we can begin to invest more in the community. That is what we are all currently working on.

Joe McElholm: The 7 per cent figure is stark. We spend the same proportion of the health budget, or slightly more, on prescribing for older people, and we would like some change in that regard. The focus on polypharmacy is one example of where we think there are gains to be made through transfers of resource.

The question of balance in supporting more people at home is not just related to spend. There is a big variation across the country in the number of people aged 65 plus per 1,000 living in care homes. That variation is not necessarily only related to spend; it is also related to the redesign of services and to a focus on how we ensure that the existing home support resource is working in a targeted, effective and efficient way and is well linked to the wider service system.

In most areas—certainly in North Lanarkshire—there is a big focus on redesign towards reablement and towards ensuring that, when people start to use the home support service, we work with them in the early stages to see what abilities they can regain and what confidence they can rebuild so that they do not need to use services. By doing that, we help people to move back out of services. That can require an intensive use of resource in the early stages, but it represents spending to save, because over time supporting people back out of the services frees up resource to support people who have much higher levels of support need to remain in their own communities.

That also connects to reshaping what we do with the care home resource. In North Lanarkshire, we have moved away from providing residential care within a traditional long-term local authority model. Our care homes are now focused on intermediate care. Two of them operate fully on intermediate care and two are moving towards doing so. We have divested from the long-term residential care model without there being an increase in the use of independent sector care homes, so it is possible to make such shifts in the balance of care through a process of redesign.

It is clear that, if we are supporting more people to live at home, we have to make a wider connection to their quality of life. One focus within the reshaping care programme is the wider connection to the third sector. How can we ensure that we address the issue—which some submissions mention—of loneliness among older people? We must give people opportunities by investing in the third sector. We have been trying to do that in North Lanarkshire through our engagement with Voluntary Action North Lanarkshire, which is a full partner in the reshaping care programme.

John Mason: From what you have both said, I get the impression that the picture is maybe not even across the country and that things are being done differently in different parts of the country. If that is the case, should more of a direction come from the centre? Alternatively, is it right that each local area works out what is best for its own area?

Iona Colvin: I think that we have done all the things that Joe McElholm has mentioned. To be honest, it is not a case of either/or.

Reablement has been a big focus for most authorities. Integration gives us a better opportunity to use the resources that we have across the NHS and the council to do that and to work on maximising independence but also getting people into better care and into a position where they live more happily in the future.

We are looking at how we work with the care home sector and how we commission services in the future. Joe McElholm has touched on intermediate care. In Ayrshire and Arran we plan to review all our in-patient beds and our purchased beds together, so that we look at all the beds that are provided by the NHS as well as those that have been outsourced, because in Ayrshire and Arran it tends to be private and independent sector agencies that provide care homes. We plan to look at the totality and ask what care we want for the

future for the citizens of North Ayrshire, East Ayrshire and South Ayrshire.

As Joe McElholm has said, it is about reshaping the care that we currently provide and people's expectations. It is about initiatives such as extra care housing, which Borders and Lothian have been looking at. We look at the best examples of practice across different authorities and try to learn from them. Some of the things that have been achieved in moving people out of residential care and into extra care housing have been remarkable. The opportunity that that model provides is that we are not moving individuals but are able to have much more flexible support and health services round about them. We need to define and look at how care should be delivered in the future. That is one of the things that we plan to do within the first 12 months of the partnership becoming a real and legal entity, which will happen next year.

John Mason: Are there any barriers? I presume that the status quo of keeping the big institutions going is a bit of a barrier.

10:15

Iona Colvin: What has happened previously—it might be different in Lanarkshire—is that more and more people have come through the hospital. The number of people who turn up at accident and emergency has increased year on year; we have a couple of thousand more people turning up each year at Crosshouse and at Ayr hospital. There is then pressure on the beds in the hospital—I am sure that Professor Mercer can say more about that—and there is then pressure to get people back out of hospital as quickly as possible.

We think that about a third of the people who turn up at hospital do not need to be there. However, two thirds of them do, which relates very clearly to the impact of deprivation on people's health and to the fact that we have an older population. In North Ayrshire, we have Largs and the north coast, which is quite an affluent area and has a lot of people who live quite a long time. Then we have Irvine and the three towns, where there are some fairly deprived areas and where we see people's health deteriorating in their 40s and 50s.

That all leads to a huge challenge for the hospital and then it, in turn, passes that challenge on to us. We still have a culture, particularly when older people are in hospital, of deciding that they are going down either the get home quickly to care at home route or the care home route. That is one of the things that we need to change. We need to change the options that are available for older people and we need to change that culture.

We need to get into exactly what is happening—Professor Mercer's paper was helpful in that respect. A lot of what we are trying to look at day to day is the question of what is driving more people to present at hospital. The pressure then comes on to social care to help clear A and E and clear the beds by getting people into care homes or into care at home.

The demand is increasing year on year. This year, there has been an 11 per cent increase in the demand on care homes and a 7 per cent increase in the demand on care at home. It is difficult to keep up with that in the current financial climate. However, we are now looking much more systematically at the whole system—at what happens, what it is that is driving people through, what happens when they come through, what we can do about that, and at what points we can intervene.

Previously, we looked at those issues separately, either from a health perspective or from a social care perspective. We did not sit down together enough and work out what was happening across the system. That is now beginning to happen.

John Mason: Professor Mercer, can I bring you in? Is there something that we should be doing at the parliamentary level—especially at the budget level, which is what we are thinking about at the moment—to move this process along or is it going to happen naturally locally?

Professor Mercer: I am not sure whether it will happen naturally locally. Different areas have developed different approaches. The bigger picture is really important; I tried to outline some of the backdrop to all this in my paper. There are a few key things to consider. The problem of the elderly is largely to do with their having multiple complex conditions. Older people increasingly have a mixture of multiple physical and mental health problems, such as dementia, heart disease, diabetes and osteoporosis. That is not suddenly going to change. As the population ages, we are going to get more of that happening, not less, unless we do something radical about prevention, which is a different task.

We have an ageing population with multiple complex problems and 90 per cent of the activity of the NHS is in primary care and general practice, but that is not reflected in the budget that goes into primary care and general practice. In fact, the percentage of the budget going into general practice has decreased over the past 10 years in the United Kingdom and the Royal College of General Practitioners has been calling for a 40 per cent increase in the share.

That is the context and GPs are increasingly struggling with the 10-minute consultations and

quick throughput of patients. It is not like the old days when patients came in with one condition; people are turning up with five or six different conditions. General practice and primary care are essential to addressing the problem, because they provide a generalist service. People with multiple conditions need generalism and holism, not 10 different specialists in 10 different places.

The bigger picture shows a problem of primary care being underresourced for the future, and something has got to change. The problem is compounded by deprivation, because we know that multiple morbidity happens much earlier—10 to 15 years earlier—in deprived areas, so when we talk about people being elderly it does not necessarily mean an age cut-off. There is a biological phenomenon here.

John Mason: Are we too fixated on ages such as 60 and 66?

Professor Mercer: I think so. Somebody in the most deprived decile of Scotland may, at the age of 50, have the same amount of multiple morbidity as somebody in one of the most affluent areas who is 70. It is not necessarily about actual age; it is about healthy life expectancy.

We have a huge problem with health inequalities in Scotland—the worst in western Europe—and multiple morbidity is compounding that, because need is not matched by resource, particularly in deprived areas. The distribution of general practitioners is flat across different deciles and different places in Scotland, but healthcare need and the problems of multiple morbidity are not flat, as there is a twofold to threefold increase between the most deprived areas and the most affluent. GPs working in those deprived areas have formed a powerful advocacy group—the general practitioners at the deep end group, about which my colleague Graham Watt from the University of Glasgow has presented evidence to other committees. We cannot possibly expect general practitioners at the deep end to be able to cope in the same way as if they were working in a more affluent area, because it is not a level playing field. That has been called the inverse care law.

That is the bigger picture that has to be taken into account. As we move into integrated care, it is essential that multidisciplinary teams join up and that each knows what is going on. That is a challenge, as we are still fragmented. GPs often do not know what is happening with a person's social care, and different services use different computer systems and notes and do not necessarily speak to one another very often.

All those things need to be improved. A lot of it is about having systems that enable people to work better together and at least to share knowledge, but I think that there is a fundamental problem of the relative balance of the budget between acute and primary care. We know that countries across the world that have strong primary care systems do better in terms of healthcare costs and outcomes, and we will not survive into the future without having strong primary care. All the international evidence points to that.

We have a fantastic primary care service compared with many other countries, but it is under pressure and it is socially patterned, in that things are just much harder in deprived areas.

Joe McElholm: Mr Mason asked whether the Scottish Government should try to direct services more towards uniformity. A lot of work has been done on the reshaping care programme, and now with the integration programme, in which the Scottish Government has set out the outcomes that we want to see achieved and then treated those outcomes as the basis for strategic planning and thinking in the partnership areas. There is scope to improve how we direct the Scottish Government's national level input around the performance regime, which can perhaps unintentionally militate against effective transitions and the achievement of some of the outcomes.

There is huge pressure to meet the four-hour target in hospitals. Iona Colvin has talked about the pressures on hospital accident and emergency departments. For many older people and many of the people with multiple morbidities whom Professor Mercer is talking about, four hours is not very long to get a resolution of the difficulties that have brought them into the A and E department. People who have dementia may be there for a reason other than their dementia. The pressure to establish the relationship that is needed to treat the person can lead to an unnecessary onward transition and admission if people feel under huge pressure to meet the target.

John Mason: Is that age related?

Joe McElholm: It is not necessarily age related; it is about multiple morbidities and the complexity of the person's needs.

John Mason: But that complexity is more likely in older people.

Joe McElholm: Yes. However, as Professor Mercer states in his paper, there are more people in that position who are aged under 65, which proves your point that age cut-offs are increasingly less relevant, particularly in areas of multiple deprivation.

Another way in which the culture of targets and performance can create difficulties and challenges in delivering what we want to do relates to delayed discharge. We are moving towards the

implementation next April of a target of two weeks from clinical readiness for discharge to the person leaving. We currently report on a target of four weeks, so there is a risk of the new target generating a pressure. During that period of transition in the hospital, the patient and the team that is supporting them may need longer than two weeks. Driving performance is a laudable thing to do if we are trying to ensure the most efficient and effective use of the acute resource, but if we drive performance too hard on the basis of a regime of time targets, we risk driving more institutionalisation and premature declarations of the need for people to move to a care home when, with a different approach, we might be able to support them to go home again.

We need to look at how the Scottish Government can work more subtly with the local partnerships to achieve the desired outcomes. It is less about whether there can be more straightforward direction than about whether the Government can work more subtly in partnership to find the best way to manage performance.

The Convener: Thank you for that. That is really interesting.

Let us move on to spending priorities. Christian Allard will ask the first questions on that subject.

Christian Allard: My questions lead on from what we talked about earlier in the context of the integration of health and social care. We talk about the national outcome, but it is a national outcome about maintaining independence among older people. From your answers this morning, it seems that we will not achieve that because some of the funding ends up in care homes. How does that address the national outcome of maintaining independence among older people? Are we going in the wrong direction? Are we not putting the funding where it should be?

Iona Colvin: If you look at the 2020 vision statement, which is about people being cared for at home or in a homely setting, you will see that, fundamentally, the funding is going in one direction and the policy is going in another direction. That is why we have gone down the road of integrating health and social care.

10:30

As I said earlier, there are things that we can drive out of the system. There are barriers and things that go on that should not go on in an integrated health and care system. We will resolve some of those issues and will stop people being caught in the referral pathways, as happens just now. However, because of the demand at the front door in acute services, the investment in many boards is going into the creation of extra resources in acute services. I think that Professor Mercer's point is that we must redraw the line and say that we need to manage more of that demand in the community. Part of the objective of the reshaping care for older people policy was about managing that demand and developing services in the community.

Do not get me wrong; I am not saying that nothing good has been done on that. A lot of really good work has been done on dementia care in particular and on developing some of the specialist home care, and a lot of good work has been done in the third sector. However, it has not shifted the main stream. Reshaping care for older people got about 1 per cent of investment, and we need to shift the 99 per cent that is currently invested in health and social work. That is what we are grappling with at the moment—that is what we need to do.

We are consulting just now on our future model. My view is that we all need to begin the shift to building the model around primary care, particularly general practice, which some areas have done. There is a fundamental question about how we begin to do more of the preventative work in the community that prevents people from turning up at A and E while we still have to build new assessment units in hospitals. In Ayrshire, we are building an assessment unit in front of the hospital—we call it building for better care—so that we can manage some of the A and E demand. We need to try to manage that demand but, at the same time, if we are not investing enough in community care and primary care, particularly general practice—I agree absolutely on that—we will not be able to shift the demand. That is what we need to attempt to do next.

We are thinking about how we can free some resource to begin to make that investment in the long term. The Government has announced the integrated care fund, and North Ayrshire will get £2.9 million. Our total budget is £200 million. We are focused on deciding how we can use that to make the change and free up some resource. However, that will not shift the main stream. Most of the money is invested in the hospitals. The big question for us is how we begin to reduce the use of hospital care and increase the services that we offer in the community—better and more joined-up services—that prevent people from turning up at A and E and being admitted because, as Joe McElholm says, we do not know what to do with them.

Once an older person—not just an older person, but anybody with multiple morbidity; in fact, any of us—is admitted, their confidence is impacted and it is more difficult for them to return home. We still have a mindset about sending such people to care homes because it moves them on. We need to tackle that and we will begin to do so, but we need

to do it in conjunction with colleagues in acute and secondary care, because it has to be done on a system-wide basis.

The short answer is that we have some short-term money that will begin to help us if we focus it—we will focus it this time, as we have learned from reshaping care for older people—on the change that we need to make in the partnership. However, in the longer term, we need to find ways to reduce what we spend on in-patient care and move it over to the community. That will not be easy.

Christian Allard: Did you do it back to front? We have heard about spending to save. Should we have directed more of the spending at A and E, where it really needed to be?

I was at a Grampian NHS Board meeting a few weeks back and the board talked about needing to invest first in A and E to ensure that the third of patients who do not need to be in hospital are not admitted. How do we change that culture? I have seen some of the programmes that started in 2007. Maybe the funding did not go to the right places at the start and we are starting to learn that we should direct our funding more towards changing the culture.

Iona Colvin: It is hard to say. A and E departments are responding to the demand at the front door and trying to manage it. We need to plan the financial investment in the health service more and consider how we are going to shift the investment out of hospital-based services—by that, I mean large hospitals; I also manage a number of small hospitals—into primary care in particular.

Do I think that it is wrong to do things such as the building for better care assessment units? Not particularly, because that is being done to deliver the best possible care to the people who currently turn up at A and E, and many general practitioners have been involved in that work. We need to improve pathways and focus a bit more on prevention and building community services so that people do not feel that their only option is to go to A and E.

I can speak only for Ayrshire in this respect, but we have focused very much on getting better pathways on enablement, which Joe McElholm talked about, and re-abling people to get them out of hospital more quickly and reduce the length of stay. We have not focused as much as we should have on how to prevent those admissions but, to be honest, it is quite hard to do that unless the system is joined up. We have now made a leap forward by joining up the system in a much more cohesive way through bringing the services together.

The Convener: The witnesses have talked about primary care. If that is the key, are there issues with GPs being independent contractors?

Professor Mercer: That is of course a thorny issue, because GPs have been independent contractors since the NHS was established in 1948 and there are mixed views across the board as to whether that is a good thing. My personal feeling is that, despite their independent contractor status, GPs have been, still are and will continue to be an integral part of the NHS, which is how they are seen. One advantage of independent status is that it gives flexibility. Generally, GPs can respond quickly when the Government asks them to respond to something such as a flu epidemic. They can mobilise quickly, and they are good at that. I think that independent contractor status probably helps with that. I would not go on record as saying that I am totally for or against that status—there are different models. However, I do not think that it is a fundamental or huge problem.

We have the GP contract—the general medical services contract—and the quality and outcomes framework, or QOF. Those are ways in which GPs across the UK are incentivised, through targets, but whether that has been a good thing is a controversial question. It has certainly reduced variation between practices, but my feeling is that the QOF is entirely disease based—and entirely single-disease based—which means that GP practices have a single-disease mindset in which they do one thing for diabetics and another for people with heart disease, for example. However, it is actually the same patients who have those conditions. There is no reward system for high-quality care for patients with multimorbidity. We do not have targets for that—we do not even know how to measure it.

The direction in which the incentives point will need to change at some point in the future. Increasingly, Scotland has a slightly different contract from that in England, in relation to some parts of the QOF, and there has been talk of a Scottish contract, although that has not happened. The issue is one for the future.

I think that independent contractor status is not a disadvantage. Generally, it allows GPs to be responsive to need. However, the pay-for-performance aspect, which is what the QOF is, will need to be revisited year-on-year, because it does not really fit—rather, it fits with a disease-specific framework.

The backdrop to all this talk about hospital care is that we are working on a 19th century model. Hospitals were set up because of infectious diseases. People went in, they were treated, they got better and they came out. The model has not fundamentally changed, but the needs of the population have completely changed. Now, the big

problem facing Scotland and the rest of the world involves non-communicable, chronic diseases. If we were building a health service from scratch today, it would not look anything like the one that we have.

Clearly, incremental change has to go on, but I think that dividing people up by individual conditions does not always make much sense to them or to doctors.

The Convener: I will ask a quick question then let Joe McElhom speak—he is sitting patiently.

If a health service that was built from scratch today would not look like the one that we have, what would it look like? How should the NHS be redesigned?

Professor Mercer: Gosh. If I could wave a magic wand, what would I do?

The service should be designed around the patient. It should be truly person centred so that the needs of that person as a person, not as a set of diseases, are what is important. Within that, all the good things about patient-centred care—shared decision making, priority setting, goal setting and so on—should be driven by the patient. Of course, we have policy directions for that, but I do not think that it always happens in the way that it could.

If we were starting from scratch, health and social care would be integrated. They would be working with the same systems and would have computer systems that could talk to each other. People in the two areas would know each other and would have good relationships. Things would be community based, largely. Hospitals would be a thing of the future, and very few people would have to go into them.

Essentially, we would take the pyramid that we have now and turn it upside down. Clearly, that cannot happen overnight, but I feel that that will have to happen at some point, if we are to continue with the NHS.

Joe McElholm: I agree with what Professor Mercer has said around the need to make a shift away from single-disease pathways.

One of the things that has happened in relation to the latest iteration of the GP contract is that a small part of the QOF has been allocated to the commitment by the GP practice to engage with their locality partners. That shift is a positive example of how the contract can be used to incentivise engagement in the development of a locality model—in other words, an integrated model. That integrated locality focus is in the legislation, and the GPs will be absolutely central to its successful delivery.

Christian Allard: To go back to the budget, the integrated model is good, but we in Parliament have to scrutinise exactly how the funding is disbursed. Is there any measurement with regard to integrated funding? Can we already measure some of the outcomes, or is it too early? Do we need to wait a few years in order to be able to measure exactly whether the funding made a real difference, or can we make an assessment soon?

Joe McElholm: It is possible to demonstrate what has happened as a result of the reshaping care spend. We can see that there has been a shift.

To take North Lanarkshire as an example, at the beginning of the programme, we decided that 20 per cent of the spend from the reshaping care budget should be spent in the third sector and we established a rigorous evaluation framework around that. A lot of small initiatives were set up on, for example, digital inclusion, such as a small local group that connects young volunteers for whom using an iPad is second nature with older people who want to learn how to use that technology, which is strongly connected with inclusion and combating loneliness, because it gives those people different ways of connecting with their families and so on.

With each of those projects, we have established a framework whereby there is regular quarterly reporting on what has been achieved with the money that the project got. It is quantitative reporting, so Voluntary Action North Lanarkshire can say, for example, that a certain number of people learned how to use an iPad or got a telephone wellbeing check. It is possible to establish that kind of measurement framework. It is labour intensive, but if we do not do that, we will not be able to make the case for the wider transfer of resource that we are talking about from the acute sector to the third sector. It is always going to be difficult to evidence the connection between such work—education around falls, for example—and fewer people being in hospital. However, as long as we can evidence the contributions—we publish a contribution story on a quarterly basis that summarises all the information—we are making the case for the transfer from the acute sector.

10:45

Christian Allard: That is one way to measure it. Are there any other ways?

Iona Colvin: Nine national outcomes have been set for the health and social care partnerships. We are currently working on how we are going to report on those outcomes. As Professor Mercer said, they are very much about a person-centred approach and about the difference that

interventions make to people's lives. We are working with civil servants on what the performance framework will look like.

Christian Allard: So it is a work in progress.

I have a final question. My colleague John Mason talked about what we can do centrally. We have spoken about the culture of the patient and how to change it. I am referring to the culture of using A and E or care homes too early or too much. That needs to be addressed centrally. Maybe some funding should be allocated to having a central message that promotes not only outcomes but different ways of working across the nation to ensure that we have a single message for everyone. How do we go about doing that other than centrally?

Joe McElholm: One of the things that we did in North Lanarkshire in terms of messages and communication was to use reshaping care moneys to appoint a communications officer, who came from the media—he worked for one of the national papers. He has had a tremendous impact by taking the stories that I have talked about this morning and many more examples of work that has been done and ensuring that those messages get out there in local media fora, including the radio and local newspapers, which are a very important part of that. There is a strong commitment to putting across the message.

The message also comes from how we engage as services. We make very clear the points that I have made about the role of the third sector and the importance of the small initiative in a community that builds its capacity. By putting the funding into that, we are sending a message to the community that it is vitally important and not something that we treat as a bolt-on.

To give an example, I talked earlier about reablement and the change in the approach to delivering home support. When we began to change our approach, we anticipated that the public would have real difficulty with that, because over decades they had built up an expectation that once they started with a home support service, they would remain with that service for the rest of their life or until they went into a care home.

There were many examples of that. One example is unwell people who, because they were waiting for a hip replacement, had a home support service before they went into hospital and, when they came out, they needed a bit of support during their rehabilitation. The medical opinion was that, two months after the hip replacement, the patient should be in better health than they were before they started using the service. However, the patient would continue in the service because that was the historical model. That was not an effective use of resource.

To return to engagement with the public, people understood the situation, as long as we explained it and our staff understood that part of their job was to communicate with the wider public. We had difficulty only with small numbers of people. People were anxious because, although they knew that they did not need the home support service for the things that it was meant to come in and do, they felt that it was their contact with the outside world. That is about loneliness. We have to demonstrate that we take that anxiety seriously and that we will develop alternative approaches to tackling loneliness. We cannot just say that we are going to reduce a home support service because we have introduced reablement and that we are not concerned about the wider issue that is being addressed.

Modelling and explaining what we do are vital. That is helped by national-level messages, but the focus is not an either/or—that has to happen nationally and locally.

Siobhan McMahon: I was going to ask about transition services, but first I will ask about preventative spend, which Iona Colvin mentioned. Do people understand what that means? Are we using different definitions? We are getting a lot of anecdotal evidence in the committee and elsewhere that our understanding of what preventative spend means may not be the same as that of service users or those who are implementing policies. Do you work to a set definition?

Iona Colvin: We have split our work between prevention and earlier intervention. A lot of adult services are about intervening earlier—Joe McElholm can probably talk about that, because North Lanarkshire has well-developed self-directed support; we have developed self-directed support, too, but North Lanarkshire has led the way—and providing services earlier so that we prevent people from becoming sicker and more frail. However, local authorities have traditionally rationed services by having eligibility criteria, and someone would need to be in a high level of need before they satisfied the criteria and could access the service.

As local authorities in particular have had to deal with reduced budgets, that approach has been revisited. Through the change fund and self-directed support, we have begun to look at whether smaller payments can be made to people on self-directed support, so that they can buy in services that will support them better, which reduces their long-term dependence and gives them much more say over their care. We are also looking at whether we can give people with disabilities some of the aids at an earlier stage rather than waiting until they meet the criteria. That is some of the work that we are doing on

older people and people who receive disability services.

In children's services, we have a particular focus on preventing children from coming into the social work system. Many children have to come into the social work system and should quite rightly be in it, but we are trying to prevent some of the harm that happens to them at an earlier stage. For example, in North Ayrshire we have a multi-agency team based in Kilmarnock police station that does work on domestic abuse. It goes out with police officers the day after there has been a domestic abuse incident. That has massively reduced the length of time that it takes to respond to women—it is mainly women, but not always—and, importantly, their children. We have reduced the number of referrals to the children's reporter and the number of requests for further reports, and we have got women and children to safety much faster. For the first time in many years, we have seen a decrease in the levels of reported domestic violence in North Ayrshire. That is one example.

We are doing other things, such as working with the early years centres and putting in money advice and social workers. We are focusing on assisting families who are on the edge of the system so that they do not get to the point of terrible need or family breakdown, or the point at which something happens to a child.

We tend to badge all those activities as prevention and early intervention, but clearly they have a different focus.

Siobhan McMahon: I am glad about all the great work that is being done, but the phrase that you used was "intervening earlier". That brings me to transition services. We have heard evidence about young people falling through the gap and older people not being prioritised in the group that they wish. If those people are identified earlier, those things might not happen. How can a better transitional approach be supported in the new integration framework that we have? Do you see room for improvement? What types of things should we be looking for across the board? I know that different areas work in different ways. I represent three local authority areas and I do not want to see a young person getting a better service just because they live a few miles away from someone else. What should we look for as we look at the budget?

Joe McElholm: Your question was about the definition of prevention. I see prevention as supporting people to live lives that are as full as possible within their capabilities or capacities and avoiding the need for a more intensive level of service intervention. One area that we are focused on is how we can use new technologies. One of the things that we know about older people is that they will come to look for assistance when it is too late, or they might come to our attention without having looked for assistance. For example, we know from research that a serious fall often happens when the person has already had several falls. It might be that no one outside the person's family knows about those falls, and sometimes people will conceal the fact that they have had falls, because they think that as soon as the issue is opened up, there will be a massive level of intervention and they will have to go into care.

We have used technology by developing a website called making life easier, which allows people to access information without having to go to a service. Many of us know from direct experience of having an older relative that when we say that they should get some help and that we can do things to help them, they say that they do not want to be referred to social work. If the people who are on one side of that conversation are internet-capable, they can say, "Let's look on a website and see what there is in this local authority area." They will find our website, which gives information about preventing falls and about small aids and adaptations that can be ordered online and delivered without a referral ever being made to formal services. That is an area in which we see great potential for prevention and for avoiding the person having to come into the formal service, or at least delaying the point at which they have to do so. That is more acceptable to many people, because they do not want to be identified in the existing service configuration.

11:00

Siobhan McMahon: I return to the issue of how we identify people and prevent them from falling through the gap. I understand the example that Joe McElholm gave, but if someone is not competent in using a computer, does not have a supportive family, is on their own, does not want to bother anyone and does not want to tell people that they are having falls, where should they go? How are those people identified?

A young person might have gone to a primary school where everything was on one level and the support might have been wonderful, but when they find themselves in high school, the fact that it is on three levels means that no one really understood that, because they were not doing home economics or technical studies, they would have a problem when they got there. How are such young people identified? How does the integration that we are now seeing through, for example, the Public Bodies (Joint Working) (Scotland) Act 2014 support young people and older people who are in those circumstances?

The Convener: I ask the witnesses to keep their answers a bit tighter, as we have three other members who want to ask questions.

Iona Colvin: Okay.

In Ayrshire and Arran, we have put children's services—along with criminal justice—into the partnership for the reasons that you mention, because of the transitions issue. We want to be able to plan better for children. We know that children with disabilities come through the system, so it is a case of better planning and knowing who those children are.

As far as your general question is concerned, when it comes to the strategic approach for children, the big ideas are about building a multidisciplinary approach, which involves having teams around children in the early years, in primary and secondary and for children who are out of school, so that we pick up kids who need support. We are doing some work with the Social Research Unit at Dartington that will identify what children are saying in each of the school cluster areas.

For adults, it is a case of attaching ourselves to general practice, building the pathways around general practice and integrating the services, because most people will go to see their GP and it is likely that their GP will be the first person who gets involved. We need to recognise that and do what we need to do to facilitate the services around GPs so that we can move people through the system and into the right part of it, take some of the burden off the GPs and work hand in hand with them on delivery.

Professor Mercer: An example of that is the deep-end link worker project, which I and colleagues are evaluating. The cabinet secretary has announced funding for the project for the next two to three years. The project is designed to deal with the situation in which, although there might be a lot of community support in an area, there are people who are isolated and GPs often do not know what is available for them in the community, particularly in deprived areas, because they do not live there.

The link worker is a fairly highly skilled person, often from a community development background, who is based in the GP practice. When a GP sees a patient and picks up the fact that they are isolated, they can refer the person to the link worker, who will see them the next day. The link worker will go through what is available locally. There is the local information system for Scotland, which is called ALISS. It can be localised for all sorts of things—for example, someone might run a lunch group or a walking group.

We are at the very start of the project, which is being run in seven practices in Glasgow. The good thing about it from my point of view—I would say this—is that a reasonable amount of money is going into evaluation, and it is being done as a randomised control trial. There are 15 practices, half of which are getting the intervention and half of which are not. That means that we will be able to compare the two groups of practices to find out whether having such a link worker works, whether it is cost effective, how many people get the service and whether it will do what we think that it will do. There are many examples of good local projects, but often we do not evaluate them. No one pulls that work together. For me, that is a frustration. We do high-level academic stuff, which involves big numbers, and there is brilliant stuff happening on the ground. We need to bring those two worlds together, and I think that the evaluation of that is extremely important.

That example, which involves link workers who are not medically qualified—they do not need to be, as they have a totally different set of skills—and who work closely with statutory services and the third sector, could be a model for the future.

Siobhan McMahon: My next question is based on Professor Mercer's comments about the money that is allocated. Everyone can say that they want more money, so I do not expect that answer, because it is always the answer. However, £173.5 million has been set aside in the draft budget for the integration fund. Is that reasonable? Iona Colvin spoke about what that means for her local authority in the grand scheme of things. Can you do all the things that you wish to do with that money? Is it reasonable to ask that of you, given the current climate? I understand that we all want more money, but is that reasonable?

Iona Colvin: It depends how we use it. In Ayrshire, we would want to use it to make the changes so that we integrate the health and social care components and make best use of the resource that we have. We would do something similar to what Professor Mercer has described with the GPs, and that will begin to make some of the changes. It is not enough to make the big shift, as we have said, but we need to use the resources to begin to make inroads towards making the big shift. Because we have been guaranteed money for only a year—we understand why that is—it is not enough to set up a whole lot of new services. We have to change the way in which we use the services, and our proposals are similar to those that Professor Mercer mentioned.

The Convener: Does John Finnie still have questions to ask?

John Finnie: They have been covered. Thank you, convener.

The Convener: I think that Alex Johnstone has some questions.

Alex Johnstone: Professor Mercer mentioned the distribution of primary care and how it tends to

be fairly even across the country and does not reflect demand. Have the planning aspects of the integration of health and social care taken proper account of that?

Professor Mercer: To the best of my knowledge, I do not think that that is taken into account. The flat distribution is historic, as GP numbers are distributed largely according to population count, and some inflation is given for working in deprived areas, but I have not heard of any current planning that takes that distribution into account.

Last week, the cabinet secretary announced an extra £43 million over the next year, part of which will go into deprived areas and general practice in deprived areas. That is welcome. We do not know yet how that money will be spent and it is only for one year, so it will not solve the fundamental problem, but it is certainly a step in the right direction. I do not know of anything that will reverse the inverse care law.

Alex Johnstone: Are GPs being properly taken into the integration process?

Professor Mercer: The inclusion of GPs in locality planning is welcome. GPs need to be involved in that, but I do not know how uniform their inclusion is across Scotland; I think that it tends to be piecemeal. In terms of health inequalities and deprivation, it is still a level playing field in the face of a relative decrease in the spend on GPs over the years, so I do not think that it will fundamentally change.

Iona Colvin: It is fundamental that GPs are involved in the integration process, because they are part of the solution and we cannot deliver what we need to deliver without them. We have engaged with them directly and they will be represented on the integration joint boards in Ayrshire. They are currently on the shadow board.

We have a job to do with GPs, because they feel quite disenfranchised from what has gone before and from the community health partnerships. That will vary across the country, but I know that it is the case in Ayrshire. It is very much a case of talking to GPs and engaging with them, so we are meeting them regularly. We see clearly that GPs need to be part of the solution, because we cannot resolve all those issues unless they are absolutely at the heart of it. We also plan to have GP leadership in our management team.

Alex Johnstone: Will self-directed support have any effect on changing the balance?

Joe McElholm: Yes. Self-directed support will reinforce the continued focus on shifting the balance of care. It will give some people options to manage their support in ways that have not been available to them prior to the new legislation. It is a big part of moving into the future as far as the balance of care is concerned.

There will be differential uptake of the various options under self-directed support. In North Lanarkshire, more older people are starting to use the option of taking individual budgets, although not everybody will want to do that.

Alex Johnstone: Is the budget adequate?

Joe McElholm: You probably know the answer to that question. The change funds do not change the fundamentals of the budget; they provide an opportunity to reshape, to redesign and to take a step back. Professor Mercer made a point about starting with a clean sheet, and the change funds allow us to do a little bit of that, which is very welcome.

Delivering within the current budget is a really big challenge, and the coming years will be harder still. As your colleague said, we cannot keep saying that we want more money, because we know what the answer is to that, too. We must find different ways of working, and we must work with some of the principles that were clearly set out in the Christie report in order to establish how we can reshape what we do within the financial realities that we work in.

John Finnie: What will be the specific purpose of the integrated care funding? What uses will it be put to?

Iona Colvin: In North Ayrshire—and, I think, in the other two Ayrshires—we are examining the legacy of reshaping the care of older people and asking what bits of that we want to sustain and change over the next 12 months. Around a third of that involves considering how we change what we are doing and how we integrate things. For example, we have two mental health teams—a social work mental health team and an NHS mental health team. There is an NHS learning disability team and a social work learning disability team. There are a number of areas in which we have separate services for older people, and we will focus on putting them together, reducing duplication and forming multidisciplinary teams by the end of the 12 months.

The other focus—

John Finnie: I am sorry to interrupt. Some people might assume that that would bring savings, rather than acquire costs.

Iona Colvin: Yes, some people might—especially my director of finance.

John Finnie: But ultimately there will be savings.

Iona Colvin: Ultimately there will be savings. We have set up a pan-partnership management team, so that one management team manages all

the resource, including that for the whole of mental health. There are savings there as far as management structures are concerned.

Moreover, there will be savings because we will not do things two or three times, as we currently do; we will do them once. It will take a bit of time to reach that point, but the increases in demand are challenging us all. Demand has continued to increase as the budget has decreased. In North Ayrshire, we have about £2.5 million of overspend in older-people services related to care at home and care homes, and that is still not meeting the totality of the need.

The challenge for us, first, is how we provide the services and stay within budget or stay at an acceptable level for our elected members. The second part of that—the bit of the model that we want to work through—is how we attach to primary care and particularly to general practice. That is very much to do with the things that Professor Mercer talked about; it is a matter of organising services differently. Thirdly, an innovation fund has been organised by our third sector colleagues, who are looking at innovative approaches that the third and independent sectors want to come up with. Those will probably be smaller schemes that are focused on addressing some of the issues that Joe McElholm raised about services and providing support to people.

11:15

One of the problems with the reshaping care for older people policy was that it was quite strict and had to be focused on the over-65s. As we have discussed, particularly in areas such as Irvine and the three towns, there are people in their 40s and 50s who are just as sick. We need to consider what we learned from the policy that was good, what we would want to extend and what else we want to do. We have to work hand in hand with the third sector to get its best ideas generated.

John Finnie: Can I pose a very quick question to the professor, convener?

The Convener: Yes. Can we have a very concise answer please, Professor Mercer?

John Finnie: You mentioned the £43 million that was announced recently. I represent the Highlands and Islands. Last week I asked the largest health board there whether there was any intimation of how that would be spent. A lot of the discussion has been about urban deprivation. You will be aware that rural deprivation, when it is compounded by issues of geography, is significant. Is enough attention being paid to that in the budget formula?

Professor Mercer: Do you mean attention to rural areas?

John Finnie: Yes. As you know, there are particular challenges in rural areas in getting medical services and innovative ways of delivering them, not least those challenges connected with the GP contracts.

Professor Mercer: I am not too sure of the detail of that, but in general terms, the issue of an ageing population is worse in rural areas. The Highlands and Islands are ageing faster than urban areas. The problems will accelerate. I am not sure whether enough is being done. I do not know what my colleagues would say to that.

John Finnie: I do not think that we have time to pursue it. Thank you very much.

The Convener: Yes. We are running out of time. Marco Biagi would like to ask some questions.

Marco Biagi: I have heard a lot about how well things are working with the third sector in North Lanarkshire. Are they working as well in the other 31 local authorities?

The Convener: Iona, would you like to comment on North Ayrshire?

Iona Colvin: I think that things are working quite well in North Ayrshire, but I would say that. In Ayrshire the third sector has been very much engaged in the work that we have done to set up the health and social care partnership. We have been working on it for nearly two years now. Our council agreed about 18 months ago the model that we would look at and all the services that we would put in. We have been working in partnership across the three Ayrshires and with the health board to create the structures. The third sector has been involved all the way along.

Marco Biagi: Would you say that your experience—[*Interruption*.] Well, I see others shaking their heads, so I will not finish my question but pass over to Professor Mercer.

Professor Mercer: Integration between the third sector and primary care—general practice—is at a very early stage. Some areas have much better links, which are historical. For example, in Craigmillar in Edinburgh, which is an area of high levels of deprivation, for 20 or 30 years there have been good relationships between the general practice and local organisations such as the Thistle Foundation. Equally deprived areas of Glasgow just do not have that. The picture is not the same across the piece.

We recently finished a project with the Royal College of General Practitioners called improving links in primary care, which had exactly that aim. We worked with four different practices for about two years. It was clear that one model does not fit every area. Although the policy is good, each local area has to work in its own way. For example, one

of the practices that we worked with was in a very affluent area. There were a lot of elderly people and a lot of commuters, whose needs were very different from the needs of people in Craigmillar in terms of the types of linkage required. In the more affluent areas, people did not need link workers, because they were quite able to look at a directory and so on. However, they needed communication with the practice.

From my point of view as a primary care practitioner and researcher, all this is at a very early stage. The Health and Social Care Alliance Scotland is a big player in this and is doing really good work. However, we should not think that it can be rolled out as a one-size-fits-all process, because it will evolve over time. The deep-end link worker project is an example of a model that might not work across the piece. I think that it will take about five years before we really know how to do this.

Marco Biagi: Is it the case then that third sector providers could work quite well at the strategic level for the board and possibly deliver services almost in parallel in certain areas, and have communications with, but maybe not connect at, the GP line unless there is a history of that?

Professor Mercer: That is entirely possible.

Marco Biagi: That is my take on it.

Iona Colvin: I can see why that happens, because it is about the history and who holds the contracts. However, the partnership will hold the contracts. The social care budget for North Ayrshire is about £95 million, half of which is spent in the third and independent sectors. The approach that we have taken is that they are our key partners as we go into a partnership with everybody else. If that works properly, it should bring the relationships that Professor Mercer talked about as we tie in the third sector as well.

Marco Biagi: Is there enough financial emphasis and recognisable funding streams coming from the centre to support the need to develop working with the third sector?

Iona Colvin: Is that question for me?

Marco Biagi: It is for whoever wants to answer it.

Professor Mercer: From a primary care point of view, I think that the answer is no. As I said, things are at an early stage. The deep-end link worker project has been well funded and well supported, but it involves only seven practices. If the project was a big success, the question would be whether that level of funding would be rolled out or whether that would be too costly. That is why we need good evaluation, including health economic evaluation. If we can show that that sort of intervention is cost effective, it will take on a very different slant. From a general practice point of view, the answer to your question would almost certainly be no, because that journey is just starting.

Marco Biagi: Is the project funded centrally by the Scottish Government? Give me a quick yes or no, please.

Professor Mercer: Yes, as far as I know—through the Health and Social Care Alliance.

The Convener: As members have no further questions, I thank the witnesses for coming. The session has been very informative and I am sure that we could have gone on for another two or three hours, or more. Our next meeting will take place on Thursday 20 November.

Meeting closed at 11:22.

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e-format first available
ISBN 978-1-78534-269-1

Revised e-format available
ISBN 978-1-78534-285-1

Printed in Scotland by APS Group Scotland