OFFICIAL REPORT
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DRAFT

Public Audit Committee

Thursday 15 September 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 15 September 2016

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PUBLIC AUDIT COMMITTEE
3rd Meeting 2016, Session 5

CONVENER

*Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Alison Harris (Central Scotland) (Con)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Paul Gray (Scottish Government)
Geoff Huggins (Scottish Government)
Professor Jason Leitch (Scottish Government)
Julie Murray (East Renfrewshire Health and Social Care Partnership)
Shiona Strachan (Clackmannanshire and Stirling Integration Joint Board)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 15 September 2016

[The Convener opened the meeting at 09:01]

Interests

The Convener (Jenny Marra): Good morning and welcome to the third meeting of the Public Audit Committee in session 5. I ask all those present to either switch off their electronic devices or switch them to silent mode so that they do not affect the committee's work this morning.

Agenda item 1 is a declaration of interests. I welcome Gail Ross to her first meeting as a member of the Public Audit Committee and invite her to declare any interests that are relevant to the committee's work.

Gail Ross (Caithness, Sutherland and Ross) (SNP): Thank you, convener. I am a councillor on Highland Council, a board member of North Highland College, a board member of the Caithness and north Sutherland regeneration partnership, a board member of the Caithness partnership, a patron of Home-Start Caithness, a community champion for Caithness KLICS and an ambassador for New Start Highland.

The Convener: Thank you, Gail.

Decision on Taking Business in Private

09:02

The Convener: Agenda item 2 is a decision on whether to take item 4 in private, which would allow us to consider the evidence that we are about to hear on the report "Changing models of health and social care". Do members agree to take item 4 in private?

Members *indicated agreement.*

Section 23 Report

"Changing models of health and social care"

09:02

The Convener: Agenda item 3 is an evidence session on the Auditor General for Scotland's report "Changing models of health and social care". We will hear from two panels today, and I welcome the members of our first panel: Paul Gray, the director general of health and social care at the Scottish Government and the chief executive of NHS Scotland; Professor Jason Leitch, the national clinical director for NHS Scotland; and Geoff Huggins, the director for health and social care integration at the Scottish Government.

I invite Paul Gray to make a brief opening statement before I open up the debate to questions from members.

Paul Gray (Scottish Government): Thank you, convener. I am pleased to be at this meeting of the newly convened Public Audit Committee. I want to say three things. First, I am delighted to be able to bring colleagues with me who will support me in delivering my evidence to the committee. Secondly, if we do not have information to hand that the committee requests, we will simply say so and provide it as soon as we can after the committee meeting has concluded. Thirdly, Professor Leitch was asked to say something about the nuka project. I will be guided by you, convener, on when you want that subject to be brought into the evidence and how long you would like us to take over it.

The Convener: Do you mean when you are giving evidence on that today?

Paul Gray: Yes.

The Convener: It would be useful to hear that evidence today. Do members have any questions on the evidence that they have in front of them?

Alex Neil (Airdrie and Shotts) (SNP): It might be useful to have the nuka presentation first, because it will inform the questions.

The Convener: Is that possible Professor Leitch? Are you ready to do it now?

Professor Jason Leitch (Scottish Government): That is easy. I can speak for five minutes or three hours; it is entirely up to you. Shall we have the five-minute version?

The Convener: Can you make it five to seven minutes?

Professor Leitch: Mr Neil understands the model somewhat because we have talked about it extensively, including on a visit to America.

The first thing to say is that it is not perfect, nor is it instantly transferable. However, in summary, the Southcentral Foundation provides healthcare to 69,000 native Alaskans across a geography that is bigger than the rest of America. The majority of them live in Anchorage but they are spread throughout the whole geography. If you lay a map of Alaska on a map of America, it reaches from Boston to Texas. It is an enormous state and the people are distributed widely.

There is a long history of inequality, alcoholism and drug abuse, particularly among the native Alaskan population. A number of years ago, the federal Government, which was providing healthcare through the Medicare and Medicaid services, negotiated with the native Alaskan leadership to give it all the money for healthcare for the 69,000 people so that it could decide what to do with it.

A group of native Alaskan leaders, along with some friends of mine—a medical director, a chief executive and others who were in the United States—formed what is now called the Southcentral Foundation to provide healthcare to the 69,000. That is the logistics of it.

Healthcare is provided at about the same value as the rest of Government-provided American healthcare. It is slightly more expensive than ours but it is not a private healthcare system, so get that model of American healthcare out of your head if that is where you are. It is not health insurance; it is free at the point of delivery, much like the United States Veterans Association and our system.

The Southcentral Foundation called its model "nuka". That does not really stand for anything; it is a native Alaskan word. The model has a number of attractive features and people have started to visit it. I was the keynote speaker at the foundation's big event last June and I spent a week exploring the model. Frankly, it is the best primary care system I have ever seen, and I have seen a number of them around the world. However, you have to bear in mind that we are talking about only 69,000 people, not 5.5 million people, so the model is not just moveable. The fundamental element of the model is that it is owned by the people. They are called not patients but customer owners—the staff and the customer owners get you into trouble if you call them patients.

The model of primary care provision is team based. Some of you would recognise it from your knowledge of the best parts of the national health service. A person signs up with a clinical team of four rather than with a general practitioner. They might have a relationship with a doctor, but there are recruitment challenges, so it might be an advanced nurse practitioner. There will also be a nurse. There is always a mental health practitioner, which is crucial—we might come to that during questions around some of the new models of care in Scotland—and there is also an administrator.

That team of four manages a panel of patients in a supply-and-demand way. It is hard to believe—I checked surreptitiously to see if it was true—but, if a patient phones before 3 in the afternoon, the team guarantees to see them that day. There are appointments available. I looked at the computers and checked to see whether that was true. They have absolutely nailed supply and demand. Even if a patient's doctor is off sick or their nurse is on holiday, other clinicians are substituted in to see them.

They have no GP out-of-hours service—let me repeat that: they have no GP out-of-hours service—because they do not need it. They say that if someone has a proper accident or emergency, they will go to the accident and emergency unit, which is there, open and available to help people. They have never felt the need for a GP service after 6 o'clock because they guarantee that they will see you up to 6 o'clock if you phone before 3. They see families, young kids with fever and so on all during the day.

The logistics are only one element of the model, however, and my final remarks are about the culture. The logistics are very impressive but the culture is the most person-centred system that I have ever seen. I sat in on some consultations and saw the mental health practitioners in action. The service was all very much focused on the family. It was hugely integrated and was delivered around the care of the individual. I only saw the service in Anchorage; I did not travel far out into the sticks, but the model is used there, too, albeit slightly less frequently because the same-day care cannot be provided in a village of 36 or 400 people.

We brought the model back here, and about half a dozen doctors and nurses have visited. We are testing it in a couple of areas of which Skye is the most exciting. It, too, is a very rural area without the provision that there would be everywhere else. One of my pals from Alaska has just been to visit the service and opened the new community health centre there. It follows exactly the same process: team-based care and a customer-owner conversation with people. It seems to be going very well.

The model is being used on a small scale because we have to test our way into it for the Scottish context. We cannot just lift and lay the

model—that would not work. Indeed, we would probably not want to start Scottish healthcare with Alaskan singing—that would not be appropriate. There are pieces of the model that we would not instantly move into our environment. However, the model is impressive and we are appropriately testing it in Scotland as one of the new care models.

Alex Neil: We are discussing integration, the whole thrust of which is to redress the balance between primary and acute care. Will you tell us about the impact of the model in redressing that balance?

Professor Leitch: The data and narrative are very impressive. I have a slide that I can share with you. Doug Eby is the medical director and I know him well. I present with him a little bit around the world, sharing our story of quality, safety and delivery and the nuka version of integration, particularly in primary and secondary care. The Alaskan model has resulted in huge percentage reductions in the number of emergency department attendances and massive reductions in the number of unnecessary bed days. I cannot remember the overall numbers but there has been a reduction in ED attendances of about 50 per cent, with consequent savings and the moving of money into that community-based care.

I am not being careful because this is the Public Audit Committee, but I must keep saying that, in our terms, the model is quite small, although that does not mean that it cannot be scaled up. Other countries are looking at the model. Singapore, for example, is looking at it very closely because it faces the challenge of an elderly population and is struggling with integration, as you would expect. Japan, too, is looking at the model quite closely.

There is definitely something in the model, but whether we can translate it into the Scottish context is a different question.

Alex Neil: We have piloted the model in Fife.

Professor Leitch: Yes, we have. The Fife pilot was really interesting. We sent the director of public health in Fife to Alaska and she became a real advocate—almost an evangelist—for the model. She persuaded a couple of GPs in Fife to take the model seriously, and they did really well in part of the practice. However, part of Dr Margaret Hannah's challenge was the cultural change, and other elements of the practice were a bit more conventional and scared of the big change that was needed, so they did not embrace it quite as she would have liked them to do. The service provision goes on—pieces of it are still happening—but that example illustrates the nature of change. A top-down, unexpected letter from Paul Gray saying "Please do nuka" is not really going to work, although it would be nice if it did. There is a need to generate the cultural change inside people.

The Convener: I am familiar with the model through the pilot in Forfar. I was very impressed when I heard Dr Andrew Thomson explain how the service would work. The committee would certainly be interested in that.

The committee has questions on the main part of the Auditor General's section 23 report. Colin, would you like to kick-off?

09:15

Colin Beattie (Midlothian North and Musselburgh) (SNP): One of the central roles in developing new types of care and so on is that of the GP. However, the GP workforce appears to be facing a number of challenges, not least in retention and recruitment, and there have been complaints about an increasing workload. How are we addressing those challenges?

Paul Gray: As the committee doubtless knows, we have announced 100 extra GP training places. The committee will be alert to the point that that does not help us today, but we are seeking to add to the overall GP cohort. The negotiations that are proceeding on the new contract are intended to lay the ground for a flexible workforce that can respond to the changing needs of the population.

We are also anxious to ensure that the good practice in general practice is spoken about. It is likely to damage recruitment and retention if we are constantly in a narrative about what is wrong. We had that problem not in general practice but in acute medicine in Aberdeen, where the emergency department was constantly described as being in crisis, and we had to address the staffing shortage there. However, once we got out of the conversation about the crisis, some very good people were attracted to the emergency department, which is now functioning very well.

We are working with leaders in general practice in the British Medical Association and the Royal College of General Practitioners to produce a set of propositions that will make general practice attractive. We have a primary care transformation fund of £20.5 million and we are investing a further £10 million this year and next year in primary care mental health services, which Jason Leitch has referred to.

There is investment, preparation for additional workforce in future years and a strong and worthwhile conversation with the leadership of the general practice community. All of that is intended to build on the excellence that exists while recognising that there is serious pressure on general practice in some places in Scotland. I do not want to pretend that I do not see that.

Colin Beattie: The obvious question is: what timescale are we looking at? For example, if students are being taken in now to be trained up in the hope that they will go into general practice, it will be quite a few years before they pop out of the other end.

Paul Gray: Indeed. That is why I said that that would not be a fix for today. However, announcing those new places is an indication of support for general practice. Seven years would be a reasonable timeframe.

We are also looking to enhance the technology that is available to general practice so that some of the workload can be taken off general practitioners. The work that we are doing to enhance other professions—for example, those of physiotherapists and advanced nurse practitioners—allows us much wider sharing of expertise and different opportunities for patients to be seen by the appropriate clinical professional.

I was recently at the new Dyce medical practice in Aberdeen—I hasten to add that I have examples from places other than Aberdeen—which has an innovative model. Patients are now satisfied that they are being seen by the appropriate lead clinician instead of feeling that they have not seen the right person if they have not seen a GP. Therefore, there is evidence of general practice being developed in ways that work and of GPs working increasingly with the integration partnerships to ensure a whole-population view of what is achievable.

Colin Beattie: I realise that the situation in some areas south of the border is the same, if not worse. What are the prospects of recruiting from there to get a quick fix? I know that there are issues around golden hellos, for example.

Paul Gray: Scotland is an attractive place to work in. The success of our junior doctors campaign, for example, in which we sought to recruit from elsewhere—not just in the United Kingdom but more generally—is evidence that we can make it an attractive proposition for people to come and work here. However, I am keen that we do not get into too much competition with colleagues south of the border. I always pride myself on having good relations with other health services in the UK and beyond. That said, I have absolutely no doubt that Scotland is an attractive place to be because of its geography, the opportunities that it presents and the variety of practices here that people can work in.

Colin Beattie: I will continue on the theme of GPs. How is the Government addressing gaps in GP and community activity data?

Paul Gray: Considerable work is being done by the Information Services Division to ensure that we make the best use of local data. I would not claim that there is perfection, but we are working to ensure that, through the integration partnerships, we have a much more transparent set of information available that enables the local partnerships to make decisions about the most appropriate models of care delivery.

I saw that in action last week in Perth and Kinross, where colleagues were able to show me the data that they were using in order to decide how services should be structured and to demonstrate why services in Perth are structured differently from those in the more rural areas. There was data to underpin those decisions; they were not simply saying, “Perth’s a city and then we have the country, and we do things differently there.” They had hard information that enabled them to make those decisions.

Geoff Huggins can say a bit more.

Geoff Huggins (Scottish Government): One of the key underpinning elements of how we have been taking integration forward has been the provision of better information. With the linked data that we now have in Scotland through the source resource, we can understand how people move through the system. We can look at the different care pathways that are followed by people who have been diagnosed with various conditions and we can see how they vary from area to area.

We have been effective in bringing together the social care data and the activity data around general practice—I will come back to that—but also the hospital data and, increasingly, other sources of data, such as on housing.

We are funding ISD to provide link workers to support each of the partnerships to understand and use the data. Simply having the numbers is not always enough; quite often, people need somebody to help them navigate the data and understand what they can do with it locally. That approach is changing how people see and understand what is going on in their locality.

Paul Gray mentioned Perth and Kinross. The footprint of activity across the city area is very different from what we see as we move further west, where we see less use of hospital services and a different pattern of social care between residential and non-residential. That raises questions about why that might be happening in that area, but also about how it compares with other rural areas. We are having quite different conversations.

This is going to be part of the meat and drink of GP clusters, in that the expectation—and our objective—is that different primary care practices will sit down collectively and understand how things are working in their area and how the picture relates to the nearby clusters. There is a

real opportunity within that work. We saw the impact that it can have through the dementia diagnosis work and some of the work that we did on antidepressants. Usually, a general practitioner—or any clinician—sees only the person who is in front of them, not all the people who have ever been in front of them. It is therefore difficult for them to see the shape of what is going on. There is a lot of data support.

General practice is one of the areas where, at present, there is less data than we would want. The work that is going on through the Scottish primary care information resource is intended to address that. However, rather than tell you exactly where we are with that today, I suggest that we write to you, because I would probably get it wrong.

Colin Beattie: You said that not enough data is coming from GPs. Given that GPs already complain about bureaucracy and the admin that they have to do, is an extra burden potentially coming to them?

Geoff Huggins: That is not the intention. The intention is that, through the new information systems that are available to them, we should be able to extract data to understand the system dynamics, rather than asking them to fill in forms. At present, we are still working through some of the issues with that data linkage. There is no thought that we want to invest further in data collection.

The Convener: I have a follow-up question on data, and then I will bring in Liam Kerr, who has some questions on GP contracts.

It is clear that, in my community, the most deprived GP surgeries are the ones that are struggling. One in my community has been teetering on the brink of closure but has now managed to get another GP. Is the data in the more deprived communities worse? How have we got to the point at which GP surgeries in communities are under threat of closure? Is the Government data so bad that it has led us to a point at which workforce planning has not been able to keep up with the situation?

Geoff Huggins: The data that we have across the piece is the same in most areas. Historically, there have been some quality issues in some areas, but that is not linked to deprivation; it is more linked to there being different information technology systems in the different boards and councils.

We are able to extract the data by deprivation, age and, in some cases, condition. That has been interesting for us, in that it shows that, for the over-65s and over-75s, deprivation is less of an issue than we had thought, and that, for those below 65, deprivation is a key issue in shaping use of and access to services. That has taken us into a slightly different conversation about what is going on and the links between resource use, activity and deprivation.

The broader question about the shape of services and how they sit across the landscape is exactly the sort of issue that is being identified in integration authorities' strategic commissioning plans. As we would expect, there is a strong focus on health inequalities and deprivation.

At the point of delegation in many areas, one integration authority kept primary care as a hosted service on behalf of a number of integration authorities. That reflected the previous board oversight of primary care. However, that is beginning to change quickly as individual integration authorities and, indeed, localities examine the pattern of general practice and primary care in their areas, setting that against the outcomes. Primary care has been pulled down to the locality level rather than being held at the board level. That change has been driven by the point that you made about health inequalities and provision.

Professor Leitch: It is important to separate data on the quality of the care that families and individuals receive and data on the nature of the delivery system.

The system in primary care is one of the most electronic systems that we have. The electronic data in primary care is, in many ways, better than that in hospitals. We know about the quality of care delivery. We have electronic prescribing data, so we know about drugs, the drug bill and drug distribution. We can compare that data across localities and make changes.

The challenge in general practice is with the independent contracting model, which dates from the 1940s. The levers are entirely different. We do not employ the vast majority of those contractors. They are independent and can make their own decisions about many things, such as how they work, the times at which they work and the design of their practices. We can influence those matters but neither the board nor the integration authority can control them.

There are two priorities. First, we cannot overestimate the challenge of the new GP contract, although we should be optimistic about that. The second priority is the GP cluster model. If the GP clusters can gather around localities and design primary care in its broadest sense—doctors, dentists, optometrists and community nurses—for whatever that context needs, those decisions can finally be made in that place. The GP contract could take away what many practices say is a tick-box exercise—it could remove the quality and outcomes framework and focus on

quality for quality's sake rather than quality for pay. To be frank, it seems that we have moved on from that approach, which is good. Those two things together might get us to the point at which the workforce data and the quality data become useful.

Liam Kerr (North East Scotland) (Con): I appreciate your point about consultants, but my understanding is that the new GP contract will, in effect, be an employment contract—a contract under which GPs will operate. I presume that you are not in a position to go to them and say, "There is your new contract. Sign that and crack on." There will need to be some negotiation. How confident are you that that will be smooth?

09:30

Paul Gray: One can never be absolutely confident about a negotiation. What I am confident about is that we have built and are maintaining sustainable relations with the BMA's Scottish general practitioners committee and with the RCGP. In other words, we are not in battle with them in a head-to-head way. They have challenged us on a number of issues about which they have concerns, but they are generally supportive of the direction of travel that the Government has set out. I am confident that we have the relationships in place to continue to have robust and ultimately successful negotiations.

Of course, although many GPs are independent contractors, boards have the option of employing salaried GPs. That is another issue that we are thinking carefully about in terms of where we want to go with the negotiations.

I completely respect the fact that general practice is usually built on the self-employed approach, and I have no wish to undermine that. However, there are circumstances in which having a salaried GP is the right approach. There is also a trend towards some GPs preferring to be salaried, so that they do not have the uncertainties and pressures that are associated with self-employment. There are different ways in which the service can be delivered. With regard to the convener's earlier point, in some cases, a salaried GP response might be the right one. I am not speaking about any specific case, but that is an option that boards have.

Liam Kerr: You spoke about training taking seven years. Obviously, that leaves quite a long gap, during which there will be retirements, people leaving the service and so on. Do we have to wait seven years before the situation starts to improve?

Paul Gray: No. Those 100 places are in addition to everything that we are doing already. Further, we are working hard to ensure that GP returners—people who were GPs but who took a career break or went off to work in another country, for example, and who want to come back to general practice—find it as simple as possible to do so, because that is another good source of people coming into general practice. We are committed to making the process as slick as possible.

I am happy to give more detail, but I am conscious of time. Would it be helpful for me to go on a bit further about that, convener?

The Convener: It would be helpful if you could say a little more, yes.

Paul Gray: Another thing that we are doing in relation to recruitment and retention involves the Scottish rural medicine collaborative, because one of the things that we need to do is attract GPs into rural areas as well as urban areas. NHS Lothian has a retired GP locum pool to fill vacancies. That simplifies the process and ensures that people who want to remain in the workforce as locums after they have retired can do so. NHS Ayrshire and Arran and NHS Lothian are recruiting for early career GP development posts. Over the past year, 15 GPs have returned to practice through the NHS Education for Scotland GP returner programme that we spoke about earlier. There is also the deep-end practice pioneer scheme, which helps us to improve services to deprived areas. If I was going to make only one recommendation to the committee—usually, it is for the committee to make recommendations to me—it would be that you should go and see a deep-end practice. You would find that really worth while.

Geoff Huggins: Another thing that we are seeing is changed models of service. There is an increasing number of community and intermediate services, which include physiotherapists and podiatrists as well as, in a number of areas, social care. That is a different form of service that is being offered, and it is intended to lift the load from GPs and ensure that they are not the only conduits. Next Monday, the Glasgow city partnership will open the new Maryhill health and care centre, which will bring together three GP practices and the wide range of allied health professions as well as support services. It will also include a physiotherapy gym, so that people can have part of their rehabilitation in the community rather than in other settings.

The models of care that GPs sit within are changing quite quickly and dramatically. Again, that is one of the areas in which the integration authorities are looking at how they can design things in future. They are also learning from the community hospitals of the past.

The Convener: From where I sit, though, Mr Gray, one of the biggest problems in practices in deprived areas and in the deep-end practices is

the difficulty in getting doctors to work in those practices. Apart from the salaried option, what other solutions is the Scottish Government pursuing?

Paul Gray: In order to lift the load, there are 250 community link workers. That approach builds on pilots that have already taken place in Glasgow and Dundee. GP practices are being given access to an enhanced pharmacist so that the GPs can focus more on patients who require assessment. We have put in £3 million to train an additional 500 advanced nurse practitioners. Again, that is taking a load off general practice. In addition, 1,000 paramedics are being trained over five years to work in community settings. As an added benefit, that should reduce the need for some people, particularly elderly people, to go to A and E. A number of things are in place that are starting now as opposed to being ambitions or aspirations.

The Convener: If we are struggling to attract medical students and young doctors to work in deprived communities, is there a systemic problem in their training?

Paul Gray: As colleagues have said, a combination of factors leads people to go into different areas of practice. I am not promoting deep-end practices as the sole example of excellence. My point is that if we can show general practitioners who might aspire to go into practice in Scotland and others with an interest how fulfilling it is to work in an area of multiple deprivation—telling them not just that it is a great job but that there is support for it—we can attract more people into those areas. The initial choices that people make in their career can define their whole career path. If we can encourage more people to see the value and satisfaction that come from working in some of the most deprived areas, I believe that we will attract more people to work in those areas. Some of the things that we are doing are intended to support that.

Professor Leitch: These are hard jobs. Some specialists will write in and tell you that I am wrong, but being a general practitioner is probably one of the most difficult jobs. It is the undifferentiated illness—when you open the door, you do not know what is coming. It can be anything: it is as likely to be a mental health or family challenge as an acute illness. That is enormously difficult.

The most successful practices feel linked to the rest of the system. They feel linked to the acute medicine doctors in hospitals and to the social care system, which is doing all the social support. It is about trying to move practices away from being three people in a practice in a town and towards more of a cluster model. It is not just about the GPs being integrated. There is the integration with the diabetic secondary care doctor, who will help GPs with their difficult diabetic cases, or social care, which will help to keep the frail elderly at home. That is the key to making GP employment more attractive; otherwise, it is a very isolated place to work, in which there is enormous responsibility for the undifferentiated illness that walks through the door.

The Convener: Thank you, Professor Leitch. We could discuss the subject all morning because there are so many issues in it. However, we want to move on. Monica Lennon was keen to ask about workforce issues.

Monica Lennon (Central Scotland) (Lab): Before I do, I want to ask Professor Leitch a question. At the beginning of the meeting, you talked about the Alaskan example and a customer-owner model as opposed to a patient model. Will you explain what that means, please?

Professor Leitch: In that culture, it means that the Alaskan community literally owns the health service. Money was given to the Alaskan leadership, which works a little bit like a local authority or regional political body, with people elected to it from within the Alaskan community. Only an Alaskan native can be the chief executive of the Southcentral Foundation, and the board has to have 51 per cent Alaskan natives and other non-Alaskan natives on it. People feel possession of the system. In effect, elected community leaders make the choices about the way that the system is distributed.

The Alaskan natives have a long legacy of doing that in other areas, so that was not new, but the health aspect was new. I met the head of the Anchorage native Alaskan community, who was almost like a mayor. He had been elected from within his peer group and was running a big part of the services for native Alaskans, including native Alaskan schools, community churches and healthcare. There is something cultural about ownership for those people, which partly comes from the legacy of their being isolated and not looked after and the legacy of racism. On a host of issues, things were done to them rather than with them, and we could learn something from that about how we provide health and social care to communities.

Monica Lennon: That helps. However, there is no recommendation to shift from speaking about “patients” to speaking about “owners” here in Scotland.

Professor Leitch: I would not be convinced about having customer ownership in Scotland. However, in my role in the Government I have the person-centred care responsibility, and I am a big fan of empowering the community, the individual and the family. I hope that some members get

updates from Patient Opinion in your inboxes every month or when somebody writes a story about your constituency. I am all for hearing the voice of lived experience, but I am not sure that a switch to talking about "customer owners" would be particularly helpful for us. However, other elements of the approach would be helpful.

Monica Lennon: You talked a lot about how cultural change and change in attitudes and behaviours can go a long way in transforming how we deliver services, but the reality is that we need resources and cash in the system to do that. To pick up on the Audit Scotland report, we are getting a picture that resources have remained static in the period from 2010-11 to 2013-14. With that hard reality, how optimistic are you that transformational change can be achieved? I extend that question to all the witnesses.

Paul Gray: One thing that we have to move into is describing the workforce not only in terms of the particular specialisms that exist today, because we are looking for a more flexible workforce. I will read the relevant bits from Audit Scotland's recommendation on that. It said that we should

"provide a ... framework by the end of 2016",

which should

"include the longer-term changes required to skills, job roles and responsibilities within the health and social care workforce"

and

"align predictions of demand and supply".

We intend to set out, by the end of this year, what has been asked for on the workforce. However, that requires a degree of caution, because the workforce in central Glasgow will be rather different from the workforce in the Western Isles, which will be rather different again from the workforce in the Borders. In the Auditor General's evidence on 30 June this year, she helpfully acknowledged that she did not want to adopt what she called a "cookie-cutter approach" in which we design something in one place and then apply it in exactly the same way everywhere else. I accept the recommendation that, by the end of this year, we should say what the skills, job roles and responsibilities of the workforce should be and—so that it is not mere aspiration—say how we plan to get there, but with the caveat that that will not be a one-size-fits-all prescription for the whole of Scotland.

Of course, there have been increases in the workforce in qualified nurses and midwives, who are extremely important in the community, and in the number of doctors, particularly consultants. Paramedics make an important contribution, and their numbers have gone up substantially by more than 13 per cent over the past 10 years or so. We are therefore seeing increases in the workforce that contributes to care outside the hospital. I am very happy to provide, as Audit Scotland has suggested, something in more detail on that by the end of the year.

09:45

Professor Leitch: The basic answer to Monica Lennon's question is that I am incredibly optimistic—I know no other way. I am very optimistic that the healthcare system is resilient enough and of high-enough quality to find a way to transform to a new reality. That transformation will be constant; it is not going to be a moment in time when we suddenly say "Oh, the health service is fixed. Thank goodness for that." It is going to be a constant journey with the demographic shift and the resources. There are some decisions that I do not get to make, such as on the resourcing, so there is no point in my dwelling on that particularly. Our role is to support that delivery system, particularly the workers in what I would call, using a bit of jargon, the microsystem, which is where the patients and their families meet the system, with the workers there doing their absolute best and improving the quality.

I think that we now have some of the policy position in place for that modern delivery. We had two big visits last week from 30 Swedish politicians and a pile of senior Danish clinicians. They said that they are facing exactly the same demographic and resourcing challenges as us, and they visited us to see how we design things, particularly the quality elements of our healthcare system. They were very interested in health and social care integration, and saw some of it in reality inside the microsystem. They were also very interested in the way in which we had designed the high-level policy position but empowered and released workers to make changes on the ground. It is not easy getting a balance between those two things, but there is something attractive for other countries about the way in which Scotland is trying to do that, and they are beginning to take it seriously, even in Scandinavia.

Geoff Huggins: The other element to talk about is how the workforce is changing how it does its business. As of today, we have around 200,000 people in the social care workforce, which is about one in 12 people who work in Scotland. That is a significant number of people and 8.7 per cent of the working population in Scotland. What we are seeing are changes in the use of their time and the flexibility that they have to provide service changes.

In terms of the additional hours that we have seen going into care at home, more of that is now devoted to rehabilitation and step-down rather

than on-going packages of care. We are seeing front-line staff having additional flexibility around decisions that they can make themselves in respect of care and how they can organise their time. We are also seeing increasing local procurement, so less time is devoted to travel and more is devoted to care. We are therefore seeing across the system that we are using that resource in a way that is more empowering for staff and offers better quality. In addition, with the work on the living wage, the staff will be better paid. We believe that that is a good investment in getting better outcomes.

Professor Leitch describes it at the microsystem level, but at the coalface we are seeing different ways of doing the work to produce better outcomes for people within the resource that we are likely to have. Having 200,000 people working in one sector in Scotland is a lot of people. In terms of the broader objectives around economic growth and gain, we also need to put people to work to do other things.

Monica Lennon: Professor Leitch, I admire your optimism. I like to think of myself as an optimist, even at this time of the morning. We have touched on the critical aspect of the home care and the social care sector, and that workforce is very significant. However, the reality on the ground for a lot of people who do those jobs is that it is very hard work that is often done on zero-hours contracts and low pay, and there is often a lot of pressure on them to be flexible. In many areas, it is therefore not an attractive career path for younger people. We still see occupational segregation there, so we do not have a lot of men coming into that workforce. There is a lot of pressure there. Does that give you concern?

Paul Gray: The commitment to seek to pay the living wage is an indication that we want to have a better remunerated, better qualified and better motivated workforce.

I do not usually express personal opinions in parliamentary committees, but, if I am allowed to do so, I will express such an opinion on this issue. The fact that some of our lowest-paid people work in caring for frail elderly people or small children is not a good sign of how much we actually value those professions. Speaking as the chief executive of the national health service in Scotland—and I point out that, as Geoff Huggins has mentioned, many of these people are not NHS employees—I think that it is enormously important that we pursue the trajectory of ensuring that the living wage is paid. As the committee will know, funding has been provided to support that. However, we should also pursue the importance of people in these occupations having proper access to training, having opportunities to learn and grow and having career paths. I am not ignorant of the fact that some care providers are under significant commercial pressure, that there are recruitment difficulties and that costs are increasing, so I do not say that in a vacuum. However, I believe it to be important that we ensure that the people who work in occupations that care for the most vulnerable people in our society understand that these are valued professions that deliver enormous social good. Indeed, that is inherent in some of the policies that we are seeking to pursue in what is a difficult and imperfect world.

Professor Leitch: The point about career progression is very important. In some parts of our workforce we have been better at educating individuals and giving them learning and development opportunities than in others. The Scottish Ambulance Service is enormously good at that; relatively unqualified people can come into the service as technicians in ambulances and then become paramedics, go back and do nursing or become paramedic consultants and run whole teams.

We are very good at doing that in parts, but our social care pathway could do with some work. The member is right about the large swathe who come in as care for the elderly workers or early years workers. We are getting better at that sort of thing, but, as well as having the living wage, the career pathway needs to be more attractive and needs to contain moments in which people, if they wish to, can achieve and move along it.

Geoff Huggins: I want to make a couple of points about this. A key issue is the quality of the work, and we have made a commitment to moving beyond the idea of time and task—in other words, beyond a scheduled appointment in which you need to be at a particular place before driving to another place—and to the idea that people can work flexibly with their case load. We are exploring some of that under the Buurtzorg model, but even two or three years ago, we were regularly being approached by consultants whose advice was all about finding a way of taking 50p off the hourly rate. Trying to push the system a bit harder and make things a bit faster in order to reduce costs is just a false economy and takes a quality component out of it.

Scottish Care's "Voices from the Front Line" reports on why people go into caring and what they take from caring are an enormously valuable resource about what motivates people. There are people who would like to have career progression, but around 50 per cent of people come into the profession either because they do the job alongside other things such as family commitments or because they take value simply in the intrinsic process of caring, which is something that we need to value. Scottish Care has identified that around 50 per cent of people see their current

job as the job that they want to continue to do. Scaled up, that means half of 200,000 people. There is an issue around career progression, but we must not undervalue the basic day-to-day care that people offer by suggesting that it is a stepping stone to something else.

Alison Harris (Central Scotland) (Con): I, too, would like to leave here feeling as optimistic as Professor Leitch, but as far as the area that I represent is concerned, I want to hear about the here and now, not a vision for the future.

As Jenny Marra alluded to with regard to her area, I know of GP practices that are closing in my Central Scotland region or being taken over and run by the health board. I am inundated with people complaining that they cannot get a GP appointment, and I do not mean an appointment with an associated health worker. There is a crazy system whereby you have to phone at half past 8 in the morning and, if you do not get through, you have to phone the next day. It is frightening.

In addition, Forth Valley NHS Board is not meeting its 12-week waiting time initiative to see patients, especially in orthopaedics, ear, nose and throat, and another department that has slipped my mind.

Alex Neil: Urology is a bad one.

Alison Harris: It is not urology. I have forgotten which department it was, but it will come back to me in a second.

When you speak to the doctors involved to find out when the patients will be seen, they cannot give you an answer. They cannot say whether patients will have to wait 15, 19 or 20 weeks for their appointment. Added to that—this is a major concern for me—is the fact that some of those consultants have no time limit for a follow-up appointment. At a patient's first appointment, the consultant might say, "I have no appointment scheduled for you and my next free appointment is in a year." What can we do about that? We were talking about the model for 2020, but we have real problems now. When will we start addressing those?

Paul Gray: First, I am happy to take specific details after the meeting, if it would be helpful, and we can look at that.

However, I do not want to sidestep your question. If a GP practice is unable to fulfil its responsibilities or the partners decide to close it, the process is for the health board to take it over and provide the service. I would not like to leave the impression that that was the wrong thing to happen, as that is the fallback.

Alison Harris: I am not saying that it is wrong.

Paul Gray: That is fine—I just wanted to clarify that.

Part of the here and now is that, if a GP practice cannot continue, the health board has a responsibility to take it over, and that was partly why I mentioned salaried GPs in an earlier response.

On waiting times, you spoke about the 12-week treatment time guarantee. John Connaghan, NHS Scotland's chief operating officer, is working with the boards—including NHS Forth Valley—that are not currently meeting that guarantee. We have been very clear that, with any delays, patients should be stratified on the basis of clinical need—in other words, they should be placed in order.

As I said, I am more than happy to pick up on any specific issues relating to a particular health board in order to understand them more clearly, rather than give off-the-cuff answers. It is not that I do not know about NHS Forth Valley—I do—but I could provide a more detailed response, if that would be helpful.

The Convener: I have let the questioning about GPs run on because it is very important, but I am conscious of time and I still need to bring in Alex Neil. Do you have a final point that you would like to make, Alison?

Alison Harris: I do not think that my experiences or my constituents' experiences are unique. I do not want to get carried away with exciting models for the future when we have real problems that we need to face now.

Paul Gray: I would not seek to suggest that there are no problems in the national health service in Scotland—it would be a unique health service if there were no problems. Part of the reason for wanting to introduce new models of care is to reduce the prospect of the current problems recurring.

As I said, I am genuinely happy to follow up in more detail on specific issues.

Alison Harris: That would be great.

Alex Neil: The thrust of my questions is in relation to the Auditor General's report on integration. Before I get to that, I have a specific question about the planned introduction of the electronic patient record, which is a tool that would help not just integration, but the health service, patients and the whole thing. It is due to be fully introduced by 2020. Where are we with that?

Paul Gray: Mr Neil, I am not going to give you a work-in-progress answer to that. I have asked Professor Andrew Morris to take on responsibility for telehealth and innovation, and I will get Professor Morris to write to the committee with a detailed outline of where we are on the electronic

patient record. We are working towards that aim but, to be frank with the committee, there are elements of it that I would like to be completed before 2020. As you know, we already have some important elements in the key information summary, which is used in emergency cases. That information can be shared with NHS 24, subject to patient consent. I am happy to give the committee a detailed response on that project, because it would be helpful for members to have an outline of where we are with it.

10:00

Alex Neil: Okay. I have three questions on integration. I will ask all three together, because we are running against the clock a wee bit.

My first question is about the fact that it is not clear what will be achieved on integration in 2016-17, which is a point that the Auditor General makes in her report. This is the first practical operational year of integration and we have to be realistic about what can be achieved in the first year, because it is inevitable that much of the work that is done will be about setting up systems, procedures, policies and all the rest of it.

At the end of the day, the national outcomes are what is key for all the integration joint boards. Will you have—or do you have—some benchmarks for 2016-17 and 2017-18, and maybe even for 2018-19, against which you can measure progress towards achieving the outcomes? By the end of 2016-17, should certain things have been achieved? If they have not been achieved in certain areas, will that be treated as a failure, and if they have been, will that be treated as a success? We need to be clear and realistic about what can be achieved, particularly in the early years, because integration is not something that can be done overnight. That is question number 1, which relates to the concern that the Auditor General expressed.

My second question is on budgeting. It is clear from the IJBs that I am aware of, and not just the ones in my own area, that budgeting remains a key issue and a potential point of contention between health boards and local authorities. Now that we have 31 IJBs up and running, would it not be a lot simpler for the Scottish Government to allocate the budgets for health and social care as an integrated budget to each IJB instead of giving the money to the health boards and local authorities and then asking them to agree on what the budget should be, with all the built-in tensions that go with that?

My third question is this. We now have 31 IJBs up and running. They are responsible for £8 billion or £9 billion out of the £12 billion-plus health service budget. The rest of the health service is responsible for the other £3 billion or £4 billion. However, we have 23 health boards managing one third of the entire health service budget. When are we going to get realistic about the number of health boards that we have in Scotland and boil that 23 down to a more realistic figure?

Paul Gray: I will answer briefly on your second and third points, which were on budgeting and the number of health boards, and I will ask Geoff Huggins to give us the detail on the benchmarks.

My main point on your first question about integration in 2016-17 is that we set out to achieve full operation of all the integration joint boards—all the partnerships—by this year, and we achieved that. That had to be the starting point. If we had not achieved that, we would have had a problem. I am grateful for your remarks about the need not to load too much expectation into year 1. Nevertheless, there has to be significant progress, and Geoff can talk about that.

On budgeting, the simple answer is that it is a matter first for the finance secretary, then for the Cabinet and ultimately for the Parliament to agree how they wish the budget to be constructed. The point of caution that I would add is twofold. First, not all IJBs are the same. In other words, we cannot say that if there is a population of this size, the budget should be that size, because there are things that IJBs must do and then there are things that they can elect to do—not all of them have children's services, for example.

My other point of caution is that although the process of negotiation is, as you rightly say, a possible point of contention, I think that the fact that an IJB has a budget that has been negotiated between the health board and the local authority means that the IJB has some ownership of the amount of money in that budget rather than its simply being able to say, "That's what we got from the Government." It is important that the IJBs own the budget and are committed to delivering within it.

With regard to the number of health boards, I hope that there are not 23, because I think that there are 22, but perhaps you were thinking of the Care Inspectorate as well.

Alex Neil: I was thinking of the Mental Welfare Commission for Scotland.

Paul Gray: That brings us up to 24.

With regard to the 22 health boards, I am sure that you have read the Scottish National Party's manifesto, in which it said that there would be a consultation on the governance of health boards. I expect that ministers will want to announce in due course when the consultation will be and what form it will take.

Alex Neil: So there is no planned date for such an announcement.

Paul Gray: Ministers have not yet given a date for such an announcement.

How are we for time, convener, with regard to moderating what we say?

The Convener: We are fine for time. You suggested that Geoff Huggins might want to add something.

Geoff Huggins: On benchmarking and progress, it is a good point that we are still in the relatively early days of integration. However, I am sitting here with the annual reports that have been produced by East Ayrshire IJB and North Ayrshire IJB on the basis that they were in place on 1 or 2 April in 2015, so they have had a year of activity and have now reached the stage of producing their reports. The East Ayrshire IJB report was agreed on Tuesday and is in the public domain, so the committee can see what it has achieved under the new integrated framework within that period. You will see the progress that has been made on delayed discharge and reducing alcohol-related admissions.

On the question of how we are looking to bring that together across the piece, I or my team will meet each of the partnerships roughly once every nine months to spend time with them and talk about where they are. In each case, I will meet the chief officer from the partnership and the two chief executives from the parent organisations.

Within that, we will focus on data issues and progress. We will also spend time on issues such as winter, delayed discharge, hospital admissions and bed days. We are doing comparisons and engagement work, and working across the system, on issues around flow, community response and anticipatory and preventative activity. However, not all partnerships struggle with those issues, so we will look at things that are more appropriate for other areas, such as social care commissioning, which has been key in some areas, and mental health service delivery.

There is some element of moderation going on. Within that, we will challenge boards, and we will expect them to describe how they are taking forward work with communities.

We will bring together the chief officers as a cohort once every two months. Again, we will use that as an opportunity to look at particular horizontal issues that apply across areas. We will bring data and will talk about the shape of the system and issues such as the use of residential care versus care at home, and the use of hospital for the over-65s as opposed to the under-65s. We are using that data to give boards a conscious understanding of what is happening on their patch, and to give them some knowledge of what appears to be working in different areas. One of our report's themes is how we take forward that learning, and we are doing that to some degree.

Alex Neil: That answer is helpful and very welcome, but it does not answer my basic question. At a national level, there are certain benchmarks for progress that we expect everybody—the system as a whole, nationally—to have achieved. That is the key issue.

The Auditor General will presumably come back and make similar comments every now and again if we do not have something against which to measure progress nationally. The absence of that means that none of us knows what to expect by the end of this year, and how far you intend to make progress in achieving the actual outcomes, which are the key strategic performance measurement.

Geoff Huggins: All partnerships are required to report against the 23 indicators that are established under the nine national outcomes. That provides a framework under which we can understand progress across the partnerships.

Alex Neil: Will you nationalise that, if I can put it in that way?

Geoff Huggins: At the beginning of the summer, we looked at the ministerial strategic group, where we bring together the Scottish ministers, Convention of Scottish Local Authorities leaders, the voluntary sector, providers and the independent sector. As part of rethinking its role now that integration has been launched, two of the standing items that we brought to the group were about performance and progress, so that we can look across the system, see how we see change, and consider whether that is satisfactory and whether intervention is required, and sustainability, which involves understanding the interaction between resource and activity. We identified the need to do that nationally and created a framework to do it in partnership with the other partners that are required to deliver integration.

Alex Neil: It would be helpful if the committee were informed once you have done that work so that we can see how we measure that as the Public Audit Committee.

The Convener: Yes, indeed. That would be helpful.

Paul Gray: I remind the committee that on 6 September it was announced that Sir Harry Burns would chair the review of NHS targets and indicators. That work will be done with COSLA, which is supporting the joint review, and we, too, are working closely with it. That means that by the end of this year, the committee will have something further to consider, based on Sir Harry

Burns's recommendations about what we ought to do.

For me, it is important to understand the trajectories in individual integration partnerships. One might easily say that partnership A is lagging behind partnership B on a specific issue, but partnership B might well have started 50 per cent behind. I do not want to get too much into having league tables on this, but it is right to say that there ought to be some national objectives, and they are set out in the overall indicators.

Alex Neil: Will you clarify whether Sir Harry Burns's review includes a review of the national outcomes or the 23 indicators?

Geoff Huggins: The outcomes have been established by regulation under the legislation, so the focus that has been identified is on the indicators that support the outcomes.

Alex Neil: That does not answer my question. Is reviewing the national outcomes or indicators part of Sir Harry Burns's review—yes or no?

Geoff Huggins: Were Sir Harry Burns to identify as part of the review that there was an issue with the outcomes, I am sure that we would look at any recommendation that he made in that respect, but he has been asked specifically to look at the indicators and targets.

We are seeing some quite interesting data in respect of interactions. With the East Ayrshire data, for example, we have been able to see not only the progress that has been made on delayed discharges and reduced delays of care but an increase in the number of emergency admissions for the over-75s. Members can see how those things might fall together; as some capacity is freed up, it gets used. That takes us into a broader conversation about overall dynamics. I am wary of having a simplistic focus on individual indicators because, in solving one problem, we need to move on and try to reduce the next problem. The system is more complex than we might sometimes understand.

The Convener: Gail Ross will ask the final question.

Gail Ross: I have listened with great interest to everything that has been said so far, but I must bring to everyone's attention the fact that, in Highland, we have been integrated since 2012. There have been challenges, but many things have worked. What lessons have been learned and taken forward nationally from the model in Highland?

I want to go back briefly, if I may, to the issue of recruitment in order to touch on rural recruitment. In that respect, there are huge challenges in NHS Highland; our problem seems to be that there are too many specialists, and we are looking for more general surgeons and consultants. We have problems, especially in Caithness general hospital, with anaesthetists and obstetricians, and we also have problems with GPs.

We are finding that more and more people are having to travel to Raigmore hospital, which for some people can be a round journey of more than 250 miles, and a lot of people make that journey only to find their appointment cancelled at the last minute. There are a lot of difficulties there.

We also seem to be spending a lot of our budget on locums. What can we do in rural areas to be less reliant on them and make it more attractive for people to have substantive posts?

10:15

Paul Gray: Last year, I drove all the way from here to Caithness for the annual review, so I have some appreciation of the challenge that folk face in making that long journey. I know that NHS Highland is thinking about models in which they take the care to the patient rather than take the patient to the care. For example, I know that it has worked with consultants to provide cover in Wick, thereby ensuring that people do not have to travel so far.

When I was in Inverness last November, I had a very useful meeting with the GP rural body, which was meeting that day. An issue that I took away from that meeting and fed back was the importance of the new general medical services contract in taking account of the circumstances of rural general practice.

As for the recruitment and retention issue in NHS Highland, it is pretty obvious in some specialisms. I know that the chief executive, Elaine Mead, and the medical director are firmly sighted and working hard on the issue.

What have we learned from NHS Highland? We have learned some pretty important lessons about local excellence. I have seen examples in Aviemore and on the Black Isle—because, after all, this is happening not just in one place but in many—of how you can remodel care for the benefit of rural communities. We have also learned that remodelling care and proper engagement with communities takes a long time. You cannot decide at the beginning of the year that everything will be done by the end of the year; it rarely works that way. Engagement not just with local communities but with local and national elected representatives takes time. When it happens, it happens well, and the services that you get are much more closely tailored to the local environment.

Of course, NHS Highland has a lead agency model, which means that some of what it does is

transferable—though not all of it, because everywhere else has chosen to have integration partnerships. Would I say that some areas are perhaps looking a little enviously at the prospects of a lead agency model? Perhaps some are, and perhaps, over time, there will be greater uptake of that model as confidence in the principles that lie behind it grow.

As I said to Ms Harris, if members have specific issues that they would like me and my colleagues to take away about the areas that they represent, I am more than happy to follow them up post the committee meeting. If time permits, convener, Jason Leitch and Geoff Huggins can add to my response. However, I want to be respectful of the committee's time.

The Convener: We are running very short of time. Is it possible to provide written evidence to the committee?

Professor Leitch: Frankly, my coming back in at this point is probably not worth it, so perhaps we should just stop there.

The Convener: I have a final question. We have covered most of the Auditor General's recommendations, some quite broadly, others in detail. Does the panel agree with all the recommendations?

Paul Gray: That question is not amenable to a yes or no answer, convener. I accept in principle most of what Audit Scotland says, but I would genuinely welcome the opportunity to write to the committee, setting out a response to the recommendations on pages 5 to 7 of the report and how we are going to address each of them.

The Convener: That would be helpful, Mr Gray. I am particularly interested in the first recommendation, which is on having a clear framework by the end of 2016. Your answers on that would be very helpful indeed.

I thank the panel very much for its evidence this morning, and I suspend the meeting for two minutes to allow a changeover of witnesses.

10:19

Meeting suspended.

10:23

On resuming—

The Convener: We move to our second panel on the Auditor General's report "Changing models of health and social care". I welcome Julie Murray, the chief officer of East Renfrewshire health and social care partnership, and Shiona Strachan, the chief officer of the integration joint board for Clackmannanshire and Stirling health and social care partnership. Shiona, followed by Julie, will make a brief opening statement.

Shiona Strachan (Clackmannanshire and Stirling Integration Joint Board): I will provide the committee with some high-level background to the partnership. As Paul Gray stated, not all integration joint boards are formed in quite the same way.

I have been in post since July 2015. As the chief officer I have a focus on the strategic planning for integration and on supporting the integration joint board. I have no direct operational responsibility for service delivery.

The Clackmannanshire and Stirling partnership is unique in that it comprises two local authorities and one health board. The partnership works closely with the other health and social care partnership within the NHS Forth Valley area, in Falkirk, and a range of services span both partnerships, including one acute hospital.

Both areas within my partnership have a growing population of older people and a lower-than-average level of unemployment. Combined with the rural nature of the communities, those things provide a challenge to the partnership in the delivery of services.

The integration joint board was established in October 2015. In March 2016, it agreed the budget and the strategic plan, which incorporates three localities. The in-scope services that form the integration scheme are, in essence, the community-based services for adults who are over 18 with community care and health needs.

Before integration, the area did not have an integrated community health partnership. However, there is a long and positive history of joint working, ranging from the single care pathways that are in place to fully integrated services such as mental health and learning disability services.

Across the partnership, there is a strong commitment from staff, including those in the independent and third sectors, and from professionals, including GPs, to work in new ways to achieve outcomes. Services have been designed across all care groups to focus on reablement, recovery and rehabilitation. There is clear evidence of a shift from dependence on care home placements, for example, to increased activity in the provision of care at home. The development of intermediate care services for older people further supports that activity.

A major investment is being made in the development of the Stirling care village, which will consolidate the intermediate care provision in Stirling on one site along with the community hospital and some primary care and social care

services. That largely mirrors the services that are in place in Clackmannanshire. In addition, both areas have full reablement care-at-home services.

Developing work is under way to prevent hospital admissions. The Audit Scotland report highlights the advice line for you—ALFY—as a good-practice example. That is supported by the use of anticipatory care plans and services such as closer to home, which provide multidisciplinary support to enable people to remain at home, to avoid unnecessary admissions and to support the management of more complex care. Further work, which is very much supported by primary care, is taking place to develop the localities, and a pilot proposal for an integrated model of neighbourhood care is being developed for one of the more remote rural areas.

I hope that the committee found that statement helpful.

The Convener: That was helpful—thank you. I invite Julie Murray to make her statement.

Julie Murray (East Renfrewshire Health and Social Care Partnership): I thought that it would help if I gave a bit more information about the arrangements in East Renfrewshire and a wee bit of historical context. Although the integration joint board was formally established in August 2015, we have a history of partnership working that goes back to 2006, when we created an integrated community health and care partnership. We have a long history of integration and of the build-up of trust and relationships, which is important.

As the chief officer of the partnership, I have a number of roles. I report directly to the integration joint board and I am responsible for delivering the strategic commissioning plan for and with the board. I have full delegated operational responsibility for health and social care services in East Renfrewshire and I am directly accountable to the chief executives of NHS Greater Glasgow and Clyde and East Renfrewshire Council for that role. I am also a member of both parent organisations' corporate management teams.

In East Renfrewshire, the IJB is responsible for all social care services and community health services, which include children's services and community justice services as well as services for adults and older people. I have had an integrated management team for some years; my heads of service are employed by both NHS Greater Glasgow and Clyde and East Renfrewshire Council, and we have integrated teams in most service areas. In the main, our staff are co-located in two purpose-built health and care centres that we are fortunate to have established over the years. We opened one centre just in August. We share those buildings with GP practices, community health services and social care, and they are jointly funded by the council and the health board.

Our services for older people and people with long-term conditions are clustered around groupings of GP practices and we have integrated teams that include advanced nurse practitioners—we had the first ANPs in Greater Glasgow and Clyde—as well as district nursing, rehabilitation services, occupational therapy and social work. We plan to align home care in the coming months and to align more specialist staff who deal with mental health and learning disability, so that practices can get to know who their link person is.

10:30

It is fair to say that the development of a shared culture and identity for the partnership has been important to us. Over the years, we have put a lot of effort into organisational development and strengthening clinical, professional and managerial leadership. Given that we began developing integrated services and management arrangements around 10 years ago, we have made good progress across a number of areas and have performed well in reducing the number of bed days lost through delayed discharge. We can also demonstrate improvements in the personal outcomes of the people whom we support. We aggregate and measure talking points, which you might have heard of, and we have made efficiency savings through the years by developing integrated management arrangements and support structures to reduce duplication.

I reiterate what was said in the earlier session: we are still on a journey 10 years on, so it is clear that integration is not going to be a quick fix.

Our role as a commissioner of unscheduled acute care is still quite new and is still in the relatively early stages of development. NHS Greater Glasgow and Clyde is a complex environment, with six partnerships and a number of acute hospitals, which are under significant financial pressure. We are working with colleagues across the health board to develop a whole-system approach, because no partnership can work on its own in that context.

It is also fair to say that our parent bodies are under financial pressure. Consequently, substantial savings targets have been passed across to the IJB.

We are optimistic. We have a very strong base on which to build. We have strong relationships with GPs, which we have built up over the years, and with colleagues in the third sector and community groups, and we are working to support community developments that reduce demand on formal services. However, the future financial climate is challenging and we are not naive about

the fact that things are not going to be straightforward.

I am happy to cover anything in more detail and answer your questions to the best of my ability.

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

Colin Beattie: Annex B in the committee's papers details the budget information for East Renfrewshire. I have two questions about that. Figure 3 shows community healthcare taking quite a big hit. Can you talk about that?

Julie Murray: An element of that, which we should have stripped out, is non-recurring in-year funding. That means that there is not really a like-for-like comparison. Some changes were made to the way in which capital charges are treated. That said, to be honest, there has been a reduction. We found out in July that the reduction in our health budget that is passed down from the health board is nearly £1.2 million.

Colin Beattie: I noticed a dramatic drop.

Julie Murray: It is not as dramatic as it appears. That is our fault for not stripping out the non-recurring funding and the capital charge changes.

Colin Beattie: How much was the non-recurring funding?

Julie Murray: It was whatever £3.5 million minus £1.2 million is.

Colin Beattie: Is it £1.2 million, not £1.3 million?

Julie Murray: The real recurring reduction is £1.2 million or £1.3 million.

Colin Beattie: Okay. Section 5 of your submission says that there is

"No mechanism for transfer of funds to primary from secondary care".

It is not going to work, is it?

Julie Murray: That is one of the big challenges. It is one of the things that we are all grappling with.

Colin Beattie: The whole point of the process is to enable the various stakeholders to get together and agree that that should happen. However, you are saying that it is not happening.

Julie Murray: In my introduction, I described the complexity of the arrangements that we have in NHS Greater Glasgow and Clyde. We are all getting together as a group of partnerships with acute hospitals, which are under enormous pressure and are overspending at a rate of knots. We are working hard to collaborate, examine our commissioning plans and consider the impact of all our activity to reduce bed days and admissions and to aggregate that into a plan for the health board. At this point, however, we do not have that mechanism.

Colin Beattie: Whatever pressures people are under, the process is not going to work unless we have some sort of transfer of funds. Someone has to agree to share their budget at some point.

Julie Murray: I agree entirely.

Colin Beattie: How are you going to get that agreement?

Julie Murray: As I say, we are working across NHS Greater Glasgow and Clyde, with the board and the six chief officers in the partnerships, to develop a collaborative plan that will start to reduce the need for hospital services over a number of years. At the moment, it is difficult to see how we can do that with the big pressures on hospital admissions. Although we have reduced the number of bed days lost, the number of admissions is still rising, so we need to do a lot to prevent those admissions.

Colin Beattie: I am not getting a feeling that a solution is coming out of this.

Julie Murray: There is no immediate solution. The system is very complex. Whatever we do in East Renfrewshire to reduce the number of bed days and admissions—as we have been doing over the years—we share a very complex system. We do not have one hospital that we relate to; we share wards and hospitals with Glasgow, Renfrewshire and so on, and we have to collaborate in order that we can act collectively to reduce the demand on hospital services.

Colin Beattie: I have a question on GPs. We discussed with the previous panel the challenges of maintaining the GP workforce, recruiting GPs and so forth. How are you on that at present?

Julie Murray: The GPs in East Renfrewshire are under pressure but probably for different reasons from the deep-end GPs. They are under pressure because of the significant ageing population that we have in East Renfrewshire. We have a large number of over-85s. However, I do not think that there are particular issues with recruitment locally.

We are working closely with the GPs. We are now largely co-located with them and we are doing all that we can to support them. We are doing some of the things that you heard about in evidence earlier: we are providing link workers, and advanced nurse practitioners are attached to GP practices. They work together on their more complex patients—the people who are more likely to be admitted to hospital.

The GPs are very busy, but we are working hard with them to reduce demand as much as we can.

Colin Beattie: Successfully?

Julie Murray: I think that we are beginning to see some success. We have worked in clusters of GPs, and we have had lead GPs from clusters doing some planning with us as part of our strategic planning process. It was they who suggested that link workers can support people who have real anxiety issues and attend GP practices regularly and that those link workers can start to divert folk to peer support and community facilities and services. That idea came from GPs. We are also supporting them significantly with prescribing support. Good relationships have built up over the years and we are starting to see some success.

In the areas of deprivation that we have—in Barrhead, in particular—the GPs really welcome integration. We are co-located with addiction services and mental health services, and they have seen the benefits of that over the years.

Colin Beattie: Shiona, do you want to comment?

Shiona Strachan: We have a variable position with the GPs. We had some difficulties and we continue to have a little difficulty within the city area of Stirling. The rural area is well served by GPs, although the practices tend to be relatively small—they tend to be one or two-man GP practices, and their long-term sustainability is an issue because of that. We are working with the GPs as a group on the sustainability of practices.

Similarly, we have some local GP primary care hub developments. Some of that work has come out of the difficulties that the practices have been experiencing. I can talk only about the one in Stirling, although I am aware that there are others across the Forth Valley area. Prescribing support and physiotherapy support have been put in, and the involvement that is showing the greatest impact is probably the community psychiatric nurse and mental health input. That is similar to what Julie Murray talked about. When people have mental health issues or are stressed or distressed, we can deal with that at a much earlier stage and divert them to the normal range of community services.

We have some GP fellows who are new and young GPs, and we are supporting them to focus on older people's services. We also have some nursing staff, allocated social workers in and around some of the practices and some physio input as well. It is about taking a place-based service approach and looking at what each community needs. We are clear that the GPs are core to delivering health services and that social care services need to wrap around that.

I referred earlier to one of the rural pilot areas. That was chosen with the GPs, who are very involved. In our area, we have locality GPs for our three localities, and they are leading the locality development along with others.

There has already been an enormous amount of community engagement in the Strathendrick ward in Stirling. We talked about that taking a long time and it has. It has come about through concerns about people not being able to access services, the acute hospital being very far away, people often having to use services in Glasgow and our not being good at the admission and discharge around that. We know that because communities are able to tell us that. The Strathendrick ward is quite a well-off community in some areas, but there are pockets of marked deprivation in it. We initially considered the Buurtzorg system because its principles—the person is at the centre, the family and communities are wrapped round and then comes the social care and health contribution—made sense to us. We are in discussions and have NHS Highland coming down to help us with some of the learning about what the system looked and felt like for practitioners who were starting off on that new way of working.

Colin Beattie: Have you made any progress on the problem of the transfer of budgets from primary to secondary care?

Shiona Strachan: The partnerships in the NHS Forth Valley area are different from the Glasgow partnerships. We have one acute hospital, which was modernised, and the community hospitals in Clackmannanshire, which I have described. We use community hospitals slightly differently—they are the community hubs. I have described the transfer a little bit. It is a transfer from Stirling Council and its current residential establishments to a community hospital hub arrangement that will have GPs, social care and community hospital beds based in it. Rather than a direct transfer, there is a realignment of resources and an investment in joint areas.

A slightly different approach is taken in learning disability services, which have been integrated for a long time. We still have some acute beds, which are based in the Falkirk area, and we are in discussion about how we can reprofile them. By reprofiling, we mean moving some people out into the community who can now be supported there and transferring that resource with them.

Alex Neil: I will follow up with Julie Murray on the Greater Glasgow and Clyde allocation of resources. Greater Glasgow and Clyde NHS Board is in a unique position in that it covers seven local authorities and has seven IJBs—I think that it is seven.

Julie Murray: Six.

Alex Neil: Six IJBs. You might not know the answer to this question, but have the budgets of

the other five IJBs in the Greater Glasgow and Clyde NHS Board area been reduced as well?

Julie Murray: Yes.

Alex Neil: Is that their budgets from the health board?

Julie Murray: Yes.

Alex Neil: That suggests to me that there is an issue that the committee needs to address. The point of health and social care integration is to shift the balance of resources from acute care to primary care. The health board makes the initial allocation to the IJBs, so we should invite Greater Glasgow and Clyde NHS Board to the committee to explain why it is cutting those budgets and where the money is going. Given the fact that it accounts for about 40 per cent of acute operations in Scotland, it will be difficult for Scotland to rebalance those resources if Greater Glasgow and Clyde NHS Board does not play its part.

The Convener: That is a fine idea, Alex. We can certainly invite the health board to give evidence on that.

Liam Kerr: I have been very pleased to hear lots about strategic planning. However, I am concerned that it all seems to be rather reactive, such that when we talk about admissions rising, funding cuts or staffing issues, the strategic plan addresses what is a previous issue, if that makes sense. What I am interested in is what modelling, if any, has been done for how the world will look in a time horizon of five, 10 or 15 years. What will the demographics be in your area? What will be the likely needs, given changes to public health and the like? What will be the impact of anticipated results from Government health programmes or interventions such as extra funding? Do you have review dates to assess how possible scenarios are panning out? Presumably, there are three or four possible scenarios. Julie Murray talked about still being on a journey 10 years' on. Okay, but a journey to where and what do you plan to find when you get there?

10:45

Julie Murray: That is an interesting question. I do not think that we ever reach the end of our journey. I think that things change—demographics change, people's expectations change and models change—and opportunities arise. Clearly, though, we have a strategic plan and have done a health needs assessment of our local population, and we understand how those needs are changing. We have particular challenges around older people and young people with disabilities. We understand what the issues are.

On your point about being reactive, firefighting always goes on. However, our longer-term strategy is to try to reduce demand, where possible, by building up the resources in our community through looking at the assets in the community and in the third sector. We look at neighbourhoods and people's own assets and see how we can support them to find solutions that mean that they do not necessarily get sucked into social work if they do not need it.

We are on quite an interesting journey around that because we are one of three partnerships in Scotland working with an organisation called the National Development Team for Inclusion, which has done similar work down south. In our work, we have found that by taking our services and resources out to community hubs and working with libraries, leisure trusts and community groups, we can answer people's questions and direct them to peer support; or, if they need our services, we can do a quick assessment there and then. That work means that we can start reducing our bureaucracy because we do not have big waiting lists, with people waiting for ages, and can try to divert people who do not really need our services but might be sucked into them.

We have also had a big focus on re-ablement, which Geoff Huggins mentioned earlier. We retrained our home care staff and almost 70 per cent of the people they have taken through the re-ablement programme in the past year have improved and do not need as much long-term help or the long-term care plan that they would have had in the past. Previously, we would have just gone in there and been with them for 10 years, for example.

We have a real focus on prevention and anticipation, and trying to understand our population. Geoff Huggins also talked about the information support that we are getting from ISD. We now understand the people who are very high users of health and care services locally and can get alongside them and work to identify how we can work differently with them and support them differently so that, for example, they do not need to go into hospital or visit their GP three times a week.

We have long-term plans and we have performance reviews twice yearly to see where we have got to with them. We also have a lot of governance around our transformational programme in East Renfrewshire, which is about trying to do things quite differently. It is therefore not just more of the same and firefighting.

Liam Kerr: That certainly sounds great for the issues that you have to deal with right now, but has there been any modelling done of future scenarios? For example, we heard earlier that it takes seven years to train GPs. Have you done the kind of modelling that takes into account current actions and looks at what the situation will

be in seven years' time with an influx of GPs and whether you would need them?

Julie Murray: I do not think that we have done specific workforce modelling around GPs, although we have done some work to identify what the impact of the prevention work that we are doing now will be later on. For example, we have a comprehensive programme around the early years and we are trying to see whether investing in early years and supporting families in different ways will mean that we will not need as many addictions workers or social workers further down the line.

We are working with health economists to try to get that answer. Quite often, we do not have that capacity locally, as health economists are fairly thin on the ground, so we use support from the improvement hub and other places to help us to work that out. That is absolutely factored into our planning.

Shiona Strachan: As you would expect, the pattern is similar for us. ISD is heavily involved in our area and we have used it to upskill our local analysts, although we recognise that that skill will move away at some point. That work helps us to understand our situation. Our information is currently calibrated to 2037. I was in front of one of the boards one day and I realised in mid presentation that I could be talking about myself. My jaw just dropped. I have to get this right for me, even if not for anybody else. We have to get it right.

I know that some of the work sounds very reactive, but there is a real attempt through the strategic planning mechanisms to move forward and take a forward look as well as we can with the demographic information that we have. To give an example of the issues, Clackmannanshire is one of the smallest council areas in Scotland and it has quite a different profile from Stirling. It has greater levels of pre-teen pregnancy and high levels of mental health and addiction issues. It will also have a falling population in the period to 2037, which is different from neighbouring Stirling, where the population will continue to rise. Also, the population in Clackmannanshire will be much older.

We already know that we will not have the workforce to do exactly what we are doing now as we go forward, so we commissioned from what was then the joint improvement team a more detailed assessment, which we called a housing need assessment, but which was actually about accommodation and support and what we could do differently. We are now pretty clear that we cannot continue as we are and that we will have to look at core and cluster systems to be able to deliver the support that is required to the community. We will not have the workforce to do what we are doing now. That is a good example of where we are starting to look forward using the demographics information that we have to try to build something.

The Convener: We are running short of time, and three members still want to ask questions. If we could have short, sharp questions and answers, we will get through everyone's points.

Gail Ross: I will be really quick. As the witnesses will have heard earlier, I was involved with the integration in Highland all the way through from 2012. We chose the lead agency model, which means that the NHS is solely responsible for adult care and the council is responsible for children's services. I must put up my hand and say that I did not know until I heard it today that we are the only area in Scotland that has done that. What made you choose not to use the lead agency model, and would you consider using it in future?

Julie Murray: In East Renfrewshire, it was an easy decision because, as I said, we were building on an integrated community health partnership, which had all the features. In fact, our community health partnership committee was very similar in make-up to the IJB, in that we had integrated services and aligned budgets. The governance and the budgeting arrangements have changed, but the structure and nature of our services are quite similar. Therefore, we were building on something that seemed to work.

The Convener: Do you have anything to add to that, Shiona? You do not have to.

Shiona Strachan: I have no comment on that, as the decision was made long before I ever came into post.

The Convener: Okay.

Alison Harris: Very briefly, I ask Shiona Strachan what the situation is with the delivery of the Stirling care village.

Shiona Strachan: I think that we are waiting for what is known as financial closure, but please do not ask me the details of that. We are currently working on the care models for that. A lot of our integration funding supports the current models in Stirling. Our Bridge of Allan care home, which is in quite an ancient building, is a really good example. It is operating a dementia and intermediate care model, which will transfer almost straight in to the new arrangements. The staff are skilling up for that.

Alison Harris: So it is nearly ready to go.

Shiona Strachan: Yes—it is very nearly ready to go.

Alison Harris: Good. Thank you.

Monica Lennon: My question is for Julie Murray. You explained that there have been 10

years of working in partnership and you gave us a flavour of some of the complexities that are involved. I want to ask about the budget-setting process. After 10 years of working in partnership, the budgets are still not aligned. There is a five-month delay between the council's contribution being confirmed and the health board's being confirmed. Is there a quick and simple reason why that is? Have we reached a situation where that will not happen in future?

Julie Murray: The simple answer is that, historically, different organisations have had different ways of approaching things. The health board has recognised how difficult that has been and the finance director has made a commitment to try to start the process much earlier this year. I think that he will come to our meeting in September or October with ideas of likely budget scenarios in 2017-18, so we should be much better aligned for the next financial year.

The Convener: As there are no further questions from members, I will sum up by asking both witnesses a similar question to the one that I asked the previous panel. Do you agree with the recommendations in the Auditor General's report and do you have any comments on them?

Shiona Strachan: On the whole, I agree with the content of the report. I echo Mr Neil's earlier comments that we have to be realistic in our expectations. We do not just set up something on a Friday and expect all the problems and issues to be solved on the Monday. The process has to be viewed as a long-term investment in Scotland's future and the future of health and social care services. Having said that, I agree that we need to pay attention to pace and the things that are working locally. We have good networks to be able to share that, although one size does not necessarily fit all.

Julie Murray: Apart from the pace issue, I agree with the recommendations. In particular, we probably need national support on shifting the balance of care. I am old enough to have been involved in the hospital resettlement programmes in the 1990s around learning disability and mental health. Specific bridging finance was allocated for that, with the proviso that we reduced bed numbers and closed sites. Although we have had lots of exciting opportunities through some of the new funds, which have helped us to be creative and innovative, if we are really going to shift the balance of care, there probably needs to be a bit more of a framework around how that will happen.

The Convener: Thank you both for your time and evidence; we very much appreciate it.

As previously agreed, we will move into private session.

10:57

Meeting continued in private until 11:16.

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