OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 21 May 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 May 2019

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HEALTH AND SPORT COMMITTEE
14th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Val de Souza (South Lanarkshire Integration Joint Board)
Eddie Fraser (East Ayrshire Integration Joint Board)
Craig McArthur (East Ayrshire Integration Joint Board)
Marie Moy (South Lanarkshire Integration Joint Board)
Moira Pringle (Edinburgh Integration Joint Board)
Judith Proctor (Edinburgh Integration Joint Board)
Anas Sarwar (Glasgow) (Lab)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 21 May 2019

[The Convener opened the meeting at 10:00]

Subordinate Legislation

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2019 (SSI 2019/145)

The Convener (Lewis Macdonald): Good morning and welcome to the 14th meeting in 2019 of the Health and Sport Committee. We have received apologies from Sandra White and David Stewart. I welcome Anas Sarwar to the meeting as a substitute. I ask everyone to ensure that their mobile phones are either turned off or set to silent mode.

Agenda item 1 is consideration of an instrument that is subject to negative procdure. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 7 May and determined that it did not need to draw Parliament's attention to it on any grounds within its remit. If members have no comments to make, does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

Pre-budget Scrutiny 2020-21

10:01

The Convener: Agenda item 2 is, as part of our pre-budget scrutiny for 2020-21, an evidence-taking session with the chief officers and chief finance officers of three integration joint boards. The committee agreed that it would build on the approach that was taken to pre-budget scrutiny in previous years by scrutinising the integration process, and that will be the focus of today's meeting.

I welcome—in some cases, again—from the Edinburgh IJB Judith Proctor, who is the chief officer, and Moira Pringle, who is the chief finance officer; from South Lanarkshire IJB Val de Souza, who is the chief officer, and Marie Moy, who is the chief finance officer; and from East Ayrshire IJB Eddie Fraser, who is the chief officer, and Craig McArthur, who is the chief finance officer. Thank you very much for attending.

I will start with a general question about the budget process. The committee has focused on trying to understand the budget-setting processes in IJBs and to what extent they are achieving the same levels and standards and, indeed, meeting the same timetable. Can someone from each of the IJBs tell the committee whether their budget for this financial year was agreed by the beginning of the financial year and whether any issues arose?

Eddie Fraser (East Ayrshire Integration Joint Board): I am pleased to say that East Ayrshire IJB was able to set its budget on 28 March, following the council having set its budget in February and the health board having been able to set its budget on 27 March. That is different from what happened in previous years. Because the budget was set at the very end of the previous financial year, we still had some issues with how we were going to bring the budget into balance with regard to certain efficiencies that we still had to work through and then take back to a future meeting of the committee of the integration joint board. However, we were able to set this year's budget.

Val de Souza (South Lanarkshire Integration Joint Board): I am delighted to say that, likewise, South Lanarkshire IJB was able to set this year's budget. As with East Ayrshire, that involved quite a bit of support from our national health service and local authority partners.

Judith Proctor (Edinburgh Integration Joint Board): The position in Edinburgh is different. We agreed the settlement to the IJB from both partners, and we in the IJB have worked through the process of agreeing the budget savings, efficiencies and transformation that we need in the

partnership. As yet, though, we have not identified a balanced budget, but we are working very positively with our partners and expect to be able to do so in this financial year.

The Convener: Do you expect that, in the future, Edinburgh will seek to be in the same position as the other IJBs?

Judith Proctor: That is most definitely the case. We want to be able to set a clear budget for the partnership as we go into each financial year.

The Convener: Eddie Fraser said that what happened with his budget was a change from what happened in previous years, but it is clear that this is work in progress across the country. I think that he also mentioned that Ayrshire and Arran NHS Board met and set its budget the day before East Ayrshire IJB set its budget. In the past, however, we have found that the differing timeframes for local authority and health board budget setting have impacted on IJBs' ability to plan ahead. Is that still the case, or is the situation changing?

Judith Proctor: Perhaps I can address that question. I think that all partners in Edinburgh recognise some of the challenges in having those parallel but different budget-setting processes, and some good attempts have been made to align things as far as possible in order to allow sufficient time for scrutiny, decision making and transparency around budgets. Although the process has been difficult, in my experience of working with our partners in Edinburgh, there has been a willingness to recognise the different processes and timelines and to try, as far as possible, to align them.

Eddie Fraser: We should also remember the role of the chief officer and the chief finance officer in setting the IJB budget, which is to give advice to the joint board about whether the finances are sufficient to deliver against the strategic plan. Indeed, that is in the legislation. If there is no surety around the finances, you cannot make the statement that the finances are sufficient to deliver against the strategic plan. Sometimes, it might be a question of amending the strategic plan to bring it into line with the available finances, and that is why getting a balance and bringing the two aspects together at the same time is so essential to us.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning. Naturally, as an Edinburgh MSP, I want to start with some questions for Judith Proctor and Moira Pringle, whom I welcome to the meeting. It is good to see you again.

With regard to the projected overspend of 2 per cent, you said in your opening remarks that you have yet to find the savings that are necessary to balance the budget. That has been coming for a while now, and although I absolutely believe that you intend to get a balanced budget, I am a bit concerned about how you expect to find the savings in the future if you have not found them now.

Judith Proctor: We have identified a very solid savings programme in the partnership, and we are talking about those savings in the same way as we are talking about the wider transformation that we need to put in place in Edinburgh. That is happening over three horizons, and we need to recognise that we have a slightly longer timeframe to become a truly sustainable partnership that really delivers better outcomes for people in the city. There is the grip and control that we want to achieve—we talk about that in our submission—and the service redesign that is required, but there is also the longer-term transformation that the board is keen to invest in.

We believe that we can deliver in-year the savings that we have identified. The partnership, we as advisers to the board and the board itself have been quite clear about and focused on the need to achieve that without any diminution in the outcome improvements that we are beginning to see in Edinburgh. We really want to continue to focus on that improvement and to ensure that people have a good experience of our services, but we also want to get to balance. As a result, we are very much taking a partnership approach with NHS Lothian and the City of Edinburgh Council and looking at how we work together as three partners. The legislation makes it clear that we need to identify things that we can do collectively and proactively to achieve balance in-year, and that might well include discussions about how we handle the set-aside budget over the year and what our partners might do to help us to achieve a balanced position in-year.

I reiterate that we are very keen to do that proactively. After all, we do not want to get to the end of the year and find that we have not done that, so we are already working with our partners on those approaches and in those discussions.

Alex Cole-Hamilton: I am certainly gratified to hear about the partnership approach, and I wish you well in that respect. However, it strikes me that you have two mutually exclusive goals. Edinburgh—I point out that Miles Briggs and I represent Edinburgh constituencies—has a real problem with delayed discharge, and the social care environment is not geared up to deal with the massive pressures that it is experiencing from not only hospital exit but the ageing population. We are actually asking you to do far more at the same time as you are talking about reducing your spend, and I just do not understand how we can square that circle. If we are going to tackle delayed discharge, in particular, we absolutely need to

bolster social care provision in the city, and it strikes me that trying to reduce your spend is not compatible with that aim.

Judith Proctor: It all comes down to how we work and operate as a partnership. Another key element of health and social care integration is the wider transformation that I have mentioned, which involves working differently in and with communities, and supporting people towards independence and rehabilitation.

It is important to recognise that we have achieved some real improvements in Edinburgh as a result of decisions that the board made to invest more of its budget in social care. Through that, we have seen a 48 per cent reduction in delayed discharges in Edinburgh over the past year and, with that, a 66 per cent reduction in the number of bed days lost in NHS Lothian. As a result of the work that we have done, there have been improvements in the number of people who are waiting for an assessment and in the length of time that people wait for care from us. There has been a good trajectory on board decisions about how it uses its budget and where the priorities are, such as in social care, and improvements have resulted from resources being directed to those areas. That is the kind of discussion that we are having about how we work as a whole system to focus on the transformation and the outcome improvement that we want to continue to drive forward in Edinburgh.

Alex Cole-Hamilton: I have one more question for our Edinburgh colleagues. Can you give us a broad timescale for the three horizons of change that were mentioned? For example, if you appear before the committee next year, will you be in a balanced budget position?

Judith Proctor: We talk about a three to five-year longer-term horizon and a medium-term horizon of two to three years. We are having positive conversations with the City of Edinburgh Council and NHS Lothian about going into the next financial year having identified, as a partnership, a balanced budget and being able to do that each year thereafter.

Alex Cole-Hamilton: I open up my questions to the rest of the panel. Do the representatives of the other IJBs have any comments to make from their positions?

Eddie Fraser: We come back to the discussion about being able to have a positive impact at the same time as improving the service to our local population. We are lucky enough to be in a position in which we are getting on very well in relation to hospital discharge and transferring people to care in the community. The result of that is potential savings in the social care budget: people staying in hospital for too long is very debilitating and, when they come out of hospital, they need higher-cost social care packages and often need to go into a care home. We have worked hard to get people out of hospital timeously and that has reduced the number of people in care homes by 10 per cent over the past 18 months. We have been able to redirect some of that money towards care at home.

The positive performance on transferring people out of hospital and the positive impacts for older people in particular cost us less money. We try to work our way into that positive cycle: we need to be able to release money out of some services—in this instance, care home services—to invest in other services.

Val de Souza: I want to build on what my colleagues have been saying. The challenge that we face is that we work in an environment in which demand and complexity are increasing as people live longer and with more conditions. That challenge is greater than we like to speak about. Addressing it is costly and complex in design and delivery.

As my two colleagues have said, the challenge for us is around transformation—what we do must be bigger than just reviewing and redesigning. We are up to that challenge. However, we sometimes need bigger national messages to bring the public along with us in relation to what is required to take the next steps. Change is a difficult topic; in general, people do not like change. As chief officers and partnerships, we must ask how we can demonstrate that change is good—as Eddie Fraser has demonstrated in the movement from residential care releasing some resource that he is then able to reinvest.

Marie Moy (South Lanarkshire Integration Joint Board): I want to pick up on Mr Cole-Hamilton's observation about the level of savings that is being requested across the partnership and the circumstances that we find ourselves in, which include demographic growth, an increase in the number of attendances at accident and emergency and other significant financial pressures and operational demands that the partners and the IJB are facing.

If there was an opportunity for additional financial investment in the budget for 2021, that would be welcomed, because it would allow us to invest further in the services that we are investing in across primary care, mental health and, in particular, social care services, where the impact of demographic growth is increasing. Across South Lanarkshire, we have been relying on our council and NHS colleagues to give us a financial envelope to allow the integration agenda to develop and grow and to give us a chance to implement transformational change. However, that takes time.

Early intervention and prevention are critical. When dealing with the savings that are required and demographic growth, it is very difficult to find recurring funding solutions to invest in reliable services in which people can have confidence.

10:15

Miles Briggs (Lothian) (Con): Good morning. I have heard all the witnesses use the word "transformational". We all support that direction of travel. However, I look back to the movement towards care in the community in the 1990s, which involved the front-loading of funding, with two systems running side by side to achieve that. Is it the case that we have not done that with the IJBs? Have we just expected to transform services, but with the same money?

The Convener: That is a hard question.

Judith Proctor: As an IJB, we have identified precisely that challenge: we need to balance managing business as usual, the performance issues and trying to get to a sustainable budget position with the need to invest in change by freeing up staff, working differently with communities—sometimes, we need to invest in community third sector organisations—and building in time to enable the transition away from traditional and institutional models that Eddie Fraser described to work through.

Our board has agreed a transformational fund from within its budget to help us to achieve that change over the three horizons. It is essential to identify that funding. At times, we will have double-running costs. We need that time and space to carve out different ways of working with our partners to achieve the transformation that we need.

Eddie Fraser: This is a very important area—it is about how we transfer care. Our clinicians are only willing to transfer care if they see safe alternative models of care: if a general practitioner is not going to refer someone to hospital, there must be an alternative that they feel is safe. We need to build the safe alternative models of care first to be able to change what we are doing.

Like Edinburgh IJB, we have a local transformation fund—East Ayrshire Council gave us money for that. We also have significant primary care funds coming to us over the next three years. Although those funds are primarily about the sustainability of primary care, they will also have a massive impact on the wider services that we deliver. The investment in mental health is also welcome.

However, it is self-evident that we need to build the alternatives first, to give people the confidence not to admit people to hospital and to give our hospital clinicians the confidence to transfer care back out. We must do that, and we need to put together different resources to enable us to do that.

The Convener: Is the transformation fund that you said is funded by the council part of the council's standard allocation or is it additional to that?

Eddie Fraser: It was an additional £1 million allocation.

Miles Briggs: When you are redesigning services and looking to redirect money into other services, what sort of assessment do you do of the impact of that? In Edinburgh, as Alex Cole-Hamilton has mentioned, there has been debate about cuts to community services such as the Pilton Community Health Project. Are the directions that the integration authorities get from Scottish Government ministers patchy, or do the IJBs have true autonomy over such areas? Members of IJBs have told me that things are often put to them and that they are not autonomous when it comes to deciding what they want to achieve.

IJBs have discussions with the Scottish Government. For example, advice was given that £2.3 million could be taken out of drug and alcohol services in Edinburgh to try to narrow the gap in finance. When you make decisions about where transformation and redesign cuts will come from, how do you act on advice?

Judith Proctor: I am not sure that I followed your question; could you reframe it for me?

Miles Briggs: When you are looking at a service redesign, which often feels like you are robbing Peter to pay Paul, just to get the money, where is the advice checked so that there is benchmarking and an impact assessment, to ensure that the redesign will not just displace people and create unintended consequences in other parts of our health service?

Judith Proctor: Ultimately, decisions about the allocation of the budget to deliver the strategic plan sit between all partners, with the IJB setting the direction.

I think that you are referring to particular funding streams that come into the health board and the council from the Scottish Government to deliver specific outcomes. We—and I am sure that all partnerships are in the same position—try to do that in partnership and to really understand the system-wide delivery that the board has to agree. Yes, we look at individual outcomes that we are seeking to achieve through separate funding streams, which is important, but given the breadth of what an integration joint board is responsible

for, we must also look at delivery right across all those responsibilities.

In doing that, it is important that we look at the overall outcomes that we are trying to achieve—the national outcome measures and the six ministerial strategic group measures, or MSG6—and try to balance the delivery of specific outcomes in one part of the system with an understanding of the opportunity costs or negative impacts in other parts of the system. That becomes part of the conversation that we have in IJBs and with all our partners and our colleagues in the Scottish Government.

We do impact assessments on decisions to guide the board in its decision making. Our board is very well aware of the complexities of decision making across a very large budget and a very broad and complex range of services, accountabilities and responsibilities.

Val de Souza: I think that Miles Briggs was asking about impact evaluation. With any service change, my approach—and I think that my colleagues take the same approach—is to look at data, look at policy and engage with stakeholders. Those three elements have to be powerful if we are to take forward a redesign or a transformational change.

Let me give you an example, which relates to the modernisation of care facilities and care homes in South Lanarkshire. We based our thoughts and proposals on a pilot or test of change that we did. For almost a year, we tried to see what an intermediate care model would look like. We considered a step-up model, which would avoid people going into hospital, and a step-down model, which would help people to come out of hospital—getting them back on their feet and back home.

Some 56 per cent of the individuals who went through the pilot programme were able to get back on their feet and home, so we designed a programme of modernising care facilities around that data. When we implement that programme fully, we will be mindful of the data, the engagement and the policy, throughout the process, and we will evaluate it as we go along.

Miles Briggs: I welcome that example. However, throughout Scotland there is a pattern of drug and alcohol partnership budgets being raided. Have any of the witnesses' IJBs taken funding away from a drug and alcohol partnership in the past year?

Eddie Fraser: We have not taken money out of the alcohol and drug partnership. As you know, a number of years ago, the money that was allocated through health boards to alcohol and drug partnerships came partly from justice and partly from health, but it was then aligned so that it all came through health. At the time, it looked as though there was a reduction in the total, but the funding was part of the overall sum that came from health to the IJB for the IJB to decide how the money was spent.

We did not reduce our funding to the alcohol and drug partnership, because the issue is a strategic priority for us—that relates to what Val de Souza and Judith Proctor said. The level of alcohol and drug misuse in East Ayrshire and in the rest of Ayrshire is high. When we did that a couple of years ago, it proved to be sound because, in the following budget, our allocation significantly increased, so we were able to make sure that the delivery was sustainable. However, the general picture is that the IJB needs to interpret the totality of our funding to ensure that it fits with the priorities of our strategic plan. The package of funding will come with a number of priorities and the IJB will take into account the mix of national, health board and council priorities when it is deciding what services to commission to meet its communities' needs.

Anas Sarwar (Glasgow) (Lab): There are different pictures in different health boards across the country. There are varying levels of challenge around the proportion of money that comes from the national health service and local authorities, the amount that you might have as a projected overspend, the amount that you might have in reserves and the projected savings that you will need to make in each of the next three years. How much money will each of you need to find in each of the next three years, either by making a saving or by pleading for more money, whether that be from the national health service or from a local authority? What amount of money are you looking for?

Moira Pringle (Edinburgh Integration Joint Board): We are in the process of developing a medium-term financial plan. However, for this year, Edinburgh's starting gap—our savings requirement—was £24 million. Given the demographic pressures in the system that people have already talked about and the on-going pressures on public funding, I imagine that we will have a similar if not greater gap in each of the following few years. That is why we have to look at doing things differently.

Marie Moy: For 2019-20, our cost pressures came to about £18 million. Through the Scottish Government, we got additional funding of about £15 million. That left a £3 million gap, the majority of which has been addressed through recurring savings but, at this stage, there is a reliance on non-recurring solutions, which we need to be alert to. Moving forward over the medium to long-term plan, from the work that we have done with both partners, I estimate that our cost pressures gap

could continue to be £3 million to £5 million. That is assuming that the level of Scottish Government funding that has been available until now continues in future years. It still does not create enough financial capacity to address the increases in demographic growth that we have spoken about and the aspirations to further develop the services, particularly the third sector early intervention and prevention services.

Craig McArthur (East Ayrshire Integration Joint Board): Our budget gap is similar to the one that Marie Moy outlined. For 2019-20, our budget gap is around £5 million. We expect that the level of challenge will remain similar year on year over the medium term. A significant element of that probably relates to additional demands such as demographic changes. We recognise that managing that demand is about transformation and delivering services in a different way. The balance of it is made up of cost increases, pay inflation and normal inflation. Managing demand is a big part of how we will deal with that in the future.

Anas Sarwar: There are 31 integration authorities and three are in front of the committee. One authority says that it will have a gap of £24 million in each of the next three years; another authority says that its gap will be £3 million to £5 million and the other authority says that its gap will be £5 million in each of the next three years. To get the total gap for all the integration authorities across the country, broadly, we can multiply those figures by 10, which means that what is needed in savings or further investment is almost £300 million a year. That is a massive amount of money. Finding that amount is not just about transformation and making recurring and non-recurring savings; it will also involve cuts to the bone for services, which will impact on service users. What is your projection of what that will mean for your service users and for the services that you provide?

10:30

Judith Proctor: We have all talked about transformation, but it is important to think about what we mean when we say that word. It will mean lots of different things. It is about how we use our traditional services quite differently and how we will utilise money that may already be in the system to do things differently in the community. It will definitely be about how we use technology to support people at home and in a community setting. That will get us into a discussion about set-aside acute funding and how we use that.

We have had a brief conversation about the number of delayed discharges in Edinburgh. Not only are people being delayed in hospital when they are ready to go home—it is not good for an individual to be cared for in an inappropriate place, and it means that we are not using public funding properly and appropriately. If we are able to tackle that in the way Eddie Fraser mentioned, with safe, effective, useful and appropriate alternative deliveries of care, that should—to go back to the intent of integration in the legislation—enable us to deliver services within a sustainable financial envelope.

To pick up Val de Souza's point, there are conversations about the national conversation that we need to get into. Our services will have to look very different, because we can do things differently over the coming years, and we have to be open and transparent about what that difference will look like.

Anas Sarwar: I accept that, and I imagine that the other two authorities would, as well. However, what Eddie Fraser said earlier about investing is interesting. It is about investing in order to be able to save, but there does not seem to be much room for investment to save if a £300 million saving has to be made across all the integration authorities this year and every year for the next three years. It seems to be about saving and using the nice word "transformation" as that is done. There will be a human cost of that, will there not? Should we not be honest with the public about the transformation that needs to take place and what that will mean for services and service users?

Eddie Fraser: We should absolutely be honest with the public and local communities, because we will have no credibility if we are not. However, we can invest in ways that still deliver savings, even within the calendar year.

We projected a 3 per cent increase in our care-at-home and social care costs. To mitigate that, we employed more occupational therapists and social care workers so that, when people first contact us to ask for those services, we work with them to ensure that they are as independent as they can be and, therefore, the size of the social care package is smaller.

It is not only about being independent. A big issue for us just now is ensuring that people are included in local communities. Some of our work in East Ayrshire has not been delivered directly by the health and social care partnership. I am not being flippant, but there is work around tea dances, for example, so that our people are included in local communities. Our public health colleagues tell us that the impact of someone being excluded and of social isolation is the same as if they smoked 15 cigarettes a day.

People working properly in local communities and including people in local communities has a massive impact on health, so some of our focus has been on that. Craig McArthur spoke about

how we reduce demand, and that is what we need to do. Then, when people need social care services, those services must be there and of the highest quality so that they are responsive to people's needs.

It is about trying to reduce demand by doing things differently. We have achieved that up until now and we are right to ask how we can do that as we go forward.

We talk about how integration joint boards work. They do not work in isolation. Some of our biggest successes have come when we have worked closely with housing services. We look at different housing models to ensure that the approach works. At one time, there were vacancies in our high-needs supported accommodation, particularly in rural areas. Those places were sick because people did not want to move to them, but we now see a lot more activity there. Our vibrant communities teams go in, and they have lots of activities that serve the people who live in the supported accommodation, which is now full, and the local community. We are driving less demand for paid social care through such routes.

That is what we mean by transformation. It is about changing people's experience.

Anas Sarwar: I completely agree with you on what integration authorities are trying to do in very difficult circumstances. You have absolutely the right intentions and what you are doing in communities is transformative. However, making savings of around £300 million across 31 integration authorities in a year will mean budgetary pressures, will it not? We hear a lot about record investment in our national health service but, at the same time, local authorities are screaming about budgetary pressures. What do the budgetary pressures that local authorities face mean for how much they can invest in integration authorities, and how could that help to bridge some of the £300 million gap?

Val de Souza: We all need to speak from our own perspective on that. The £300 million that you mention is not my challenge, personally; it is our challenge nationally. Again, I want to build on my colleagues' comments: there is an honest conversation, but at this point it is not about closures and shutting, but about replacement and redesign, and about the fact that change happens and that sometimes change is good. It is about building confidence and putting something in place before you take something away, as often as we can. The question about—

Anas Sarwar: Do you think that we are having that national conversation?

Val de Souza: I think that we could do better. Locally, I and my colleagues are having that conversation, but we need a scattergun approach to communicate the need for change and the fact that being in hospital is a bad thing. The general public still believe that a hospital is a good and safe place in which to be, but—with no disrespect to my acute colleagues—it is not a place in which to languish or stay. We need to have people in hospital who should be there and we need to develop the flow and get people back on their feet and back home as quickly as possible.

We are having those conversations, but sometimes it is hard to shift national thinking on the matter. Change can be good and is necessary, and I suppose that we need some support in the integration authorities to get that message across.

On the budget, the NHS in South Lanarkshire has not had its full NHS resource allocation committee funding allocation. That means that there is a 0.2 per cent lower allocation, which accounts for about £9 million. That means a status quo position for us. We have worked very hard to balance the budget, and have done so. However, as Marie Moy said, it is going to be more and more challenging, particularly in 2020-21 and 2021-22 when we are not able to find recurring funding. We are all getting into a place of redesign and transformation.

I have sympathy for my local authority colleagues because they are very supportive of the IJB. I look at my corporate management team colleagues from housing, roads and the other community functions—not so much education because it is a little bit more protected—and I see the kind of interconnectedness that we need to have, as described by Eddie Fraser. However, if you protect education and social care and social work, other colleagues across the team have to take a bigger slice off their budget. That is a tension in itself, but one that we need to continue to get around. We need to keep a vision for what is best as a whole for our communities, and have a conversation that is not just about each of the different budgets. However, there are real tensions around that.

George Adam (Paisley) (SNP): You have to look at different ways of working. The whole idea of the integration joint board was about looking at different ways of doing things and delivering services. As we have heard today, people hate change—it is always going to be difficult. How do we take that next transformational step and make the changes to services? You are at the coal face and act as a bridge between the health board and the council, which is a challenging but—in my opinion, having worked as a councillor—great place to be. The most important question is: how do we make that transformational change, and how do we ensure that we take the public with us and that they see the benefit in what we are trying to provide?

Eddie Fraser: Again, it comes back to how we work with local communities. As well as being the chief officer of East Ayrshire IJB, I am a director of NHS Ayrshire and Arran and a director of East Ayrshire Council, and when I go out to talk to local communities, I find that no one cares about any of that. What they want to talk about is how services can be delivered to communities and what the priorities of those communities are. As a result, we have been working with community-led action plans. There are 31 local communities; they look at their priorities and put together their action plans; and we look at how we can serve them.

The participatory budgeting role that we have put in place and which the local council, in particular, has taken really seriously has led to local communities prioritising how money should be spent and, indeed, to big changes being made, especially with regard to the preventative agenda that people have been talking about. For us, this is not just about the sustainability of the integration joint board, the council or the health board but about all of us talking about these things together. I suppose that that is the privileged position that we have, as you point out, in bridging all these different aspects.

This might sound flippant, but this is not about doing something to communities. Instead, it is about talking with local communities, local people—including the general practitioners who work in those communities—and even local schools about their priorities and the right things to do in their local areas. Our way forward in East Ayrshire is to have our 31 local community-led action plans and to work with our local communities on how we take things forward and meet local need.

People are very honest. We have meetings in village halls and town halls at which we talk to them, are honest with them about the pressures that we are under and listen to their ideas about how we might resolve them. For example, we are looking at developing what we call place-based approaches. That is being done primarily not by the health and social care partnership, but by our department with responsibility for communities, and it focuses on how local people working in local areas can do a range of different jobs. For example, if someone in Dalmellington pulls a community alarm, I will most likely have to send one of my social care vans from Cumnock over there to see whether the person is okay, but there will be guys around there who are, say, cutting the grass. Why can they not chap the person's door and make sure that they are okay? It is all about ensuring that we get the best resource to serve local communities.

Another example of a place-based approach relates to the totality of funding. There is no point in just saying, for example, that grass should be cut once a month, no matter what the weather is like; this is all about devolving power to local communities to allow them to do whatever is important to them. That is the type of thing that we need to do if we are going to become more sustainable.

That is why it is important for me to keep pointing out that IJBs do not work in isolation. They work alongside not only the council and the health board, but the wider community planning partners. Our relationships with, say, Ayrshire College, Police Scotland and the Scottish Fire and Rescue Service are all really important to us in that wider community planning arena. Police Scotland is doing work on trauma; the fire and rescue service is making safety visits; and a whole range of different types of engagement is happening. This is a public service for the future that we are part of and which we are delivering.

Val de Souza: I agree with Eddie Fraser. We are not quite as established yet, but we are certainly moving in that direction.

We use the word "transformation" a lot—and sometimes we try not to—but one of the things about transformation is that, once you start the journey, you just do not know where you will end up. That is a real challenge for us. If you propose a change and can say, "This is what we're putting in place, and this is what it's going to look like," it is so much easier to bring people with you. However, when you say, "This is what we're hoping to do, and it's going to take three to five years. We're going to look at the data as it emerges and we're going to do the best thing for you," it is all very nebulous and people find it far more difficult to hook on to what you are going to do and have confidence in it. Sometimes transformation requires a leap of faith.

Our approach to that is to have full engagement with our communities. Recently, we launched our three-year strategic commissioning plan for 2019-22. We invested a huge amount of energy and time in going out to our communities, asking what they want and what their priorities are. We did that in two phases: we went out and asked what people want and collated all the information and then we went back out and said, "This is what you said, do you agree?" We did that to try to prioritise things from one to 10. Early intervention and prevention was the first priority.

10:45

George Adam: Ironically, the answers can often be a surprise. I know that when we carried out such engagement when I was on the council, the answers that we got back were rather surprising. How do you then take that to the next stage? In

your case, that would mean taking it back to the public.

Val de Souza: I go back to the answer that I gave earlier: if we are surprised, then we need to listen because that is what we are there to do. We are there to listen, make sense of the response, understand it and work in a very big partnership about place—it is not about any one thing but about people and their place. We need to understand that. However, we also need to check that against the data and the policy direction. We need to take sensible decisions about how we take forward some of those priorities with our communities.

I have a small example of listening that I hope the people of Tarbrax do not mind me mentioning. I am not sure where we are going to go with it. We have a programme called building and celebrating communities, which aims to address some of the issues around that £300 million funding challenge that we were talking about earlier. It is trying to do something really different, but building on the strengths in the community.

We are having quite a lot of discussions about community and we had a meeting in Tarbrax about two or three weeks ago. Quite a lot of active local people were saying that they only have 400 people in the village, many of whom are ageing, and they talked about some of the themes that Eddie Fraser mentioned earlier, about trying to keep people well by avoiding social isolation and by keeping them involved and included. Some of those folk are coming back to us to say, "How about you pay us as families in our local community to undertake care?" They are saying that they would care for folk, but would also do the other stuff that those people need, such as taking them to pick up prescriptions, taking them for a walk, taking their dog for a walk, cutting their grass or whatever. That is an example of joined-up thinking from our communities.

Traditionally, when we have gone into the consultation and engagement piece, we have sometimes been a bit frightened about what we will be asked. Like Eddie Fraser, I think that our communities are very realistic. Largely, they do not over-demand. We need to be braver about having honest conversations in our communities.

Judith Proctor: It will not surprise the committee to hear that I agree with most of what my colleagues have said about those approaches. There is a variation in Edinburgh, because the city is large and diverse. However, working with communities where they are is an absolute principle of health and social care integration.

Another element in all of this is how we support our staff to change. A key question for us in Edinburgh is how we work at locality level—we have four localities in the city and each of those is very large. How we empower and support our front-line managers, staff and teams to work with people in a co-operative and co-productive way—that sounds like jargon, but it gets to the heart of what we are trying to do—is very important.

We are doing several things on that topic. We are developing a three-conversation approach to humanise the care that we provide—we are trying to embed that in the way that we all work, from practitioners through all staff. That approach is centred around the individual and the support that they need to live a good life in the community, connected to the sorts of things in the community that Val de Souza and Eddie Fraser have described. In parallel to that, we need to think about how we invest in community provision, third sector organisations and communities and neighbourhoods themselves to create the vibrant and resilient support that people need. A big element of strategic planning is based around that and a big element of the hearts and minds of our teams and staff is focused on how they can work in that way.

We have really good examples of our locality managers leading engagement with partners—the police, local GPs, third sector organisations and the communities—on what will make a difference and what we can do. The things that we could do might be surprising, but they are important, as they are about community cohesion. Community growing schemes, allotments and so on make a tremendous difference to communities.

More broadly than that, as a public sector partnership, we are having a lot of discussions across Edinburgh about the place-based approach. When opportunities arise to develop new capital builds, we as joint partners have to think about how to use that approach in what we do. It might go beyond a local authority needing to build a new school to it looking at the other opportunities sitting around that need investment in the community to deliver services differently and in a far more joined-up way. There is a lot of strategic thinking about that approach.

We do a lot of work with our partners in the council and the NHS on development opportunities and how we might move investment from traditional institution-based care into housing models that support more people in a different and more sustainable way in the community. There is lots of discussion about that. It is gratifying that, increasingly, we see that coming through the community planning approach with our broader partners. We are all trying to do the same thing and we will do it far better if we do it collectively.

Miles Briggs: As Edinburgh representatives, Alex Cole-Hamilton and I have people coming to see us who say the polar opposite of what you just

said, because they do not feel included. Pilton Community Health Project, which is Scotland's oldest community health project, was told of funding withdrawal with no notice. We can see from online comments that people in Pilton feel that they were not included in future proofing or in discussions about service redesign. What would you say to them in respect of what you just said? They do not feel that any of that has taken place.

Judith Proctor: There are different processes: that was a grant process that was overseen by the integration joint board. Grant processes, by their nature, are quite challenging. You might not be aware that the grant that we had to distribute under the health and social care partnership was made up of different elements from previous NHS funding and a council grant. Against the £14 million that was available, we had £35 million-worth of bids. The IJB undertook a thorough process with our partners in the third sector—we were supported by the third sector interface—to develop an approach that we felt was as fair and appropriate as possible, in the circumstances.

We are all well aware that some organisations were not successful in drawing down funding; however, through the process we have seen the development of new health and care organisations in communities. That is really positive, because integration has to be about new responses that are adaptive to communities' current needs, as well as being about sustaining organisations that are able to develop new approaches.

We worked very closely with organisations in the community, with Edinburgh Voluntary Organisations Council—EVOC—and with our other third sector interface partners, on the transitions that might be needed. We worked closely with Pilton Community Health Project after the funding decision was made, and my colleagues have met its representatives on several occasions to look at how it might rationalise what it currently does, secure other funding sources or work differently. We believe that we have undertaken as thorough a process as possible. Our board holds us to account on impact assessments and we have undertaken in-depth work with the organisation on that. We recognise that the situation remains difficult for organisations; the board is very interested in looking at the impact, with our partners.

The Convener: I want to ask you all a couple of questions.

In relation to this year's budget, have all the social care contributions—the additional social care money that has been provided to health boards—been passed on to you? Have your local authorities taken the opportunity to reduce the contributions that they make to social care budgets in your areas?

Craig McArthur: I can confirm that, in East Ayrshire's budget-setting process, all the additional contributions from the health and local authority partners were passed on, and the local authority elected not take a further reduction at Easter.

Marie Moy: All Scottish Government funding has been passed on to South Lanarkshire IJB. From the transformational point of view, we agreed a small amount of savings with the local authority partner, which we thought could be implemented in-year. However, over the past three years the local authority partner has, in support of the agenda, minimised the level of savings that it has asked of the IJB.

NHS Lanarkshire has also passed on all the funding and has continued to manage the risk that is associated with budget pressures on the set-aside services. It is a good and supportive working relationship.

Moira Pringle: There is a similar position in Edinburgh. We have a budget-setting protocol, which we agreed with our partners. I think that Judith Proctor mentioned earlier that we have regular tripartite meetings with our partners. The strengths and benefits from those discussions are among the things that will help us to move the IJB forward. I think that it was pointed out in the recent ministerial strategic group report that we will make progress only if we all understand each other's positions and have a shared view of the IJB's financial position.

To answer the specific question, NHS Lothian passed on in full its 2.6 per cent uplift and a share of its other funding because, like NHS Lanarkshire, it is below NHS Scotland resource allocation committee parity. The council also passed on in full its share from the local government settlement, and has set aside some additional funding that is subject to potential performance.

The Convener: On the funding gap issues that you all addressed in answer to Anas Sarwar's questions, it is clear that efficiency savings will be part of the issue. Is there scope for on-going efficiency savings, or is it all about fundamental change?

Moira Pringle: In Edinburgh, we have set out a three-horizon approach to financial sustainability. Judith Proctor referred to that earlier. Part of our programme is about grip and control and being more efficient with what we have, and part of it is about redesigning existing services. Another part of it—this is the three-year to five-year part—is about transforming services, doing things very differently, and changing our conversation with the people of Edinburgh. Therefore, it is not all about cuts to services.

Eddie Fraser: It is very difficult to see how we could deliver some of what we do and make efficiencies. Many of the services that we deliver, in particular through the NHS, are staffed services. For instance, we have 42 health visitors, who are part of the additional 500. If they all go from band 6 to band 7, that will be a cost to me. I understand the benefit that we will get from that, but it is a specific cost, and I do not see a saving there. I do not see how, if we are to continue to shift towards supporting people in communities, cutting the number of my community nurses would be effective.

In respect of our mental health priorities, I would not want to reduce my community mental health teams. If we are asked to look for cash-releasing efficiency savings and all we have is a staffing budget, it is very difficult to square that circle.

The frank answer to the question whether we can continue to make efficiencies all the time has to be no. At some point, we have to ensure that we have the full funding to deliver what we do. That is where transformation and/or additional funding comes in. Overall transformation will happen only if there is money that can be moved from one part of the business to another. I am not clear, for instance, whether the scale of funding that is needed to deliver for our local communities is available for transfer from the acute service. The number of beds that we will need to close in the acute estate to deliver an effective community estate has not been evidenced. We can be efficient and can consider scaling back, but we need to listen and we need to think about how we can actually deliver services. It cannot all be about efficiencies—some of it will be about transformation, and there will need to be additionality.

11:00

Marie Moy: I agree with everything that Eddie Fraser has just said. The scale of the challenge is such that because we need to embark on transformational change, we need to identify additional funding that will allow us to progress that agenda. The aspiration to find more efficiency savings will never stop, however, and we will always look for improvements in service delivery.

Over the past 10 years, local authorities have been managing within tighter financial constraints. As Val de Souza has highlighted, there is good and effective management in NHS Lanarkshire, but that is in the context of there being a smaller financial pot, under the NRAC. In being realistic about what can be achieved in the future, we have to be careful that we build on sound financial plans. Much of the transformational change agenda and its outcomes—in financial savings and performance—are still to be tested. A whole-system approach needs to be adopted. How realistic is it for both partners to continue to help us to find savings and how realistic is it for the IJB to find savings in front-line services that have been delegated to us?

The Convener: The Scottish Government has made several changes, including introducing the medium-term financial framework—planning its own funding for five years for the NHS—and the financial requirements that have been placed on health boards. The Government has been criticised for it, but it will also sometimes provide additional one-off in-year funds for delayed discharge and waiting times initiatives, and so on. To what extent do those changes offer opportunities for you to strengthen your financial planning, and how much can you take in-year payments into account when faced with the challenge of balancing budgets annually?

Eddie Fraser: If we can get more clarity around three-year funding settlements, that will give us more time, and if we know what we are doing with funding, we can give more surety to some of the people from whom we commission services—particularly in the third sector—who will also have more time. The differences are small amounts; annually, we can predict our budget to within 1 or 2 per cent.

However, of a £250 million budget, 2 per cent is £5 million, which means a lot of services having to be adjusted at the end of the year. The longer-term budgets help us to align better budget setting with our strategic plan, and to see where we could shift services and resources from and to. That is very helpful for us.

We are always keen to work at change. Quite often, in-year settlements come with particular support around how we test change, what the learning is and how we can take something and embed it more widely. On that basis, such settlements are very helpful. Reactive change can be more difficult—it can be difficult for us to have suddenly to go out and recruit staff to deliver against that reaction.

Recently, we had further investment for a couple of years confirmed for technology-enabled care for one of our localities. We can now think about how to fund clinical leadership and social care support for that, and how we will communicate to the public what we are trying to achieve. That in-year investment is helpful.

However, reactive investment can be difficult. For instance, if University hospital Crosshouse is full and we need to take people out of it—we do not have delayed discharge, but that is another story—we cannot magic up the social care service. We cannot just go out and immediately

recruit social care workers to deliver on that investment.

Judith Proctor: I will build on that point. When in-year moneys come in, they do not often come direct to the IJB through the process, so it is important that we discuss with our partners how money can be used differently. The convener mentioned funding coming to health boards to help them to address pressures; sometimes, the solution to such pressures is to invest more in a community setting, in order to achieve a longer-lasting change. That is important.

As we mentioned in our submission, the Edinburgh integration joint board recognises the challenge of one-year settlements in partnership situations, because it means that the discussion around the budget is a continuing process, as we mention in our submission. In some ways that is useful, because it helps us to understand one another's positions and to have live conversations about how we, as a whole system—including the people who are involved in the system—will operate, but it can mean that we spend an awful lot of time on that, when we want to focus on the change and transformation that are happening.

We would welcome any opportunities that the committee could take to consider the existing levers that the Government, the partnerships and their wider partners can use to help, such as budgeting over three years, rather than always doing so in-year. The levers are there for Government to do that without any significant or specific change to the legislation.

David Torrance (Kirkcaldy) (SNP): What progress is being made in linking budgets to outcomes and in complying with the legislative requirements?

The Convener: That is about the on-going challenge of outcome-based budgeting.

Eddie Fraser: As part of the integration scheme, we are required to report twice a year to the council and the health board. We report once a year on our strategic plan and once a year with our performance report. Our performance report is built around the national outcomes. We have 20 national outcomes—outcomes for children and young people and for justice, as well as for adult services. Our reporting therefore includes getting it right for every child, in relation to children and young people services; the community justice agenda for the criminal justice services; and delivery of health and wellbeing services.

You can see from our reports that our approach is not just about how efficient our services are, but is about how we change in order to invest in preventative services and in wellbeing, as well as in health and social care. For example, we also look at how we can work in partnership with housing colleagues and with education colleagues on the inequalities that we see. We align our whole reporting structures around the national outcomes.

Val de Souza: We do likewise. As we mention in our submission, in South Lanarkshire we have adopted a tool called contribution analysis, which is about identifying how confident we are that not only our finances, but any of our inputs or resource—time, money or people—are leading to positive outcomes in terms of the nine national outcomes. It has been a number of years in the making, but we now have evidence showing that we can connect what we are putting into the system with how we are supporting the nine national outcomes.

In the methodology that we use, we identify the resources that we put in, and then try to put together a plan for what we expect the outcomes to be in the short, medium and long terms. It is a bit like logic modelling. We then interrogate the different resources that one might claim will be successful in achieving an outcome: we narrow down to the areas of investment that have had the greatest effect with regard to efficiency, and we disregard those that have not contributed so much. There is a constant cycle of reviewing what we are doing, looking at the contribution that is being made by all our investments, disregarding those that are not making much of a contribution and trying to take a scientific approach to the link between finance and outcomes.

Our starting position is that the question is vexing and the area is complex. It is not about inputs and outputs, so the tool has been very helpful to us, in South Lanarkshire. I can give you a best-value example, if you want.

David Torrance: Yes, please.

Val de Souza: I will need to read it to you. It is about use of technology in meeting our last outcome, which is on best value.

As part of our technology-enabled care—or TEC—programme, we have looked at how investment has impacted on national outcome 9, which is about

"Resources"

being

"used effectively and efficiently".

An average of 4.3 blood-pressure appointments are avoided by the remote monitoring that is provided as part of our home monitoring programme. If we multiply that by the 3,545 patients who are registered in South Lanarkshire, and then by the £5.41 per 10-minute practice nurse appointment, we get a saving of just over £82,000. You can see why I had to read that out.

[*Laughter.*] Basically, we are looking at the impact of technology-enabled care and home and mobile health monitoring on the ninth outcome. In our modelling that approach results in a saving of over £80,000, but it might not always be a cash-releasing saving. It is a response to managing demographic demand and the other demands that we are facing.

Moira Pringle: It is probably fair to say that we in Edinburgh have not made much progress with linking finance and outcomes, but we are looking at how we invest in evaluation, in general. The whole idea of linking money to outcomes is valid, but as has been indicated, it is not straightforward. There is not a one-to-one relationship between investing money in a service and getting the outcome that you want, because outcomes are delivered through a variety of services. It is quite a complex area to get into: I think that we will be visiting South Lanarkshire to find out more about that approach.

The Convener: Fair enough.

David Torrance: What support has the Scottish Government provided to help integration authorities to develop their reporting on the nine national health and wellbeing outcomes?

Judith Proctor: We have local support through our partners in NHS Lothian and the council for some of the evaluation as well as the intelligence-led data gathering and reporting, and the Scottish Government's Information Services Division also provides each partnership with list analysts, which we have found to be an invaluable resource and support.

As Moira Pringle indicated, there is no one-size-fits-all approach, and the conversations that we have with those colleagues, who are experts in the field, are often about what we want to find out and understand. They usually help us to identify and gather information that helps to interpret the outcomes.

11:15

We work quite well with our support colleagues from ISD, who are embedded locally with our data colleagues. That is important—something is not done by people landing in Edinburgh and then going away again. Instead, people are embedded in our system and understand the way that we work, which is helpful.

As my colleague Moira Pringle said, we are looking at how to strengthen that approach further, particularly in relation to transformations. For changes that we want to make which we believe will result in better outcomes and might help us to manage within our resources, we want really good evaluation right the way across to tell us whether we are going in the right direction, whether we need to trim our sails or whether we need to completely change what we are doing. That is an important underpinning.

Eddie Fraser: I have a couple of examples of what we have been doing recently with different parts of Government.

Alongside the integration team, the chief officers have been trying to look at best practice and variation with regard to hospital discharges and sharing that information. They are looking at which areas are doing well and which are not, and are using self-evaluations to enter into conversations with one another. They are doing a different type of benchmarking that is about not just looking at numbers but visiting one another, and the teams visiting one another. That is one area in which we work with the integration team.

Although some of the data is still quite acute focused, it is of interest to us in the IJBs. The atlas of variation looks at the variations in different health procedures around Scotland and tells us, for instance, that there are proportionally more hip operations in Ayrshire and Arran than there are in other areas. Things are done simply with shaded maps, but the maps get us to ask questions about the variations. Is the variation clinical variation or is it to do with the health of or obesity in the communities?

We are starting to get a lot of rich data from Government that helps us to ask questions about how to change the health of our communities and what the big priorities are. It is not simply the case that consultants in Ayrshire and Arran must be deciding to do too many hip operations; if we take a step back and look at the health of our population, we can see that those hip operations are required. Why are they required? Is that about obesity or community health services? We have quite a lot of data, and it is our job to translate that into meaningful information and take action to deliver against it.

Val de Souza: We receive good help and support from the Scottish Government through ISD Scotland and on what we call the big six—unscheduled care, delayed discharge, accident and emergency admissions and so on. Nationally, we are growing that support.

I want to make a point about qualitative data. We are trying to listen more to patient and resident stories and to hear people's feedback on their experience of services. That is not so much about the input-output bit but about what we are contributing and what the outcomes are. Are people living better lives? Are they keeping themselves healthier? Are they able to look after themselves better? Do they have the information that they need when they need it? Do they have

the right interventions when they need them? What are people telling us about that? We collectively recognise that we want to be stronger in that area, and we are working on that.

In South Lanarkshire, I have appointed a communications manager. As members can probably gather, the engagement and communication piece is really big for us locally. I go back to the conversation about what we need to do to grow that nationally. A communications manager was brought in to link the communications from the partnership to the nine national outcomes rather than simply to respond and react to the requests from the media or other sources that we get in the system every day. The communications manager will proactively communicate what we are doing and how we are doing it and link the different parts of our work together. That will help us with our outcomes and our patient stories.

Miles Briggs: I want to go back to a point that Eddie Fraser made about outcomes and the third sector. On the legislation that established IJBs, third sector bodies were not part of the discussion at the start. Was that a mistake? How are you trying to build up the involvement of the third sector? I know that, in Edinburgh, the hospice movement works incredibly well as a charitable third sector partner and that such bodies often deliver services and transformation far better than the NHS and the local authority do. How can we get such bodies into discussions at an early stage?

Judith Proctor: I absolutely agree that third sector bodies are fundamental partners in the way in which we work. Third sector interfaces across Scotland sit on IJBs as advisory, non-voting members. That sends an important signal. However, we want, of course, to tap into the people who sit behind those interfaces—the people who work extremely locally in communities and neighbourhoods.

As the Audit Scotland report highlighted, a huge amount of work has gone on and continues to go on in Edinburgh with regard to how we engage with those partners. I am sure that that is also the case elsewhere. We are currently engaged in discussions about our new strategic plan. Many of those discussions are hosted and led by third sector organisations, and they help us to understand their contribution to doing some of the things that have traditionally been done by the statutory sector and the role that they play as a link into communities, neighbourhoods and people in Edinburgh whom we want to work with and discuss change with. That approach is important.

The third sector is broad. We sometimes talk about the third sector as one thing but, of course, it includes bodies that are national or international all the way down to hyperlocal bodies. It can be quite difficult to ensure that we cover all those bodies, but we stick to the principle that they are partners in the work that we are trying to do.

Brian Whittle (South Scotland) (Con): I want to consider the impact of the shift from acute care to community care. We have been given an example from South Lanarkshire that involves redirecting provision towards community-based services. The impact of that was the closure of a 30-bed elderly care ward in a hospital. That is the brutal reality of what we are talking about—that is the impact on the ground in our communities. As this committee discussed last week, we are emotionally invested in bricks and mortar in terms of care. What challenges and difficulties are faced in making that kind of decision? Is there a pushback against that kind of thing?

Val de Souza: That is definitely a question for me. That decision was tough, but sometimes we get caught up in the before and after and do not spend enough time talking about the relationships and how we build relationships when we are going from A to B. I would say that, in the example that you gave, the relationships with the South Lanarkshire partnership became very much stronger during the process. It took quite a long time—about a year—but we started pretty much from scratch because, given the territory that we are in with the integration authorities and the health and social care partnership, there is no route map or pathway when you are thinking about closing a ward. My colleagues might have one—I will need to ask them later—but we did not have one.

We started with the position in which there was a care of the elderly ward with 30 individuals—it was the Douglas ward at Udston hospital. It was managed by the acute sector, so the acute sector could be forgiven for thinking that, when that money was released, it would have gone to it. However, it was in the set-aside budget.

We were very early on in our agenda with regard to trying to understand the process. A lot of the challenge was about who we should engage with, who would make the decision, and whose money it was. Those were the three big issues. The engagement issue was interesting, and that would take us quite a long time, because integration joint boards do not have to comply with CEL 4—chief executive letter 4 of 2010—which includes the major change guidance that the NHS usually has to adopt. We did not have any guidance on engagement as such, so engagement was tricky. The best thing that I could do was to listen very actively to my partners. I had to act counterintuitively, because I come from a local authority background, but some of the intervention was from an NHS point of view. Sometimes you

have to do that—you have to listen and realise how that part of the system works. There was a bit of that for me.

We did not want only to look at the costs of the ward, which were £1.072 million, and say how much the community should have and how much the acute sector should keep. We benchmarked around the country and did not find a scientific approach that we could apply, so we got together a steering group. For each of the 30 individuals in the ward—and those who went before and would follow—we plotted what their care would look like in the community and what it would cost, what their care would have cost if it was still in the acute sector, and what we would need to put in place. The length of stay is quite important in that.

We applied a bit of science to the matter, and the approach took quite a long time. That was also about building up trust—that goes back to relationships. We were building up the shift to the idea that a lot of the money would be moved from the set-aside budget to the community to bolster that and get the whole system working, and that needed the release of that cash. Some of the approach was about giving reassurance about risk, and some of it was about engagement with staff, relatives and patients.

As I said, the starting position was £1.072 million. The end position was that we agreed that £700,000 would go into the community and that two pots of money would stay with the acute sector. About £760,000 was provided because staff in the acute sector said that the patients who remained under their watch would be more complex cases, and they wanted recognition of that. It was a negotiation, and we said that that was fine. Marie Moy mentioned earlier that the NHS has been very supportive of the IJB and has not passed on to it the on-costs and uplifts of the set-aside budget, so we negotiated another £760,000 in recognition of that.

The bigger point is that, using a kind of scientific methodology—which was probably not perfect, but was as good as we were going to get—three quarters of the money was transferred to the partnership. As a result, we have been able to invest £760,000 in our four localities for rapid access to get folk out of hospital a little quicker, for work in our locality teams around community pharmacy, district nursing and home care, and for building our integrated teams in those localities.

That took a long time. People might think that that is an easy thing to do, but I cannot emphasise enough the importance of relationship building and trying to understand each other's agenda, the shift in policy, and how all that knits together. Very respectful relationships grew out of that. It was one of our successes last year—so thank you for the question.

Brian Whittle: I will move on from that to a discussion that we had last week. If we extrapolate that out, we are probably talking about losing 1,000 beds in hospitals in the shift away from acute to community care. Are we as a country ready to have a discussion about that?

11:30

Eddie Fraser: That goes back to communication and, actually, trust. The partnerships and acute colleagues regularly do what we call day-of-care audits of all the patients who are in a hospital. At any one time, between a quarter and a third of the patients in a hospital do not need acute hospital care—they are there because they are waiting for something else. If we can provide that something else, that is when the trust bit comes in, so that the acute hospitals reduce capacity by that amount and we do not fill them up again. If we close a ward and move on, there will be no nurses there and no space to do that.

We have spoken a few times about using data, but it is about more than that. We need to start with the data and the day-of-care audits, which evidence that, every day, a lot of people who are in our hospitals do not need to be there. We then need to build an alternative to that. We need to build trust in the different services, which include care at home and care homes, which we have not mentioned yet. We have fantastic relationships with care homes, and we do work on physical activity and through the "My Home Life" management programmes in care homes. For people who need that level of care, they are good places to live in local communities and in a much more homely environment than a hospital.

Those are the types of conversations that we need to have. Anyone who tries to make that argument without giving a sound alternative to hospital care will not be basing it on a sound foundation. If someone just says that we should shut 1,000 acute hospital beds and do something differently, that will not be well received. We need to give evidence that there is a different and better way of doing things for the quarter to third of patients who are in hospitals and who do not need to be there.

Judith Proctor: Again, I whole-heartedly agree with Eddie Fraser on that. We are getting to a place where we are more likely to be able to have that conversation, but it is about achieving the balance of talking about what we might change and what we might not do while celebrating the alternatives that we now know that we can provide safely and well in communities. It is a fact that a hospital—a bricks and mortar thing—is far more recognisable in a community than the largely invisible things that we do to support people in

their homes or in care homes. We do not see or celebrate a lot of what happens and, unfortunately, some of the things that we hear and read about care in the community and in care homes are at the other end, when things do not go well, although such cases are by far in the minority. Nationally, we would benefit from a conversation about how our care and support system is changing and how that is improving people's lives and is better for people.

It is about a whole-system approach. If we can deliver safe and viable alternatives in the community, our acute hospitals, which are valuable resources, can work at their optimum for people who need them when they need them and for no longer than they need them. Right the way across the change, we need to think about what we are putting in place and the benefits that it can have for people.

Marie Moy: To be ready to close 1,000 beds, we would need to create the conditions that would support that. As Eddie Fraser and Judith Proctor have highlighted, we need safe and reliable alternative community-based services. In South Lanarkshire, test of change pilots are being taken forward. We have spoken about telehealth and telecare and giving people the opportunity to manage their care. Through contribution analysis, we are seeing that that is resulting in a drop in attendances with doctors and GPs because people can communicate their results electronically and get feedback. Those are positive developments.

We have also had a test of change pilot for intravenous therapies in which people have received the therapy in the community and so have not had to be admitted to hospital for it. Those tests of change are predominantly funded from non-recurring funding solutions. The challenge now is how to scale up to an extent where we can move the resources and move the care to a more appropriate place that is better for the individual and better from an efficiency point of view across the system and then, after that, release the resources.

It is difficult to predict from where in the system resources will be released and when. The complicating factors are the budget pressures and other challenges that both partners are wrestling with, which feature in our conversations. Val de Souza highlighted the example in Udston hospital. We recognised that our partners had problems, so we could not insist on securing that £1 million investment in the community. We thought that it was fair and appropriate that part of the funding should remain with our acute services colleagues, who deliver critical services.

The fundamental point that I am getting to is that up-front investment is needed if we are to develop safe and reliable services that we can all rely on and have confidence in. Once we have those, it will be easier to have the conversation with the public about closing beds.

Brian Whittle: Two areas interest me greatly—the third sector's impact on healthcare, in relation to prevention and rehabilitation; and the use of technology, which is paramount if we are to shift care into the community. Eddie Fraser said that he was not being flippant when he mentioned tea dances. Such initiatives are massively important.

How do you account for the third sector's involvement in and impact on your budgets? We all know that third sector budgets are being hugely squeezed; the sector seems to be an easy target. Is that factored into your thinking about your ability to manage your budgets?

The Convener: That is a difficult question.

Eddie Fraser: One of the first things that we did, to flag up the issue's importance, was to put prevention and early intervention at the top of our priorities in our strategic plan.

How we work with our third sector partners is very much about funding them and treating them as partners. Many of our third sector partners in East Ayrshire are precisely that; they are not commissioned services. When we work with the Council of Voluntary Organisations (East Ayrshire), the citizens advice bureau, East Ayrshire Carers Centre or East Ayrshire Advocacy Services, that involves partnerships, so people can work with us differently, because their funding is more sustainable.

We have been able to work more widely with smaller—if I may call them that—local partners by funding the third sector interface to produce outcomes and making the TSI the conduit for funding smaller partners. That approach takes away the red tape that many smaller partners say that they have to get through when they work with statutory bodies—such partners make that criticism. We work with the sector.

Our rep on the community planning partnership is the IJB's third sector member, rather than one of the officers, health board members or councillors.

The work is much wider than what we might regard as traditional health and care work. Our work to address violence against women is heavily supported by the third sector—indeed, it is led by the third sector. In some of our work on community justice and rehabilitation in HM Prison Kilmarnock, the third sector is centre stage. I do not think of the third sector as a parallel service; it is integral to the delivery of what we do.

In the context of care homes, I mentioned the independent sector. I also want to talk about the faith sector. For some of our work on

homelessness and learning disabilities, we get fantastic support from the faith sector. There is a whole community out there, and that support from wider Scottish society is important to us.

We need to commission appropriately to give all those partners sustainability, because one of the big dangers is to do with sustainability. If IJBs do not have early notice of what is happening with their funds, how can they work with third sector partners or other commissioned partners? Partners come to us and say, "Are we going to be funded in the next financial year? If you can't tell us, we'll have to serve our staff notice at the end of December." In February, we might be able to say that their funding is safe, and then they need to withdraw that notice. That is not the way to deliver consistently high-quality services. The issue is important for us. If we had longer-term funding, we could build better relationships with the third sector.

The Convener: We are a little tight for time, so I encourage Judith Proctor and Marie Moy to respond briefly to the question. We will then address the set-aside budget, which we need to cover.

Judith Proctor: I agree with Eddie Fraser's point about third sector organisations, procurement and the importance of being able to invest in those organisations over the longer term. I also agree that, in valuing our third sector, we must not forget the role of faith groups, which are important for communities. We need to invest in them and in independent private sector bodies, as they are important partners, too. We have to think of them as part of the continuum of what we are doing in Edinburgh—we are all in this together.

Marie Moy: On the funding that is available for the third sector, we have allocated funding for such initiatives. We have tried to protect third sector organisations from having to apply savings, but we have not been able to add further to the investment that we have committed to. It is a challenge for such bodies to manage cost pressures that they have within the financial envelope, and we aspire to contribute more to them.

There is also the role of volunteers in the third sector. We have two areas of work that involve volunteers—the distress brief intervention project, in which volunteers who have lived experience are contributing significantly to the outcomes, and the recovery hubs, which are being set up through the alcohol and drug partnership. It is people with lived experience who are better placed to assist people at a time of crisis in their lives, when they are suffering from difficulties and challenges.

The landscape is complex and the statutory partners definitely cannot deliver on it alone. Partnership working with the third sector and the wider community is key.

The Convener: Brian Whittle has a supplementary question; I ask for brief answers.

Brian Whittle: I will tackle the implementation of technology. There is fantastic healthcare technology out there that is not being deployed in the healthcare sector. The question is not just about purchasing the technology; it is about deploying it and offering continuing professional development to those on the front line who will use it. Within your budgetary restraints, is that an issue?

Judith Proctor: We very much want to use technology as far as possible. It is not always about using the cutting-edge stuff; there are basic things to support people at home that we might not have embedded nationally.

I was thinking about your comment about losing 1,000 hospital beds across Scotland. Moira Pringle and I visited our colleagues in our assistive technology-enabled care 24—ATEC 24—service just last week. It was great to see the technology that the service has and how it is distributed across Edinburgh. We saw the sheer number of adjustable hospital beds that we have—across the community in people's homes, we have hundreds of them, some of which are used to deliver palliative care and some to deliver really complex care.

The transfer from hospital care to care at home is happening and we are doing things differently through the use of equipment as well as technology. We could do more to highlight the ways in which technology, adaptations, aids and so on can support people.

11:45

As we begin to work with our training establishments and higher education, we need to prepare students and new workers who are coming into our systems to work using technology more. The generation who are coming in as nurses, occupational therapists and social workers are far more familiar with technology and more used to using it, so we have to think about the next generation of people who we will be looking after and be open to testing new ways of working.

Some of that comes down to a willingness to invest in testing and the underpinning evaluation of whether technology works and is as safe and effective as previous approaches. As Val de Souza pointed out, the individual's experience is often far better, and we need to be better at communicating that and sharing the good news stories, as well as being willing to do things differently.

Val de Souza: I will build on colleagues' comments. We are fortunate in South Lanarkshire to be developing a strong team around our technology-enabled care. Some of that relates to the attend anywhere platform, which allows us to do home visits in which OTs are in the room while physiotherapists are somewhere else. That is useful as we cover a bit of a rural area, where transport can be an issue.

We do a lot of videoconferencing around our care homes and independent sector care homes, which can be about connections or some types of surgery. Another aspect is mobile monitoring, which I mentioned earlier.

We are well supported and have good connections with the Scottish Government in relation to technology-enabled care. We therefore hope that we will be able to scale that up even more in the future.

We must not forget some of the basic things that Judith Proctor covered, because some fundamentals need to be in place. Home care scheduling, for example, is becoming really complex, but it is important to the efficiency effect and to getting the right person in the right place and at the right time. I could go on, but I will stop there because of the time.

Eddie Fraser: To move from technology-enabled care to support for our staff, we can use tablets and so on out there to access records only if the records are digitised. Over the past year, we have had to spend significant amounts of money to get all the social work records digitised so that we can access them, and we still have a bit of work to do on community health records.

In the future, when we talk about employing staff, an element of technological support should be included so that recurring investment is in place to allow staff tablets to be renewed every three or five years—or whatever period is required—and to ensure that, if a tablet does not work, nobody tells staff that they need to wait a fortnight before they can get it fixed, when it needs to be fixed that day.

We need to build the basic infrastructure to make sure that people can access the range of technological support. Many of us have parts of it but, if I ask whether my IJB has a recurring budget in place to ensure that, for example, every one of my 2,000 staff who might need a tablet or mobile device has it renewed every three or five years, the answer is no—I do not know about other colleagues' IJBs.

We do some such work in an almost opportunistic way, but we need to invest in the teams that support staff with technology. As well as doing the advanced stuff on what we can do and what we can imagine for the future, we need to build the foundations of technological support, which need work.

Emma Harper (South Scotland) (SNP): I am interested in the set-aside budget. Val de Souza talked about a good example of how that was used in South Lanarkshire, when a ward was closed and care was delivered in the community. We have discussed the set-aside a lot in the committee; it is operating well in some areas and maybe not as well in others. As a consequence, my concern is about whether the set-aside, if it is not managed well, impedes integration.

I am aware that NHS Dumfries and Galloway does not use the term "set-aside"—it uses a different term.

I have a couple of questions for the panel. Is the set-aside budget operating as intended in your areas? If not, what is preventing that and what needs to be changed?

Judith Proctor: In Edinburgh, we have good discussions about the set-aside. Through the self-assessment that we submitted for the MSG review, we identified that we are part established and moving towards being established in understanding the position with the set-aside. We get good information and data from NHS Lothian on our share and we understand what that means.

The challenge in the use of the set-aside is that it is embedded in the delivery of current services. When we think about the set-aside in conversations that we have now, we are thinking about services that are being delivered using those resources.

Sometimes we fall into the trap of thinking about the set-aside as a budget and just as money, but it is more than that—it is about all the resources that the funding provides, such as staff, expertise, infrastructure and costs. The transfer of all that to a community setting can be quite difficult. The conversation about the set-aside is complex by its nature and because it is part of a wider transformation from what we do now to how we might deliver services in the future. The starting point has to be a transparent conversation and clarity about where responsibility sits.

In Edinburgh, we are making good progress on understanding the resources and our responsibilities—although we are not there yet—and how we as an IJB would commission the use of those resources differently. When opportunities arise to talk about changing services, we discuss what that would mean for the potential release of funding or the transfer of funding and resources to a different model. We are having those discussions, but they are complex.

We have examples of where we have managed to take that approach in mental health and support

for people with learning disabilities. We have transferred the resource for supporting individuals who have lived in institutional care to supporting them in the community—the resources have followed the individuals. That gives us a good blueprint to work from.

We have had positive discussions, but I would not say that we have achieved our ambitions yet.

Eddie Fraser: The set-aside is code for the number of unscheduled care bed nights that an IJB wants to commission from the acute sector. That comes down to 10 specialties that the IJB can influence. To use the set-aside properly, we need to think about what we want to commission from the acute sector this year and what we think will be the direction of travel. That is where there is an opportunity for the IJB to give directions—in the legal sense—to a health board and the council over the next couple of years that say, "We want to commission 100,000 beds this year; next year it will be 98,000 beds and the year after it will be 96,000 beds." The issue is about seeing how we can do that and using directions to do that.

The MSG indicators on unscheduled care bed nights show that many partnerships across Scotland—probably the majority—have reduced the number of unscheduled care bed nights that they commission from the acute sector, but sometimes the acute hospitals are just as busy. In board areas such as NHS Ayrshire and Arran, where more than one IJB uses a hospital, all the partners need to reduce the pressure on the hospital before there is any release.

There are two things—the equity of the use of the resource by each IJB and the totality of the resource, which goes up and down. If we put use down but the IJB in North Ayrshire or South Ayrshire puts it up, there is no release from the acute hospital and it delivers the same level of service. We need to work together to bring down such demand.

We are still at an early stage with the set-aside. I agree with Judith Proctor about understanding where we are. We are working with the Scottish Government integration team on what directions should look like so that we can be more strategic next year. However, it is equally important to understand the relationships between IJBs and the relationship between IJBs and the acute sector.

Emma Harper: I will just give an example of what set-aside could mean. Anticoagulant therapy monitoring can be done at home, so why are patients going to get their blood drawn once a week, with all the associated costs, when a CoaguChek device can be installed at home? It will talk to the GP remotely and tell patients how to fluctuate their warfarin tablets, for example. All that can be done remotely. Could funding to support patients using a CoaguChek at home be a function of set-aside? Would that money come from the NHS and then move towards community care?

Val de Souza: Eddie Fraser might have a better answer to this one, but the direct answer is probably yes, but it is tricky because it is complex. We were fortunate with the Udston hospital example but, as I said earlier, there was no pathway or guidance when we started to work on it.

One of the other things that we did with the NHS South Lanarkshire partnership was what we called a 5 per cent project. It was a wee bit like Emma Harper's example. We looked at what is going on in the acute sector ward to see whether we could try to do 5 per cent of it in the community. It is like a test of change and we did it with intravenous therapies. We got a responsible medical officer to oversee the project and put all the staff and clinical safety and effectiveness procedures in place. Approximately 14 people at any one time in any hospital are on IV therapies, and they could probably be in the community, so we had a threshold and took out two at a time, in terms of the scale. The project was successful but we need to know how we would scale it up if we were to transfer the resource.

Our next challenge is how we will build that in the community, but we are starting from a really sound basis. We have also taken a similar approach in Clydesdale in relation to chronic obstructive pulmonary disease. That is a really interesting model.

We are looking at how we can get the cash released from that approach. It is difficult to release that cash when you have a ward that has staff, information technology and a lot of other bits of infrastructure that are all embedded in delivery on that ward when that is only one of its functions. The Udston hospital had one care of the elderly ward of 30 individuals. There was sort of a boundary around the unit, so we could put a cost on it. However, delivery of the core functions of the acute sector is wider and more complex in terms of the infrastructure and staff that we need. It is very difficult to release resource unless we are doing it on a big scale.

Emma Harper: The set-aside is normally held within the NHS. Does that mean that the NHS owns it or makes it difficult for it to be released? Does the NHS consider it to be its budget that is being handed out?

Marie Moy: To add to what Val de Souza has said, Lanarkshire has taken an open and transparent approach to the set-aside services. There is an unscheduled care group that is made up of key stakeholders. The director of acute services manages the services on a daily basis on

behalf of the IJB, and Val de Souza and the chief officer of North Lanarkshire Council are key partners in taking the set-aside concept forward and transferring and shifting the balance of care.

I would like to pick up on your earlier observation about what could be impeding the implementation of set-aside as well as NHS Lanarkshire's role and transparent approach. Although we are trying to move resources and shift the balance of care, I think that we need to revisit the fundamental underlying assumptions upon which the set-aside budget has been based. We know that, over the next eight years up to 2027, the older population in Lanarkshire will increase by almost 30 per cent. To accommodate that increase, we would need to make available more beds and more social care services, and we would strive to manage that growth within the financial envelope through shifting the balance of care. However, the underlying assumption that we could release resources from the acute services to fund that shift is unrealistic and flawed.

12:00

In terms of the totality of the whole system and all the cost pressures, including new medicines and drugs, we need to recognise that there are acute services outwith the set-aside budget that are also critically important to the people of Scotland. There is a whole range of services—cancer research, out-patient clinics and so on—and we need to adopt a whole-systems approach to them. It might be helpful to revisit the underlying assumptions that money can be transferred out of acute services to fund community services, and this is probably the opportune time to do so.

The Convener: That is an interesting point of view. Are there any other contributions on that theme?

Eddie Fraser: My point is almost along the same lines. In everything to do with set-aside, we tend to take things back to occupied bed nights. However, changing what we do with specialties impacts not only on bed nights, but on out-patients, prescribing and some of our primary care services. By doing positive things in relation to some of the specialties, there is a much wider impact, so continuing to focus all the time on occupied bed nights is not the most helpful approach to take.

The Convener: That is very interesting.

Emma Harper: The issue of leadership came up previously, too. Do the panellists agree that there are challenges around leadership? If so, have they hampered progress? Are there any thoughts on how we support and develop people to become leaders? I think that Judith Proctor talked about supporting staff through change. That takes good leadership, because a lot of folks do not like change. What is happening in that area?

Judith Proctor: That leadership challenge is not just for chief officers individually or as a group, but for all the public sector leaders who are involved. If integration is to work well, we all have to work together. We might need to give up some things and we might need to recognise that the responsibility for some things sits elsewhere. Therefore, we need to have quite a sophisticated conversation across our partner organisations about where accountability and leadership sit.

A big part of that is leading the cultural change that we want in our health and social care partnerships. Our staff mostly work to the terms and conditions of their parent organisation and those of the NHS or council—I say "mostly" because the Highland partnership is set up differently, but that applies to the majority of the 30 other partnerships. The leadership role for us as chief officers and our IJBs is to create an IJB and health and social care partnership identity—what we are trying to do as distinct organisations—and to lead our staff towards the outcomes of that organisation. That is really important.

You are right that doing that is beyond us as chief officers, and is beyond our senior officers. This is about how our front-line managers and leaders throughout our organisations are leading and supporting change. A big part of that is about creating the conditions in which ideas and different ways of working can come forward. Therefore, it is not about having leadership that just sets the direction and says what is to be done, but about how we work together to build movement for change in our organisations and beyond.

Eddie Fraser: Leadership, at a number of levels, is key in delivering change. There needs to be leadership in terms of understanding our local communities. There is also the issue of how local political leadership is supported by the wider partner organisations, including the health board or local colleges. Leadership on community planning and a real belief in wellbeing for our communities are key.

The relationship between the chief officer and the two chief executives is also key—there has to be trust; there must be an open relationship among all three. That is hugely supportive in taking forward not integration itself but the outcomes that we try to achieve from integration. If there is a high level of trust and openness, that is transmitted when we go back into everyday discussions not just in the IJB but at the council and the health board. We need to make sure that those relationships are strong and that that openness continues.

Val de Souza: I will briefly build on what my colleagues have said. Leadership is key, and trust and respect across all the partners are absolutely key. There are two parts to this: the leadership of people and leadership with a focus on place. We have more or less covered that. It is about understanding what you are leading and where you are leading. Being a leader for your place and your people is really important. The people part of it is to do with the workforce. Sometimes, when we are introducing a bit of change, we will test it out with our 5,000 staff, because they live and work in the area. There is something fundamental about having leadership at all levels; that is really important.

Emma Harper: The convener has said that time is tight. It might be that we send you some follow-up questions on housing, which I had wanted to ask about. Eddie Fraser talked about vibrant community teams, supported accommodation and how integrated the IJB is with housing services. I would be happy to follow up that up at a later point, if we need to.

The Convener: We will do that, if witnesses are happy with that approach. We may have one or two other things to ask about. Thank you for your contributions—the session has been very informative.

12:07

Meeting continued in private until 12:26.

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