OFFICIAL REPORT
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Public Audit and Post-legislative Scrutiny Committee

Thursday 27 October 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
6th Meeting 2016, Session 5

CONVENER

*Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Alison Harris (Central Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Liam Kerr (North East Scotland) (Con)
*Monica Lennon (Central Scotland) (Lab)
*Alex Neil (Airdrie and Shotts) (SNP)
*Gail Ross (Caithness, Sutherland and Ross) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Bill Alexander (Highland Partnership)
Jan Baird (Highland Partnership)
Robert Calderwood (NHS Greater Glasgow and Clyde)
Mark White (NHS Greater Glasgow and Clyde)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 27 October 2016

[The Convener opened the meeting at 09:01]

Decision on Taking Business in Private

The Convener (Jenny Marra): Good morning and welcome to the sixth meeting of the Public Audit and Post-legislative Scrutiny Committee. I ask those present to switch off their electronic devices or switch them to silent mode so that they do not affect the committee's work this morning.

Under agenda item 1, the committee is invited to agree to take in private item 3, which is consideration of evidence received under item 2 on the "Changing models of health and social care" report, and item 4, which is consideration of the committee's work programme. Are members agreed?

Members *indicated agreement.*

Section 23 Report

"Changing models of health and social care"

09:02

The Convener: Item 2 is an evidence-taking session on the Auditor General for Scotland's report "Changing models of health and social care". We have already taken oral evidence on the report from the Auditor General, the Scottish Government and two social care partnerships, and we have agreed to take further evidence today, including on the extent to which funding decisions are allowing new models of health and social care to develop fully. I therefore welcome to the meeting Jan Baird, director of adult care in NHS Highland, and Bill Alexander, director of care and learning in Highland Council, who are representing the Highland partnership; and Robert Calderwood, chief executive, and Mark White, director of finance, NHS Greater Glasgow and Clyde.

First of all, I will invite Jan Baird to make a brief opening statement. I understand that NHS Greater Glasgow and Clyde does not wish to make such a statement. Is that correct?

Robert Calderwood (NHS Greater Glasgow and Clyde): That is correct.

The Convener: Okay.

Jan Baird (Highland Partnership): Convener, thank you for inviting us and affording us the opportunity to say a few opening words.

The Highland partnership was the first to take the radical step of putting in place the integration that, in our view, was needed to change models of health and social care. The benefits of the lead agency can be summed up under three headings: single management; single budgets; and single governance.

We have single management of community health, children and family social work and education by one organisation, which is Highland Council, and we have single management of primary, secondary and community care for adults by another—NHS Highland. We have single budgets with the quantum to deliver all the functions that have been transferred from the commissioning agency to the lead agency. Given the amounts involved, that was a very brave step for the Highland Council in 2012. Finally, we have single governance, with clear accountability across the lead agency, an assurance route to the commissioner and committees and district partnerships in which elected members can be involved, can inform and can scrutinise.

In changing models of health and social care, we need to be transformational and engage every level—individual, team, community, organisation and national. Integration is neither a quick fix nor a magic bullet, but alongside strategic commissioning, an evidenced, outcome-focused approach, genuine and equal partnerships with the third and independent sectors, self-management and the rest, it is delivering change in Highland. It is a journey for which we have a clear plan and a methodology for driving the change that will reduce waste and harm, manage variation and drive up quality.

There are still a number of challenges, including how to embed and sustain some of the changes at community level while ensuring that the aspirations of the Community Empowerment (Scotland) Act 2015 enable that community-driven change; how to work with the Highland pounds—not health or social care pounds—while evidencing efficiency and effectiveness to commissioners; how to improve and sustain the flow across and between services and care so that patients and carers do not get caught up in systems or have unnecessary delays; and how to plan for increasing demand against a backdrop of reducing funds and when announcements of budget settlements are made at different stages of the planning cycle and changes to budgets and allocations can be made across the year.

Highland believes that it is essential to remain committed to changing models of health and social care, not forgetting that this is about improving lives, and that we work together to evidence the true benefits.

The Convener: Thank you very much. I invite questions from members.

Colin Beattie (Midlothian North and Musselburgh) (SNP): It is clear from the Auditor General's report that the changes are not proceeding as quickly or as efficiently as one would have hoped. What are the main challenges that integration authorities are finding in implementing the change? Clearly, there has to be an acceleration or step change to permit the changes to go through. It is a key policy, and it is absolutely essential that it happens.

Robert Calderwood: I will offer some observations on that. The first thing to understand is that the need for change means that we all need to agree that the status quo is not the most desirable outcome in the short to medium term. Therefore, we have to embrace change.

Colin Beattie: Do you believe that the status quo is sustainable?

Robert Calderwood: I believe that, if we pursue a model based on the status quo, there will be no ability, certainly in the short to medium term and particularly for the duration of the current parliamentary session, to move the significant resources that we aspire to move to primary, community and prevention services. We have to be brave and take forward the service redesign that allows us to make headroom in the overall health and social care economy so that we can make those changes.

As colleagues in the Parliament will be aware, NHS Greater Glasgow and Clyde is proposing a series of changes to how we deliver acute services, and we believe that they will provide a safe and sustainable range of services while releasing a significant resource to enhance community-based services. That has proved challenging, and continues to prove so as we go through the pre-engagement and consultation process, because the public and many elected officials believe that the status quo on hospital services is desirable. There needs to be a coming together and an understanding that we are all progressing change with a view to enhancing the population of Scotland in the medium to long term.

Jan Baird: I understand the frustrations that people have about the speed of change. When we were looking at the lead agency model, we visited Torbay, where, seven years in, people were just beginning to see changes. We are four and a half years down the route and we are seeing changes in outcomes. The focus has always been on outcomes, in the belief that efficiencies will flow from that. It is a major cultural change for not just some but all staff across our organisations, and we have to take our staff and our communities with us. It is important that we have a step change and that we do not see things as a quick fix. Whatever we change, we need to get the chocks in behind and not allow ourselves to slip back. We need to ensure that we sustain the change, because otherwise we will be having the same conversation 10 years down the line.

Colin Beattie: I am concerned by what I hear from Greater Glasgow and Clyde. I might be wrong, but it does not sound as if there is much impetus in or buy-in to the integration process.

Robert Calderwood: I have to disagree. Greater Glasgow and Clyde had the first joint community health and care partnership back in 2006, and the health board led on the whole idea of health and social care integration in the framework that we had in 2006. We are one of the health boards that have successfully agreed, with five of our six integration joint boards, that the totality of health and social care and criminal justice systems should be integrated into a successful organisation, because we believe that that is where we can make the biggest impact.

Over the past 10 years, we have made a series of investments working with colleagues in the

Government. For example, there has been significant investment in health and social care premises. In the past three or four years, we have opened six of the largest health and social care premises in Scotland; two premises are actively under construction; and business cases are well advanced for a further three.

One of our big investments has been in creating health and social care infrastructure and integration. Indeed, the health board has successfully taken matters forward through in its previous 2002 to 2015 acute services strategy, in which we closed five major acute hospitals on the back of building new, improved and more efficient healthcare facilities. As I have said, changes are currently out for consultation. Should they be agreed through due process, more resources will be transferred from acute services to health and social care partnerships.

Colin Beattie: Can you quantify what resources have already been made available to the IJBs?

Robert Calderwood: The IJBs that have been constructed in Glasgow are now strategically responsible for commissioning around 70 per cent of the board's available allocations.

Colin Beattie: Are the integrated budgets being used efficiently to achieve the required change?

Robert Calderwood: In any organisation that spends in excess of £3.1 billion of taxpayers' money, there are always opportunities to improve and learn. The various IJBs are at different stages in their journeys. When my colleague Julie Murray appeared before the committee, she intimated that our experience in East Renfrewshire has been of a single integrated organisation that goes back 10 years and which has many examples of successful integration.

We have had two episodes of engagement with Glasgow City Council, the first of which was back in 2006 to 2011, when we had the community health and care partnership. Since 2015, we have had the shadow IJB and now the formal IJB. The impact of that integration in the city has been a significant improvement in delayed discharges, and with its intermediate care and step-down facilities, the city has been very innovative in seeking to address what historically was one of the poorest delayed discharge performances in the Scottish health service.

Colin Beattie: Do you have a detailed plan for achieving your objectives?

Robert Calderwood: I would have to quantify what our various objectives are. Currently, the health board has to deal with multiple aspects of services. If we look at acute services and NHS Greater Glasgow and Clyde's activity, we see that in the period from 2012-13 through to 2015-16, for which we have the last full set of figures, there was a reduction of just under 2 per cent in emergency department attendances. That is going in the positive direction of providing the population with access to more appropriate and alternative facilities. Despite that, over the same period, there was a rise of some 9.6 per cent in emergency admissions. That recognises, as the Auditor General for Scotland's report published this morning recognises, the demographics of Scotland's population, the ageing population and the fact that, regrettably, we make greater use of national health service services with age.

Against that backdrop, we have continued to move resources into and the emphasis on to primary and community services while dealing with the pressure on the acute services. As I keep saying, we have proposals to further redesign acute services, the principal aim of which is to meet healthcare needs in an acute environment for patients who need to be there and to create a more comprehensive range of community and primary care facilities for patients who should not be in the acute setting. As the Auditor General points out in paragraph 3 of part 1 of her report and later on, that requires us to take quite bold decisions to move out of institutional care, release that money and put it into community and primary care alternatives.

Colin Beattie: Highland is perhaps a wee bit further ahead than a lot of other areas. How are the lessons that you have learned along the way being shared with other organisations?

09:15

Bill Alexander (Highland Partnership): In many ways, they are not. For various reasons, we adopted the lead agency model, whereas other boards adopted the integration joint board model, which involves an entirely different governance process, decision-making process and financial model. Perhaps the integration joint boards do not think that there is a lot to learn from a lead agency.

Nonetheless, there are opportunities for sharing because, although the structures are important, this is all about systems getting along together. To pick up on Mr Beattie's first point, I should say that all that we managed to do when we achieved integration in 2012 was to bring two structures together; we did not deliver integrated services, cut out duplication or implement preventative responses. We have had to work through the change that has been possible following that structural change. Whether an organisation is an integration joint board or a lead agency, it still has to put in place those process changes and bring people together. There is a lot of room for learning, but I do not know that there has been much sharing to date across Scotland.

Colin Beattie: Is there any mechanism in place for that? Is anybody managing it?

Bill Alexander: There are a lot of different groupings. Social work directors, education directors and chief executives of NHS boards come together in their respective groups, but we do not have a single forum in which to discuss integration strategically as a collective. The chief officers for the IJBs come together, but we do not have those strategic discussions.

Colin Beattie: So there is no formal process for sharing experiences in different areas.

Bill Alexander: No.

Colin Beattie: That sounds unfortunate.

Jan Baird: The biggest advantage is in bringing the IJB chief officers together, and we are part of that. Although we do not fit in the sense that we do not have a chief officer in the same way, we provide input to that forum. It would be useful to have such discussions, and everyone would welcome it as a place for sharing good practice.

The Convener: I should ask the same question of NHS Greater Glasgow and Clyde. There is no forum in Highland to enable IJBs to share their experiences. Is there one in your area?

Robert Calderwood: There is. The six chief officers regularly meet as a collective to look at the balance of locality need and planning for localities versus interacting with the board, which serves a population of 1.15 million, to ensure that we do not have postcode prescribing and that there is broad consistency in the direction of travel. In that interaction with the acute service as a single entity in NHS Greater Glasgow and Clyde, the six chief officers act as a collective.

Where services are small and provided across the board, they are embedded in the lead agency approach in one of the IJBs. A single chief officer, such as Keith Redpath as chief officer for West Dunbartonshire, is responsible for board-wide musculoskeletal services and physiotherapy in the community across all six partnerships.

Jan Baird has alluded to the regular meetings that the chief officers have with colleagues in the Scottish Government health department, under the auspices of Geoff Huggins and Paul Gray, to talk about opportunities for learning and to learn about challenges and difficulties. There are a number of fora in which IJBs can interact and learn. Audit Scotland, along with other external agencies, can bring forward examples of good practice and commend them to the system.

Liam Kerr (North East Scotland) (Con): Good morning. I am interested in the people issues, in particular the roles of general practitioners and staff. The report mentions that GPs are central to developing new types of care. There are pressures building in general practice, which we know about, and the report suggests that new models of care are needed.

What precisely are those new models of care? How do you see the development of GP recruitment and training being adapted to those new care models?

Jan Baird: We acknowledge the role of GPs and all our staff. They have been central to—indeed, at the heart of—the developments around community care and providing a community service.

We have a number of different models, including community huddles and virtual wards, that involve GPs and the extended primary care team and community care team to ensure that we are proactively managing patients—particularly vulnerable patients—within the community. The recruitment of GPs and consultants is a challenge across Scotland, and we are looking at different models of delivering what would traditionally have been GP care.

We have to realise that we cannot be dependent on one person and one profession; we must take a multi-profession approach and look at where enhanced practitioners in the community might be able to supplement GP practices. It is a huge issue for communities in Highland, as people feel attached to their GP and want one in their community, so we must work closely with communities in taking the new models forward to ensure that they realise that the safety element is still there. That might involve some double running, but that will enable us to demonstrate that the model is safe for people and that they will receive a good-quality service without the dependence on GPs that there has perhaps been in the past.

Robert Calderwood: It is widely accepted that GPs need to be at the centre of developing a preventative culture and a community primary care-based service, and there are numerous pilots across Scotland that are looking at how GPs would fulfil that role. In his report for the review of out-of-hours services, Professor Sir Lewis Ritchie talks about the general practitioner of the future becoming the conductor of the orchestra rather than the soloist. It is all about multidisciplinary working.

The Government has supported an initiative to recruit a significant number of additional pharmacists with the aim of embedding pharmacy in general practice where clusters of GPs come together to work in practices. There is also the issue of what colleagues have referred to as people working at the top of their licence, so that nurses and allied health professionals all take on a

bigger workload as part of the primary care service alongside the general practitioner. A number of such initiatives are going ahead.

That should have a positive impact on GP recruitment. However, we encounter many factors around GP recruitment, and they all relate to why we find ourselves in the position that we are in at the moment. Over the next five to 10 years—a regrettably long period—we will need to work effectively to put primary care front and centre from day 1 in the medical schools and right through the whole service.

I read in previous evidence about the model of the GP principal being—dare I say it?—a private businessman with a section 17C contract whereby they are a salaried part of a team. Such things need to be part of the debate as we go forward, and they will all impact on primary care differently in various health boards. That may be to do with the need to increase recruitment in remote and rural areas that the Government has been seeking to address through the premiums that are attached to GPs who undertake training for remote and rural practice, or it may be about recognising that we have a changing workforce and a significantly greater proportion of female medical graduates, who have different expectations of how they want their career to be planned. We need to be aware of that and work with them to ensure that we create career opportunities that fit with the changing workforce demographic.

Liam Kerr: I will come back to that in a second. Jan Baird points out that there is a challenge across the whole of Scotland. Is there—or is there going to be—a nationally co-ordinated approach to recruitment and training?

Jan Baird: I am not aware of that, but I am sure that there needs to be and that there will be. We are exploring the models that Mr Calderwood referred to, particularly around salaried GPs, as well as our model of integrated teams with a GP as the single point of access.

With regard to the training of GPs and the expectations of GPs and other professions in the future, an important point is that we still seem to be training people in silos even though we do not work in silos any more, which means that people come out of training with expectations of working in a particular way in primary care or secondary care and have to re-learn how to work. That is extremely challenging for a health board when we have to continually keep the system moving. I would welcome the opportunity to have some time with our universities and training colleges to encourage them to think about the legislation and the joint working that we expect in the future.

Liam Kerr: That is an important point. This committee knows that I have a thing about scenario planning, modelling and so on. My penultimate question to you is: what workforce planning is being carried out? Mr Calderwood talked about a time horizon of five to 10 years. Why is that the time horizon? What scenario planning is being done? What modelling is being done to look at the needs of the future?

Robert Calderwood: There are two aspects to that. First, NHS Education Scotland is responsible for working with the Government and colleagues across higher education to look at the educational component and the intakes to the medical schools, nursing colleges and so on. There is therefore a central co-ordinating body in the NHS in Scotland that creates a conduit for dialogue with the higher education sector and sets out the needs.

Also, Shirley Rogers, who is director of human resources and organisational development in the Scottish Government's health directorate, has a significant role in co-ordinating the individual health boards' workforce planning scenarios and making sure that they are future-proofed with regard to how we deal with succession planning and future recruitment. To put that in context, we have a shortage of GP principals and we have an inability today to fully recruit to the training opportunities that exist in Scotland. Those two issues will be addressed in the medium to long term only by making general practice much more attractive in the medical schools and therefore in the career development of medical graduates.

We need to discuss the short-term issue of making Scotland more attractive to existing general practitioners. Again, the issue is being addressed by the Government looking at the long term with regard to increasing the number of GP trainees and creating incentives for them to be the kind of general practitioners that Scotland, with its geographical constraints, needs. In the short term, though, the Government has been taking forward pilots in various health economies across the system, such as the deep-end practice initiative, which has been working in some areas of deprivation in greater Glasgow, and initiatives that colleagues in other health boards are taking forward that are about working with the general practice population of today to make general practice more safe, sustainable and desirable.

Professor Sir Lewis Ritchie, who I mentioned previously, was commissioned by the Government to look at the out-of-hours service. Since 2004, it has not been a contractual obligation for general practitioners to look after their registered population list out of hours. We have seen the out-of-hours service decline as a fundamental part of general practice. To take NHS Greater Glasgow and Clyde as an example, in 2004 we had 650-plus general practitioners registered to take shifts on for the out-of-hours service, but that figure is

now down to just over 300, despite the fact that the number of general practitioners in Glasgow is higher—I do not have the exact numbers with me. We have more general practitioners working in Glasgow today but fewer of them will register for out-of-hours work, which puts significant pressure on the service. That is the point that I was alluding to when talking about having to understand the work-life balance and aspirations of our current and future workforce.

Jan Baird: We have a workforce plan that takes us from the short to the medium and longer term—recently, it has been extended to cover the period up to 2035. However, at the moment, we are focused on testing out new models because we think that it is important to give support to existing GPs, recognising the retirement rate that is coming towards us. We want to build more flexibility into the roles of GPs and give them more support. We are also looking at how we can redesign the out-of-hours service to deliver it differently. All that work is being driven in the communities and with colleagues and partners, such as the Scottish Ambulance Service.

09:30

Liam Kerr: I have a final point. The report makes a number of recommendations about the 2020 vision and suggests that, by the end of 2016, there should be a clear framework, with predictions of supply and demand being aligned with recruitment and training plans. We are at the end of October. Has the Scottish Government provided that clear framework of how it expects NHS boards, councils and integration authorities to achieve the 2020 vision?

Jan Baird: I do not have specific information on that, I am afraid. I know that we are working to the 2020 vision and that our local plans reflect that. I would have to speak to human resources colleagues to get you that information, if that would be helpful.

Liam Kerr: Sure.

Robert Calderwood: I will make two points. I have alluded to the fact that Shirley Rogers is co-ordinating and bringing together all the health boards' workforce plans into a coherent whole so that Scotland's needs over agreed time horizons can be looked at. When Paul Gray gave evidence to the committee, he alluded to the Government's commitment to publishing the plans by the end of the year. To the best of my knowledge all the organisations are working towards that position.

Monica Lennon (Central Scotland) (Lab): Good morning. In the Audit Scotland report "Changing models of health and social care", we see that councils and NHS boards in general are finding it difficult to agree budgets for the new integration authorities. Does that reflect your experience in NHS Greater Glasgow and Clyde and NHS Highland?

Robert Calderwood: Not from our perspective, no. I think that all six IJBs recognise the difficulty that we had in the first year, because there was a significant gap in the timing between the approval of the draft finance bill and the ultimate allocations to health boards. Traditionally, the draft bill has been introduced towards the end of September or early October, with the Parliament approving it in early to mid-February. Health boards do not get definitive allocations until after that process.

Normally, my allocation letter from Paul Gray as director general would come in early March. For this year's allocation, the process was extended because of other issues, so it was mid to late May before the health board was in final receipt of its total allocations and its gross income for 2016-17.

Throughout the process, the chief financial officers, along with the chief officers of the IJBs, worked collectively with the board's executives to deal with the scenario planning that underpins how those resources are used to meet the population's needs. If you were to ask whether people would have welcomed more funding to deal with the challenges that they were being confronted with, the answer would have been undoubtedly yes. All my colleagues would have welcomed more resources to deal with the challenges.

There was full transparency throughout this year's process. Although there was greater certainty in the period between October and councils taking definitive decisions at their meetings in early February, there was the same transparency of risk in the health board's position. We made that clear in looking at the board's 2015 expenditure for all the embedded services. The chief financial officers were involved with Mark White and his colleagues, and they saw the rollover of those allocations, the uplift that the health board had received and the Government priorities. We then debated how we would choose the resources to deal with inflationary pressures and the Government priorities for 2016-17, which resulted in a service profile that is underpinned by that financial resource.

Monica Lennon: How long did it take to set the budget? When did you set it?

Robert Calderwood: Notification of the final budget for the IJBs was given in writing at the end of June, after the board's local delivery plan was set and discussions with the Government were concluded, and after the board's annual accounts for 2015-16 and the rollover consequences of that were agreed with our external auditors, Audit Scotland.

Bill Alexander: Is agreeing the budget for the Highland partnership difficult? Absolutely. It is probably the thing that is the most difficult. Have we managed to do it? Yes, we have managed to do it.

It is difficult for the reasons that Mr Calderwood has set out. We have two separate channels of funding that have to be brought together. Mr Calderwood talked about the timescales. The process is not helped by the fact that we have single-year budget setting. Highland Council gave NHS Highland a three-year financial commitment but, this year, we were not able to honour that because of the significantly different grant settlement, which we learned about very late on. The process is clearly difficult when there are flat or reducing budgets at a time of increasing and significant demand. It is also difficult when the channels of funding have to be spread more widely. The channel that the council gets has to fund adult social care but it also has to fund filling potholes and the running of schools, so politicians have difficult decisions to make.

All of that is very challenging. We have managed to come to an agreement in part because we have structures but also, in large part, because we have relationships and we work through things. Ultimately, it is because the greater imperative is to achieve that and keep going, because we can deliver an integrated service only if we resolve that challenge. That is probably the final overriding issue that hangs in there when you walk away at 7 o'clock at night, having still not quite sorted things out. You do not say, "Let's stop and chuck it." Instead, you say, "We have to get through this," and you just keep working at it.

Highland Council agreed in its February budget meeting what the allocation would be to NHS Highland and NHS Highland knew in advance of February what that was likely to be, but it was not easy to get there and it will not be easy to get there this year, either.

Monica Lennon: Thank you—I appreciate your openness about the difficulty of the challenges. Both Highland and Glasgow have been able to set budgets for this year, but do you have budgets, or indicative budgets, for next year?

Bill Alexander: In Highland, we are working on a scenario—we are scenario planning—but that is based on assumptions about what the council's grant settlement might be and on what the NHS might get, and we will not know until December whether those are true. Those assumptions will be discussed at various levels in the two organisations, including senior officer level and elected member level, but we will not actually know until December how much money the organisations will have, so we will not be able to conclude those discussions until then, in advance of what will again be a February budget for the council.

Mark White (NHS Greater Glasgow and Clyde): The situation in Glasgow is similar. We have a budget for 2016-17 and we are coming to the mid-year point. We are performing a detailed review of that, which is proving challenging, so we are not out of the woods yet for 2016-17—although we have a budget, it has some risks in it. On 2017-18, as my colleagues have alluded to, we have attempted to bring the planning process forward to align much more with that of local authorities, but we still have some way to go with that. NHS Greater Glasgow and Clyde certainly plans to issue to our IJBs indicative numbers within the next 10 days to two weeks. Obviously, those will be heavily caveated and will depend on a number of factors, such as the outturn from 2016-17 and the budget that will come in the middle of December. We are striving to achieve a much more aligned process, but that has its difficulties.

Jan Baird: We all strive to have a longer plan—a three-year plan—so that we can get on with the business. The process of debating and deciding takes up a huge amount of the energy and time of officers in the council and the NHS. It is a very important decision, but it takes a lot of time every year. If we could agree a three-year plan and be clear about what our budgets would be, that would let us get on with it and would be welcomed.

Monica Lennon: Bill Alexander made a point about late nights. I am sure that you are all working very hard and against the clock. Given that you are working those long hours just trying to get things signed off for the year, and given the scale of transformational change that you are trying to achieve and the challenges that you face, do you feel at all optimistic that the outcomes can be delivered?

Bill Alexander: Absolutely—although there is still that challenge. Jan Baird and I met with councillors at the end of last week and we told the story that she and I used to meet at breakfast and then lunch, and then we used to shout at each other at teatime every single day to try to run joined-up services.

Joined-up services are better than silo working, but they are very bureaucratic and laborious. In terms of bureaucracy and hassle, they are a hell of a lot of work. Having an integrated arrangement where we just let one system get on and do it is much easier, but there is still hassle and bureaucracy, and budget setting is the greatest challenge.

Jan Baird: We have to make it work, however, because there is no alternative. We cannot

continue to do what we have done in the past. When we launched integration in 2012, the plan was to have a joint board with complete sign-up to it. Everyone agreed that it was about making things better for the people of Highland, and that is what we have to hold on to.

Robert Calderwood: Health and social care integration is a much-needed way to address the challenges of the Scottish population. As a structural change, bringing together health and social care and looking to plan them on a bottom-up, locality basis is absolutely the right building block. We have to be bold in that ambition and understand that we are going to have to make sizeable changes to the way that we meet the population's needs.

If I may refer to the past, the last time we embarked on anything this ambitious was in the early 1990s in relation to mental health and learning disabilities. We all agreed that it was wrong to have large hospital institutions where people spent inordinate lengths of time in institutional care—years or lifetimes in the case of people with learning disabilities. In those days, we were more able to create what was referred to as bridging finance whereby we could roll out a programme across Scotland, using a rolling programme of bridging finance to create alternative community facilities and then, with the new facilities in place, run down and ultimately close those institutions.

To put that in context, in a period of less than 20 years, just in the Greater Glasgow and Clyde area, we have gone from having almost 3,000 learning disability beds to fewer than a few hundred, and from 5,000 to 6,000 mental health beds down to 1,100 or 1,200, and the service is significantly better. It all community based and is all about intervention and prevention.

That is an indication of what we can do. We now have to achieve the same effects in a more constrained financial environment. That is about making those bold changes to community services and prevention and taking out the costs from the institutions. That, across the piece, will be what dictates the pace. When clinicians across the piece say that they genuinely believe that the alternative is better, we have to be able to make that resource switch. We therefore have to be bold in switching off what has been the custom and practice.

Monica Lennon: You said earlier that there was a 10 per cent increase in emergency admissions between 2012-13 and 2015-16. In that context, how are pressures on acute budgets affecting the shift in resource that is needed?

Robert Calderwood: That is the rate-limiting factor. In the current financial year, 2016-17, our acute services are overspending against the allocated budgets, and that has been brought about for two principal reasons. First, the demand is changing. In some cases, that might be not numerical demand but the acuity of the patients coming into the system. We have the ability to treat patients differently and more aggressively due to changes that have been made in the Scottish health service, such as the changes with regard to access to end-of-life drugs. They are all important changes for individual clinical groups but, cumulatively, they have been behind the 10 per cent year-on-year rise in prescribing costs that Audit Scotland alludes to in its report this morning. Also, although an element of that is the volume going up, a large element is that we are now prescribing expensive drugs—what we call third and fourth-line treatments—to patient populations.

09:45

The acute sector is one of the conundrums. In Glasgow, for example, we are using fewer occupied bed days. If we look at the period that you mentioned—2012-13 to 2015-16—we have patients in hospitals for less time. We have reduced the bed days that we use. Although the population of admissions is rising, cumulatively, people are in hospital for 6 per cent fewer days. That is about clinical teams interacting with the patients, making use of faster access to diagnosis and greater use of interaction with social care colleagues for onward movement into the community and ultimately back to their own home.

So, at one level, that is a success story. However, the cost of that is significantly higher than it was in 2012-13. Despite the successes, we still have cost pressures. We need to continue to redesign acute services to strive to get the greatest efficiency. There have been many success stories over the years. The problem is that we have to take stock of where we are now in 2016. The previous success stories have only got us to where we are today, which is close to but not necessarily in balance.

Monica Lennon: But surely a 10 per cent increase in emergency admissions is not a success.

Robert Calderwood: I am saying that we can handle that 10 per cent increase in admissions, in the expectation that it will go down. However, at the moment we cannot handle it in a more efficient way. At the moment, the clinical community in Scotland would sign up to handling the current demand in a different way within acute services, which would have the impact of improving efficiency and improving care for patients. However, that would not be on the basis of how we do it tonight; it would be about using our premises and staff differently.

Monica Lennon: How much is that overspend?

Robert Calderwood: For Glasgow this year? As an accountable officer, I am not allowed to overspend. The official answer—just because my colleagues in Audit Scotland are behind me—is that I will not have overspent on 31 March. The pressure at the moment is that we are—

Monica Lennon: Sorry, but just for clarity, you mentioned an overspend—

Robert Calderwood: Yes, as we said, as we sit here in 2016, the acute division is about £9 million overspent.

Jan Baird: I can give some examples from Highland, where we have similar pressures. We all feel those pressures from the demographics. Because of our lead agency model, we have been able to focus on improving the community services and enabling better choice for GPs or integrated teams when it comes to the decision to admit or not to admit.

That involves anticipatory care planning and virtual wards where consultants from the hospital and GPs and community teams plan together in relation to the vulnerable clients and patients they have in the community, to try to ensure that measures are in place to prevent admission. Having those choices for GPs has made a big difference. We now have no patients waiting to come out of hospital for care at home, because we have been able to work with our independent sector to improve how we deliver care at home and we have patients moving more quickly through the hospital for care at home.

It is not all a good news story, but it is for care at home. That also helps our reactive service to put in emergency or crisis care rather than somebody ending up in hospital, which is part of the problem.

Monica Lennon: What are your long-term plans for transferring resources from the acute sector into the community?

Jan Baird: We are developing our teams in the communities to work differently and to work differently with their colleagues in acute care. We have seen a significant shift over the years. Since we integrated, we have put a considerable amount of money into community care. The difficulty for colleagues sometimes is to see where the money is that is coming out of the acute sector. However, it is not a level playing field, because we still have increasing demand. As Mr Calderwood said, there are also expectations around new medications and new interventions, so there is still a huge demand on the acute sector.

We have made a shift, however. In 2011-12, we had a £70 million gap between our expenditure on community-based care and institution-based care; in 2014-15, that gap was reduced to £26 million. We are investing in our communities, keeping people in the community and preventing hospital admissions unless they are absolutely essential. It is about making sure that hospitals are treating people who need to be there and receive that level of care. Mr Calderwood referred to people working to the top of their licence.

Monica Lennon: I have one final point. I think that Robert Calderwood made a point about resistance to change, perhaps from local politicians or people in the community. What steps are you taking to engage with patients and communities to bring people with you on this journey?

Robert Calderwood: We are engaged on a range of initiatives. Through the IJBs' public engagement responsibilities and their patient panels, they are actively engaged on, dare I say it, a weekly basis. They do that through locality clusters.

There is significant engagement with the staff, whether with primary care community staff about alternative models or with acute staff about opportunities, and we provide regular interaction with our elected colleagues. With councillors, we do that through the IJBs. We also have direct interaction with MSPs through a newsletter or following an individual request for information, when we meet.

All future changes that are proposed by the board are signalled in our annual planning round. Depending on the changes, a comprehensive range of engagement and formal consultation must take place with service users, communities and elected officials, all of which results in final papers and recommendations coming back to the board. In some cases, the board makes recommendations to the cabinet secretary.

Bill Alexander: The vast majority of us would prefer community-based solutions for ourselves and our families. We often say that people would much rather stay at home than go into a care home and would much rather be supported in the community than be admitted to hospital.

Having said that, there is undoubtedly a challenge when it comes to reducing the number of beds, closing a ward or even closing a hospital in a community. That generates a response, which we need to work through. We do that in a range of ways. We endeavour to engage with community groups, local organisations and representatives of patients and service users in some of those change processes. We have a range of improvement groups, in which we have broad stakeholder involvement.

Another of our success stories has been that, when we initiated integration, we developed a range of what at the time were called district

partnerships, which were locality planning groups. We endeavoured to get community organisations based in those partnerships to talk through the changes. That has not been an easy journey. The notion of locality planning groups was included in the Public Bodies (Joint Working) (Scotland) Act 2014. We now have the Community Empowerment (Scotland) Act 2015, and we are transforming our district partnerships into local community partnerships.

We really believe that, if we engage with people round the table over a cup of coffee, we can change their way of thinking about things. We have some evidence of that. That does not mean that we do not still have major challenges with communities that view significant changes in the local infrastructure as very worrying and troubling—we always have a number of examples of those. When that feeling exists, it is difficult to recover the ground and to get back to basics. A lot of dialogue is necessary. Whenever possible, it is best to start with dialogue. Rather than coming to people with a plan, it is better to talk to them about developing a plan. It is a long road.

The Convener: In an earlier response to Monica Lennon, you said that integration makes things easier but that having two separate budgets and getting budget agreement does not. Are you suggesting that integration needs to go further?

Bill Alexander: The integration journey has been interesting. Through the 2000s, we all talked about getting to an integrated destination, and we asked when that would happen and what it might look like. I do not think that any of us believes that we have reached the end point, but we are well down the road. Unfortunately, no one ever gave us a map, so we do not know where the next turning might be. We have a compass and we are all walking in a particular direction, but there are a number of continuing developments. There is discussion about NHS governance, education governance, funding arrangements, the role of local government and local versus central, all of which will play into the process.

We believe that we can now consolidate and sustain the existing position and continue to move forward. However, the discussions about regionalisation and changes to local governance are troubling and unsettling, and I do not think that any of us thinks that we have reached the final destination.

We do a lot of work in the north with our island colleagues, and they certainly have aspirations towards a single public agency. They think that a single funding stream will be more helpful to them than two funding streams. That is more difficult to achieve elsewhere, but none of us thinks that we are at an end point.

The Convener: Does there need to be better governance of IJBs?

Bill Alexander: It is not for us to comment on IJB governance. We would suggest that our governance model has clearer roles and accountability. It has clearer roles for elected members, because they act as elected members. When they scrutinise the delivery of adult social care by NHS Highland, they do that as the council. There are fewer of them, which has been a challenge that we probably underestimated when we moved towards integration. When you move towards an integrated model, you are enlarging governance, because you have governance over a larger remit, but you are also reducing it, because you are sharing it out more broadly.

For example, I would have worked with 22 members at a committee, but we now have 11 members who scrutinise NHS Highland's delivery of adult social care. They act as elected members when scrutinising delivery, and they are confident to act as elected members. I am not quite sure what elected members on an IJB think that their role is, or whether that has been worked through.

We have gone through different iterations of governance. We started off with a model in 2012 and we have changed it this year. We will continue to review it, to try to get it right.

The Convener: You said that no one ever gave you a map for this. Is there a need across Scotland for clearer targets, benchmarks and best practice sharing for integration at national level?

Bill Alexander: We welcome any such strategic discussion. As I said earlier, there are lots of different groups meeting in different places. Two weeks ago, I was with the Association of Directors of Education in Scotland, talking about integration; I will be with chief social work officers next week, talking about integration; and there will be another meeting with chief officers of IJBs, talking about integration. I just think that it would be good if we had an overall structure, talking about integration.

When we integrated in 2012, we did it for Highland. I remember Alex Neil in 2011 thinking and talking on many platforms about developing integration on the back of what was starting to happen in Scotland. However, we worked out our model for Highland; we did not do it as part of a national initiative. It would have been great to have had a map that we could have Highlandised in order to get to where we wanted to get to.

Jan Baird: In terms of support, the significant shift—which is difficult for staff, difficult for evidencing and difficult for government—is in how we evidence outcomes. We are still asked for information about how many social workers or nurses we have, which means nothing if they are not good at their job. How do we ensure that our

indicators and targets reflect the outcomes that we are trying to achieve? That is very difficult to do. Government has been working on that and helping. We have just redesigned our performance management process with a balanced scorecard to try to reflect a link right back to the health and wellbeing outcomes, because they are what we are all trying to deliver. It is difficult to decide whether outcomes are wholly attributable to integration or whether integration just makes a contribution. Where do all the other things that we do fit in? Undoubtedly, all the other things together make up the jigsaw of achieving the outcomes. Taking them apart and trying to have indicators or targets against each of them is problematic and difficult to evidence.

The Convener: Mr Calderwood, do you agree that there needs to be a map or overall structure?

Robert Calderwood: There needs to be a clear understanding of the direction of travel and potentially a vision of some stations that we will pass through on that journey. There has to be the opportunity for local innovation.

The Convener: Who would identify those stations?

Robert Calderwood: There will be a combination. The Government has a significant role in setting the direction of travel for the health and social care services in Scotland as part of the public sector landscape.

The bottom-up innovation that is a core principle of the design of IJBs should not be lost. We have to watch that we do not end up with 57 varieties of everything, because there is an issue of equity for the Scottish people, but we should not have a single model to fit everywhere. If I look at Greater Glasgow and Clyde and Highland, I see that we have two different models.

We have—amicably, with council colleagues—created the governance structure and the service delivery organisation for our six IJBs. In the first year, no instances have been reported to me or my fellow local authority chief executives in which the IJB as a governance body has not collectively made a decision. I know of one instance in which something went to a vote but, in all other instances, the policies and the way forward have been jointly agreed.

To go back to your first question, about whether we are at an end point, I do not think that we are. The current legislation and organisational construct will mature, and the situation with duplication between parent bodies and the IJB will potentially develop over time, which may require a tweaking of regulation.

10:00

The Convener: My question was not whether we are at an end point, but whether we need more guidance on how to get to the end point.

Robert Calderwood: As I said, we need to be clear collectively about where we are going so that each of the IJBs and their respective parent bodies can demonstrate that they are progressing to that point.

Alex Neil (Airdrie and Shotts) (SNP): Going back to budgets, money is vital to the whole thing. You spoke about the time—including managerial time—and effort that are going into the negotiations, with 31 different partnerships across the country, and the uncertainty that is involved, which I appreciate.

Has the time now come for the Scottish Government to change the way in which it allocates money? Should it give each IJB a budget so that the social work and social care element, which is currently part of the local government settlement, and the health element, which is currently part of the health budget, are brought together? We can have a national support budget that is allocated to the 31 IJBs, which would remove all the negotiation and difficulty. I presume that, as we are now moving back to a three-year comprehensive spending review period, and on the basis of what Jan Baird said, the certainty of knowing in the next three years the minimum amount of money that will be coming would be extremely helpful.

It seems that we are almost at a stage at which we should be allocating the IJB budget directly, which would take all the nonsense out of the system.

Robert Calderwood: That would be a debate for the Parliament to have.

I have seen Paul Gray's evidence to the committee. At present, the Cabinet Secretary for Finance and the Constitution introduces the budget bill and the Parliament debates the use of the gross resource, which is then allocated to public sector priorities. In health, under the Cabinet Secretary for Health and Sport, there is a debate about how that works. Once the allocation to territorial boards is agreed, the resource is distributed under the NHS Scotland resource allocation committee formula. Much is made of that formula, and those of us who lose out always take a view on whether it really reflects our circumstances—it was always thus—but it is a recognised formula.

The money then comes to the health board, which—I can speak only for NHS Greater Glasgow and Clyde—takes cognisance of the NRAC formula. If we get a gross allocation for our

population of 1.15 million on the basis of those characteristics, we can subdivide that into the six IJBs using the same formula. There is an element of trying to be transparent all the way through from the Parliament to the IJBs.

On your second question, I personally do not think that the current construct in which the IJBs have a strategic commissioning role for acute services can work with a model where all the resource is not included.

The grey area—I was going to say the fudge—in the strategic commissioning of unscheduled care in an acute setting, with the health board in its current construct responsible for the balance of acute care—which is semi-elective care, the elective care and the regional and tertiary model—is that it would be very challenging for the Parliament to work all that out and decide that one element was for primary and community unscheduled care and that what was left was for the rest. You would have to work through that governance issue. If you were to look at true health and social care in primary and community settings, taking into account locality needs, you would have to work through that as a formula.

Alex Neil: Is that not because you have six joint boards whereas Highland has one? Would that model work in Highland?

Robert Calderwood: Although Highland is a single region, it is not single from a health and social care perspective, because Argyll and Bute IJB gets about 80 per cent of its acute care from NHS Greater Glasgow and Clyde simply because of the geography and the flows.

That model would work with the six or seven—I think that it is six—health boards that are coterminous with their local authority and therefore have a single IJB. If you put the totality of the funding in, you could work from a parliamentary level down. What that suggests—again, I stress that this is a personal view—is that you do not need three legal entities to do that if that is the model that you choose.

NHS Greater Glasgow and Clyde is a more extreme example, if you like, because we provide acute care for 10 IJBs, six of which are coterminous with our boundaries. Because of the geographical flows into our basic acute services, we also deal with Argyll and Bute, South Lanarkshire and North Ayrshire. In that model, it would be highly challenging to collect—almost in a purchaser-provider, old-speak way—money from those bodies, then arrive at a budget and design the acute service that the board, if it existed, would be responsible for commissioning. The debate has merit but it would have to be part of the journey. In my opinion, the current construct could not switch to that overnight.

Jan Baird: We would welcome any discussion on that issue and for the Scottish Government to reconsider it, given the issues that we have raised today about timing and our desire to lose the identity of the pound—an issue that is in legislation and guidance, too—and our aspiration to move to a health and social care pound all in one.

The other challenge is the one that local authorities have with other aspects of their budgets and where the cuts fall. Some areas of local authority budgets seem to be protected. Will adult social care be protected in the future, given the demographic and the change that we need to make? Currently, when some council services are protected, the cuts in other services are greater. Adult social care sits within that. Elected members have difficult decisions to make, so we would welcome it if the Government were to think differently about allocations of funding.

Bill Alexander: On the back of what Jan Baird has just said, elected members in Highland would certainly want me to say that we need to think about local democracy and the role of the elected member in deciding local priorities within their community. They would certainly not want that role to be lost.

Alex Neil: Let me rephrase the question without saying that a straightforward budget allocation from the Scottish Government to each IJB is necessarily the answer. Judging by what Robert Calderwood has said, as things stand, the relationship is quite complicated—particularly in Glasgow, where the board is dealing with six IJBs, not to mention what you do with Ayrshire and all the other bits and pieces. Given what you have said about the frustrations with the current way in which the money is allocated, is it time for the Government to look at doing that in a better way, without defining here what that better way would be?

Bill Alexander: Definitely.

Jan Baird: Yes.

Alex Neil: With all due respect, we have an army of finance people in all the different finance departments in the health service and in the local authority sector, and employing a lot of accountants is probably not the best use of resources when we need the money to go into services for patients. Is there agreement between both of you—although there are very different systems operating in Highland and in Glasgow—that now is the time to look at whether the system can be simplified and made more straightforward while, at the same time, ensuring that resources are allocated on the basis of need?

Robert Calderwood: There is merit in continuing the dialogue to see how we can move to that longer-term horizon of setting a budget over

a three-year period, which is what we aspire to do, so that the respective organisations' planning can be presented to communities with certainty regarding the direction of travel, the movement of resource and the consequences of that.

There is an element of duplication in the current system. It would be worth having a review after a period of time to see whether that duplication could be eradicated by relationships—Bill Alexander alluded to that—or whether streamlining is required. However, I come back to the point that I think we have all made, which is that health and social care integration, leaving aside the governance model, is undoubtedly the only way in which we can address the demographics and needs of the population of Scotland. There are almost linear consequences for health and social care, so those areas have to work in partnership.

We are all aware of stories of families interacting with multiple professionals who are individually capable of doing more. We need to enable that through, for example, the one-stop phone call whereby the GP phones to get the range of services that a family needs instead of there having to be 14 phone calls. Another concept is that of the district nurse who deals with a family being able to commission the social care elements that the family needs and there being no need for a referral to another professional.

Alex Neil: So, there is a long way to go.

Robert Calderwood: We are all agreed that the direction in which we are going is the right one.

Alex Neil: You are a chief executive with long experience of the NHS. There is a debate going on about the number of territorial health boards that we have, because we have 14 of them. Other parties have officially expressed the view that we should go back to the previous position of having three strategic health boards allocating resources to the various bits of the health service. Would that make life easier? You gave a very good example regarding the complexity of NHS Greater Glasgow and Clyde. I think that I am right in saying that something like 40 per cent of all healthcare that is funded through the health service in Scotland is funded, in one way or another, through NHS Greater Glasgow and Clyde.

Given the conversation about the allocation of resources and, per the evidence that we have heard this morning, the wish to make life easier for everybody, would it now make sense to talk simultaneously about rationalising the number of health boards? Would that make life easier?

Robert Calderwood: Because of the questions that Mr Neil keeps throwing at me, I am not sure whether what I hope will be my last appearance before the committee will be an infamous one.

Alex Neil: If you are about to retire, you do not need to stick to the party line.

Robert Calderwood: There is that as well, of course.

When I joined the national health service, there were four regional health boards for Scotland. Their specific responsibility was to plan for acute services, and the interaction with local authorities around public health and community aspects was clearer. There is, therefore, precedence in that regard, and we would not be inventing something that had never been tried.

10:15

At the moment, we can look at the IJBs as strategic entities that can—and need to—use their resources to develop. That role overlaps with the current role of the health boards, and that needs to be reviewed over time. The national clinical strategy written by Angus Cameron, which has been adopted by the Government, talks much more about planning for populations and removing artificial boundaries. There is no doubt that the challenge in making strategic planning decisions in acute services, as well as in elements of specialist services in mental health and so on, is that you need bigger populations than we have in the 31 IJBs. When looking at capital investment in a country such as Scotland, you cannot look at capital investment separately for all 31 IJBs. Instead, you need to look more strategically at a map of Scotland.

There are issues about taking certain aspects of responsibility for bigger populations. There is much to commend a discussion about whether that should be achieved by codifying health boards' responsibilities so that they act collegiately through a regional overarching network or by looking at the public sector landscape and coming up with a more streamlined version.

Bill Alexander: That is a very significant debate and, as Mr Calderwood alluded, it would be difficult to get into some of its more sensitive areas. Some things are best done at a local community level, some things are best done at an authority-like level—which is not to say that the current authority boundaries are perfect, but good things are done at that level—and some things should be done at a regional level. Our experience suggests that transformational change needs to be done at a local-ish level—[*Interruption*.]

The Convener: Excuse me for sneezing.

Alex Neil: We might need to send for a doctor for the convener. [*Laughter*.]

Bill Alexander: The coterminosity of the Highland Council area and the NHS Highland area allows for regular meetings between the chair of

the board and the council leader. It also allows for regular meetings between the two chief executives and between senior officers, which has provided a platform for transformational change. I find it difficult to conceive how such change could have been achieved in Portree, Inverness or Dingwall if the decision making had been in Aberdeen or Dundee.

Alex Neil: There was an underlying theme in your earlier evidence—particular in answer to Colin Beattie's questions—that there seems to be a bit of a vacuum regarding the national need for a business plan for not only integration but acute services and so on.

NHS England, for example, does not just have a vision and a strategy; at a national level, it has a business plan that says where it is going to shift resources from and where it is going to shift them to. It is a much more detailed approach that brings into one document workforce planning, financial allocations, the strategy for shifting resources from the acute sector into primary care and the community, and so on. I tried to initiate such an approach when I was the health secretary, but I will not go into further detail of that as it would not be right to do so. However, it seems to me that we are operating without the kind of national plan that many other parts of the United Kingdom have.

As the witnesses have said, financial allocations are made on a year-to-year basis. However, although NHS Greater Glasgow and Clyde is operating a budget of around £3 billion a year, you do not get the allocation letter until about 28 days before the start of the new financial year. None of you has a detailed business plan for the next three to five years because, for a start, you do not know how much money you will have.

It seems to me that there are quite a lot of improvements that the Scottish Government could make to the framework in which you are operating that would help you guys to do your job. We are back on a three-year comprehensive spending review—we have not been on that for a while—so the Scottish Government knows what its allocation will be. It might change in the autumn statement but, at the moment, we know what the allocation will be for next year, the year after and the year after that. If we could pass on that degree of planning, would that help you guys to plan at least three years in advance instead of giving you 28 days' notice of what next year's budget will be?

Jan Baird: Without a doubt, the more we are able to plan for the long term, the better—and the more certainty we will have about funding and everything else. We conduct lots of needs assessments and assessments of demographics locally, so we know what the challenges will be and what changes we will have to make.

I would shy away from having a plethora of plans. We have been there in the past. It is certainly helpful—

Alex Neil: I am sorry to interrupt, but is not the problem the fact that there is a plethora of plans? The whole point of having one national plan is that that one document would cover all those things.

When I was the Cabinet Secretary for Health and Wellbeing, one of my frustrations resulted from getting workforce plans. There are different types of workforce plans: there are local workforce plans and workforce plans for different sectors in the national health service. I know that the situation is changing under Shirley Rogers and that there will now be a national workforce plan, but a workforce plan is meaningless unless it is put in the wider context of the wider business plan. I was frustrated that there were so many plans when one would have done.

Jan Baird: I understand that, and we can see that members are heading in that direction. Locally, we look at the matter particularly in the context of community planning, community empowerment and requests for locality plans. We have two sets of legislation on community empowerment and public bodies, both of which require plans. We are quite clear that, if those plans are worked up from a community basis, one plan feeds into the two sets of legislation. We do not intend to produce different plans.

We certainly welcome the vision and the expectation of outcomes from the Government's point of view, but delivery and improvement must take place at a local level. We must be responsible for saying how we will deliver that improvement, because the approach will be completely different in Highland and in Glasgow, as it should be. If we are all focused on the same outcomes and members are clear about what outcomes are expected, how do we evidence them effectively? That will give us all the route map that we need to say which way we are going, how we will get there whether the year is 2020 or 2035, and what funding will allow people to make longer-term plans.

I said in my opening statement that there is no quick fix. It takes time, but we are spending an awful lot of time refreshing plans every year and waiting to see what the allocations are.

Robert Calderwood: There is much to commend the debate.

I will give two practical examples. In 2002, after a two-year period of engagement with the population, the then Greater Glasgow Health Board published an acute services strategy that attracted much comment and debate. Ultimately, after agreement with the Parliament on the way forward, that gave us a route map that resulted in

our reaching the end of that particular exercise in opening the Queen Elizabeth university hospital campus in 2015. It allowed us to align capital and resources to that journey and it was tweaked—as it inevitably would be over such a lengthy period—with debates carrying on through 2004 and 2006. As changes came, we debated them, but we had a direction of travel and were able to align all our resources.

Similarly, in Greater Glasgow Health Board and now in NHS Greater Glasgow and Clyde we have had the same debate with the public about mental health and learning disabilities, which has involved the end point, the balance between institutional care and local care, crisis intervention and the skills that are needed. Again, on the basis of publishing the document, we have had five-year certainty that we need a certain amount of capital or resources in respect of skills. We have been able to move forward in that direction because we have been very clear about what the status quo and the end point are.

In my opinion, Greater Glasgow and Clyde NHS Board and every other health board will need to be very clear early in the new year about what their next road maps are and where they expect to be in 2021 and 2025. The challenge will be in how we engage collectively, within our individual responsibilities and with the communities, to describe something that people find challenging. Our not welcoming the status quo but promising something different is something that people have concerns about, because they know what they have but they are not always certain about what we say the future should look like.

That is where we are. Greater Glasgow and Clyde NHS Board needs to engage with the community in creating a very clear vision of being here and going there. Having spoken to my colleagues in other health boards, I think that they are in the same place. After that debate and agreement, we can say that we are clear about where we are going so that, when we put forward resource utilisation proposals, they are consistent with the direction of travel and are not opportunistic and not just to do with what today looks like.

The Convener: We are running short of time, and I still have a couple of members to bring in.

Alex Neil: I have just one final question.

The Convener: A bit shorter questions and answers would be much appreciated.

Alex Neil: Okay. We could debate that point about plans ad infinitum.

Highland has one model and the rest of the country has basically the other model. Highland has been going for longer, but it is early days for the statutory approach and the joint boards. Even anecdotally, is there any evidence that one model is performing better than the other?

Jan Baird: I am not sure that that is a possible comparison, given the timing. As I said, when we were exploring the issue and we looked at Torbay, the system there was seven years down the line. We set ourselves a five-year plan, which finishes next year, and we have achieved a number of the outcomes that we expected to achieve. To be fair, the IJBs are not in the same position.

Alex Neil: Yes, although in places such as East Renfrewshire and West Lothian, they have in effect been running for 10 years or more.

Bill Alexander: We probably do not have enough evaluation to allow us to look at that. It would be nice to have an overall evaluation that can externally take a view on that.

Alex Neil: That plays into the theme that the Scottish Government needs to do more on benchmarking performance across the system, including between the two models.

Bill Alexander: Convener, can I add one very quick point?

The Convener: Very quickly.

Bill Alexander: Mr Neil talked about a single plan. I do not know whether there can be a single plan, but there needs to be clarity on some of the issues. We have talked about a long-term financial plan, clarity of outcomes and consistency in organisational arrangements. I suggest that we also need to look at a new framework for delivery in adult social care and adult services. As many people in the room will have heard me say before, we need a GIRFEC—getting it right for every child—approach for adults. Mr Calderwood talked about how a nurse might commission social care. We have not actually worked that out or thought that through. In children's services, we know what nurses and social workers do, but we have not yet worked that out in adult services.

Alex Neil: I would add that we need a national acute services plan.

Bill Alexander: Yes—one that is integrated and does not look at acute services separately.

Alex Neil: Absolutely—that is right.

Alison Harris (Central Scotland) (Con): Good morning. I have been listening with interest to everything that has been said, and I want to go back to a few issues that have been raised. I think that Jan Baird said that you have to make this work and that it must be made better for the people. When will the people—the users or the patients or whatever we term them—see an improvement?

Jan Baird: We are already capturing evidence that improvements are being seen from our work with the Highland Senior Citizens Network and our user groups across Highland. Interestingly, when we had consultations with those groups when developing the methodology and the model, they could not understand why we had not done this years ago. The users do not care who employs the staff, as long as they get the services. So we are very consciously involving users and carers. Again, that goes back to working with communities. We are ensuring that we get that feedback, although it is always difficult to get it accurately. For example, do we get it by giving people an evaluation form when they are on the way out after having a service? We are looking at a range of ways of gathering that feedback, and that informs our planning process.

Alison Harris: I am conscious of time, convener.

I think that Robert Calderwood said that less time is being spent in hospital and in beds, but he also said that, on the acute side, the board is currently £9 million overspent. Did I pick that up correctly?

Robert Calderwood: That is correct.

Alison Harris: We have alluded to the fact that there are problems with obtaining general practitioners and consultants. Are your locum costs high in Glasgow and are they contributing to that overspend?

Robert Calderwood: Erm—I pause only to determine what is high in a Glasgow context.

Alison Harris: Well, £9 million over budget by this stage is quite high in my books.

Robert Calderwood: Yes, although my finance director would tell me that that is less than point something of a per cent.

Alison Harris: Well, it is £9 million.

Robert Calderwood: I accept the point wholeheartedly.

Alison Harris: Are you at the year end yet?

Robert Calderwood: No.

Alison Harris: Therefore, £9 million is running over budget in my books.

10:30

Robert Calderwood: That is absolutely correct.

The quick answer to your question is that we are finding that we have had to use more locums, particularly medical locums, in the past two years than we have had to in the past.

I can comment only on NHS Greater Glasgow and Clyde. Our financial position for senior medical staff—consultants—was in balance. In other words, our senior medical staff pay each year more or less broke even or was a marginal underspend. In the past two years, we have seen the introduction of significant payments to locums—so much so that our expenditure this year is likely to be about £12 million for senior medical locum pay. Over recent years, that expenditure has been driven by the intensity of activity and the volume of work, which has increased so much that when an individual post is not occupied—that can either be because of maternity leave, vacancy or sickness—there is a requirement to backfill. That was not a phenomenon for senior medical staff previously. It has always been an issue with junior doctors, where there are rotas and the need to comply with the 48-hour working week. Therefore, if a number of juniors on a rota were not at work for whatever reasons there was always a culture of using medical locums to replace them.

Senior consultants used to always just cover each other. We are now at a stage where, in many specialties, we need almost 99 per cent of the workforce at work to meet the status quo. Therefore, when they are not there, there is an immediate pressure. Legal compliance—that is, the need for a consultant to be on duty or on call—and meeting the performance targets, be they on unscheduled or scheduled care performance, drive the need for the senior medics to be about. That is a big cost pressure that is relatively new.

The other thing that is relatively new for us—

The Convener: I am sorry to interrupt. I know that it is an important question, but can you keep your answer bit shorter, please?

Robert Calderwood: I will stop at that point then.

The Convener: Thank you very much.

Alison Harris: I had a few more questions, but given the time pressures I will stop there.

Gail Ross (Caithness, Sutherland and Ross) (SNP): I draw the committee's attention to my entry in the register of members' interests, which states that I am a councillor at Highland Council.

I extend a personal welcome to Jan Baird and Bill Alexander—seeing them here today makes me feel a bit more at home. I also sincerely thank the officers and staff at NHS Highlands and Highland Council for all the work that has been undertaken. We know that it has not been easy. Indeed, we should not underestimate what has been done, and we are proud of what you have all achieved.

As we have heard, the lead agency model is not without its challenges. I want to speak a little bit

about the staff, because huge numbers of them are involved. We know that some staff had to shift from one service to the other. That happened at a time when we were also in the middle of education service reforms. A lot of things were going on—they still are, to be fair. How did you make it work? How did you take the staff along with you, get them on board, share information and reassure them? Are they happy now?

Jan Baird: Yes, they are happy. We understand that none of them would like to go back to how things were.

Through the programme of change that we developed, and up to the point of integration, we had great involvement with the staff and the unions. We had a separate partnership forum for the programme of work, so we discussed all the developments and how we were progressing the programme. We had staff side representatives on the programme board. We went out to staff groups across Highland and spoke to them in their silos, as we might say, or in their facilities. We had risk and issues logs for all staff to contribute any issues that they wanted to raise. Throughout the process, our chief executives were quite clear that if, at any time, anything was deemed unsafe, we would stop the whole process—everyone knew that. For example, we had concerns raised through child protection about how it would all pan out. Our chief executives, and Bill and I and others, immediately met paediatricians and child protection staff to listen to and allay their fears and dealt with the issues right away.

We dealt with matters as soon as they came up. Staff felt well supported. We had more issues from nursing staff transferring into the council. In discussions with them, we discovered that that was about grieving for the NHS—leaving the NHS was really difficult for them. Now that they have made the change, they see the improvements and they are comfortable with that, but we had to support them through the process.

Bill Alexander: Across Scotland, there was a lot of concern about the fact that we were TUPE-ing 1,500 staff one way and 200 staff the other way. However, in the main, the TUPE issue has not been a big issue; the issues have been the culture, the branding and different perceptions. There are still some oddities. For example, my health colleagues in the council have different public holidays, which is a bit weird, and there is the odd grading issue. However, in the main, the TUPE issue has not been the big issue; the issues have been the cultural issues that Jan Baird referred to, and working through those issues has been good because people have more in common than they have apart.

The Convener: Gail, do you have any further questions?

Gail Ross: No, that is brilliant.

Colin Beattie: I am sure that we would all agree that a key requirement for the success of the new model is that the IJBs receive adequate resources, both financial and otherwise. However, it appears that every one of the six IJBs in the Glasgow model has had its budget cut. Do you have any comments to make on that?

Robert Calderwood: All six IJBs have received increased resources in 2016-17 in absolute terms compared to 2015-16, just as the health board has an increased allocation in 2016-17 in cash terms compared to 2015-16.

Colin Beattie: That appears to be at odds with the evidence that we took on 15 September, when we queried East Renfrewshire's allocation, which had been cut. Julie Murray confirmed that the East Renfrewshire IJB and the other boards had had savings targets handed down to them and that, in fact, their resources had been cut.

Robert Calderwood: They were given savings targets—absolutely. The Government sets a minimum 3 per cent efficiency target every year within the health service and the IJB's health budget is part of the health service, therefore it is subject to that 3 per cent target. Every part of the business has to look at how it delivers its services, year on year, in a more effective and efficient way.

Colin Beattie: Given that all the IJBs seem to be struggling to get more resources in order to deliver the new model, it seems anomalous that their budgets are being cut at the same time as there is an imperative to increase—or to move—their resources.

Robert Calderwood: I accept your point and make two points. First, if the health board receives an uplift in cash and passes that on but the cost of doing business as usual, with real inflation, is greater, that drives a need to look at delivering services in a more effective and efficient way. Nevertheless, in cash terms, there has been an uplift. Secondly, section 11 of the Audit Scotland report that was published this morning highlights specific decisions that were taken by Parliament to make cuts in budgets that are ring fenced and passed straight to IJBs. If the board gets an uplift and pays its staff more than the uplift, there are inflationary pressures. There is an interesting semantic debate about what constitutes cuts.

Colin Beattie: It seems odd to me that, when we are trying to move resources from one area to another, the area into which those resources are supposed to be being transferred in order to deliver the new model is receiving budget cuts rather than more resources.

Mark White: In real terms, 72 per cent of NHS Greater Glasgow and Clyde's £69 million savings

target for 2016-17 sits within the corporate and acute functions and 28 per cent of it sits within the partnerships, so our savings target has not been split proportionally across the whole organisation; the brunt of it sits within the acute and corporate divisions. In relative terms, the partnerships have to achieve savings of just over 2 per cent, whereas other parts of the business are looking to make savings of 7 or 8 per cent. The shift in resources might not be happening at the top level, but we are striving to make sure that we are achieving that end result.

Colin Beattie: I will leave it at that just now.

The Convener: I return to something that was said right at the start of the evidence session. Mr Calderwood, in response to Colin Beattie's questioning you said that the status quo prevents change. Can you tell me exactly what you meant by "the status quo"?

Robert Calderwood: Yes. I can give you a practical example. At the moment we are out to do a series of service changes, one of which is redesigning older people's services in the east end of Glasgow. The proposal is to cut back on institutional services and invest in community services and, as a consequence of that, take away a standalone older people's hospital and close 56 beds.

That has been the subject of debate in Parliament as something that is neither welcome nor appropriate. That is what I call the debate that we have to get into between the status quo and the new world. In the current financial climate, we cannot have both.

The Convener: Are you saying that it is necessary to close hospitals if we are to move towards true integration?

Robert Calderwood: It is a requirement in the current budget that, in order to do more locally in or near to the patient's home, we have to disinvest resources that have been in institutional care and reinvest them. The trick is in the timing and trying to get that ability to invest in the new services while running the old services down. There is an element of the people seeing the new before they see the loss of the status quo and that is challenging in the current climate.

That is a practical example of where we have worked with the IJB to redesign a model for older people when we do not believe that they need to be in an institution because of the changes. We have put forward a proposal to release that resource and reinvest it.

The outcome of that will go through the appropriate channels but it has already attracted significant comment as being the wrong thing to do.

The Convener: Your definition of the status quo is therefore the difficult politics of this. Would you also define the status quo as budgetary pressures or is it just the politics that are preventing the change?

Robert Calderwood: No, the changes that we aspire to make for the population of Scotland are multifactorial. We have debated different aspects this morning: how we change the workforce, and whether we can get the workforce that we want. We have debated the investment in alternative services, which will include money, the new workforce and capital. I am saying that, if every building, every member of staff and every way in which they work is protected, and we talk about only investing the uplift, regrettably we are not in a financial position to give the entirety of public services real uplifts. We have to redesign and we have to look at efficiency and best practice.

My final point is that the chief medical officer Catherine Calderwood's report on realistic medicine talks about us not overmedicating the Scottish population and recognising that some things that we do do not add value. We need to work with the population to persuade people that going to their general practitioner and getting antibiotics every other week is not in their long-term best interests. That is what I mean about the status quo. Everything in the status quo has to be challenged. We are not necessarily always going to agree on a change but it has to be challenged. We cannot start from the assumption that it is good and everything that we do next is a risk.

The Convener: Integration became statutory only very recently but the process has been on-going for many years now. We know that over the four-year period from 2010-11 to 2013 the balance of expenditure on the institutional services did not shift at all. Are you really saying that it is that complexity of reasons that is the reason for that? When do you think it will shift?

Robert Calderwood: It is going to be a slow process because we have not yet won the hearts and minds of the public and persuaded them that some of the changes that we are planning are better than what they have. Over the years, there has been a number of initiatives to improve the acute sector and expand the range of treatments that we provide for the Scottish population.

We have also had a quite different pay policy in Scotland compared to the rest of the United Kingdom, particularly on low pay. Given that the head count in the acute sector is higher than in community primary care, will an absolute top level always drive an apparent protection of costs? It is not that we are setting out to do that; it is just a factor of all these things.

I am trying to say that individual boards are bringing forward examples of where they want to redesign services, rely less on the older traditional model of institutional care in a hospital and move to care in the community. We need to work through that.

That will affect everything. If I join Greater Glasgow and Clyde NHS Board tonight as an intensive therapy unit nurse in a big critical care unit, I will not be immediately attracted when I hear the chief executive talk about care in the community; that is not what I would be doing tonight. You have to work with the staff whose skill sets you want to change to deliver their services in a different environment.

Jan Baird: Earlier we were asked about what support the Government can give. The changes that we have to make are emotional for a lot of communities. We need support from national and local government when it comes to making those really difficult decisions. No matter what evidence we have about safety and sustainability, communities are absolutely committed to looking after buildings and that is what they want in their communities. It is a difficult task for us and we need support. When the evidence is there to make the shift, we cannot do it on our own. We need the public to be behind us, but the public turn to their politicians, whether locally or in Parliament, and we need their consistent support to make these changes.

The Convener: I thank you all for your evidence this morning. It has been a long session and we very much appreciate it.

We now move into private session.

10:47

Meeting continued in private until 11:31.

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