OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 4 June 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 4 June 2019

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HEALTH AND SPORT COMMITTEE
16th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Bob Doris (Glasgow Maryhill and Springburn) (SNP)
Stephen Fitzpatrick (Glasgow City Integration Joint Board)
Jim Forrest (West Lothian Integration Joint Board)
Alan Gilmour (Glasgow City Integration Joint Board)
Yvonne Lawton (West Lothian Integration Joint Board)
Kenny O'Brien (Aberdeen City Integration Joint Board)
Sandra Ross (Aberdeen City Integration Joint Board)
Anas Sarwar (Glasgow) (Lab)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 4 June 2019

[The Convener opened the meeting at 10:02]

Pre-budget Scrutiny 2020-21

The Convener (Lewis Macdonald): Good morning, colleagues, and welcome to the 16th meeting in 2019 of the Health and Sport Committee. We have received apologies from Emma Harper, David Stewart and Brian Whittle. They are at Westminster today participating in the Scottish Affairs Committee on behalf of this committee. Anas Sarwar and Bob Doris are here as substitute committee members. I ask everyone to ensure that their mobile phones are switched off or are in silent mode.

I welcome from Glasgow city integration joint board Stephen Fitzpatrick, who is assistant chief officer, and Alan Gilmour, who is the planning manager in older people's services and south locality operations. From Aberdeen City IJB I welcome Sandra Ross, who is the chief officer, and Kenny O'Brien who is a service manager. From West Lothian IJB I welcome Jim Forrest, who is the chief officer, and Yvonne Lawton, who is the head of strategic planning. Our witnesses are here to assist us in our pre-budget scrutiny, following on from the meeting that we had two weeks ago and some other work that we have undertaken, which is directed at the budget for 2020-21, and is building on the approach that we have taken in previous years to highlight issues around integration and integration authorities. We are glad to have you here.

An issue that the committee has pursued vigorously over the past couple of years is access to financial information and publication of financial information on integration and IJBs. We have certainly seen progress on that; nonetheless, it is still the case that the financial information that we receive on the budgets of IJBs arrives quarterly, in arrears. Therefore, although we know that you have set your budgets for the current year—at least, we assume that you have—that financial information is not made available to us until three months after the decision.

Is there any reason why you cannot provide timely financial information direct to Parliament? We are looking for the most timely information that we can obtain, while acknowledging that there are will be changes to the budgets of your partner organisations. Who would like to kick off?

Stephen Fitzpatrick (Glasgow City Integration Joint Board): I am happy to start. It is not my area of responsibility, but I know that our IJB meets every six weeks or so and looks at the monthly financial reports then. We set our budget at our March meeting, just over two months ago. That information is in the public domain. It would be straightforward to find a mechanism to share that information with Parliament, because it is routinely made publicly available. I am sure that that would not be problematic. I will commit my finance colleagues in Glasgow to sharing that information.

The Convener: I am sure that they will be grateful. Does a similar situation apply in Aberdeen?

Sandra Ross (Aberdeen City Integration Joint Board): Yes. Our budget has also been approved with our partners. I am sure that we could share it.

The Convener: Thank you very much.

Jim Forrest (West Lothian Integration Joint Board): The position in West Lothian is the same: we also agreed our budget in March. The IJB meets every six weeks and the updated financial information goes through the IJB. It is a public document. If that is the detail that the committee requires, we will happily come up with a mechanism through which to provide it to you.

The Convener: That is very helpful. From your descriptions of the mechanisms, it appears to be that the situation is, likely, the same in each and every one of the IJBs. I see a lot of nodding in agreement to that suggestion. We are certainly very grateful for your offers and we look forward to hearing from you. That is also a point that we can raise more generally, with a view to ensuring that such information is made available to Parliament timeously by all the integration authorities.

On finance, will the move to three-year financial settlements in the national health service, and potentially also in local government, assist long-term budgeting and planning for the integration authorities?

Jim Forrest: Yes—I think that that will assist us with financial planning. Clearly, the challenge for us is to get to the stage at which we have medium-term and longer-term financial planning. If we get that in place, the strategic planning and the commissioning decisions that we need to make will become clearer. We welcome the move.

The Convener: I take it that the situation would be the same for Glasgow?

Stephen Fitzpatrick: Yes—I second that. I think that it comes through in our submission that one of our challenges is to do with short-termism and uncertainty around the financial settlement.

Even when the financial settlement is difficult, there is value in our having a degree of certainty about what we face, because that allows us to make longer-term financial decisions.

The Convener: Are there any barriers that prevent longer-term planning based on broad indicative budgets? Are there things that you are not able to plan because you do not have certainty about the last 1 or 2 per cent of your budget lines?

Stephen Fitzpatrick: Yes, there are, to an extent. However, as you suggest, that is proportionate to the level of certainty. We have quite a lot of indications about what we will be facing financially. Nonetheless, if the savings targets that emerge from the partner organisations are higher than expected, or the settlement figures are lower than expected, for example, that can have a significant bearing on our detailed planning. To be proportionate about it, I say that that can be at the margins, but we want to be as certain as possible. Planning ahead is a difficult task, which we will, I am sure, explore during the meeting. Our plea is for as much certainty as possible.

Sandra Ross: I echo that plea. Three-year planning would allow us to move more into the prevention agenda, which would have an impact, particularly as demographics and other things are shifting. A more committed and well-understood direction of spend would allow us to shift the balance.

Jim Forrest: In addition to what my colleagues have imparted to the committee, there are a number of things that we have to be mindful of in relation to financial planning. At the moment, we have to do some forecasting based on the settlements that are coming out.

Clearly, in the health service it takes a while for a national wage settlement to be negotiated with staff-side organisations. Then, there has to be a decision about whether the budgets will be increased to pay for increased salaries or whether the salaries will partly be paid for centrally, through additional efficiencies. There are things that we have to try to balance: we need to work out what we think pay settlements will come out at. Sometimes we get it right, but sometimes we are a bit adrift. That has an impact, because salaries are probably our most significant cost.

The Convener: The other area that I would like to ask about is benchmarking. At the 21 May evidence session, we heard from Eddie Fraser and other witnesses about the work that is being done by IJBs to learn from each other's experience on benchmarking. What access do you have to benchmarking data from other integration authorities, and what use are you able to make of it? Are there good examples of which we should be aware?

Jim Forrest: West Lothian Council has a benchmarking family of local authorities that we have used as a basis for looking at how we perform, particularly in social care. We are considering how we would incorporate the health information to do the same thing, in order to give us that coterminosity and consistency.

Stephen Fitzpatrick: In Glasgow, we benchmark across a range of activities. If you are asking about financial planning, that is not so much my area. However, similar to West Lothian, we tend to look within our health board area. Many comparisons can be made across NHS Greater Glasgow and Clyde's constituent health and social care partnerships. In Glasgow, given the nature of our authority, we also try to look further afield at comparable health authorities. We look to the cities of Edinburgh, Aberdeen and Dundee, for example, but we do not restrict ourselves to Scotland. We often look to cities in England as well, including Leeds, Birmingham and Liverpool, to see how they deal with challenges that are similar to those that we face. We have a good relationship with Manchester, as well: we have spent time with our peers there. As another big and complex post-industrial urban authority, it shares some issues.

Sandra Ross: Aberdeen has a more locally based approach on benchmarking; we look at the local HSCPs. I take on board what my colleagues have said, but benchmarking tends to be more local for us.

The Convener: In the data, it is striking that there is quite a lot of variety, even between close-neighbour authorities. Is that something that you analyse in order to learn lessons about what more can be done?

Alan Gilmour (Glasgow City Integration Joint Board): We certainly use a lot of the LIST—local intelligence support team—resource that is available to us, which is very helpful. We use the Information Services Division's data and the information on partnerships that we get from Healthcare Improvement Scotland. A lot of it is about bringing in benchmarking data for us to use. We have developed local dashboards, as Stephen Fitzpatrick mentioned, to compare what is happening across the six partnerships under NHS Greater Glasgow and Clyde. The important thing is comparison; we need to compare like with like. Some of the variation can be explained in different ways by different systems, so it is about getting to the intelligence that sits behind the data in order to ensure that we are looking at the right things.

Yvonne Lawton (West Lothian Integration Joint Board): We have tried to look at the

available benchmarking data, but visiting other authorities has also proved to be very useful because we can get behind data to understand the circumstances that we are comparing. It is not only about access to data: it is also about the opportunity to share good practice and to understand the challenges that are faced in other areas.

Kenny O'Brien (Aberdeen City Integration Joint Board): I echo what my colleagues have said. My particular area of focus, more than anything else, is delayed discharge performance. Although the top line of comparison is important, you have to dig deep underneath that. For example, some areas might have very different delayed-discharge performances, but they might also have very different labour markets with regard to social care, and they might have different volumes of care home beds available in their partnership areas. We need to work out what lessons to apply in our areas. I reiterate that visiting places and pulling out the relevant stuff is probably the best thing that we can do in relation to benchmarking.

10:15

The Convener: It sounds as though that is now quite common practice. Would it be fair to say that that is something that all integration authorities engage in? I see that panel members are nodding. Good.

Another matter that we have addressed in previous years is outcome-based budgeting. Would any of you like to comment on what support the Scottish Government provides for developing budgeting that relates to outcomes? Is that something that you are engaged in or familiar with?

Perhaps the fact that no one is answering—

Stephen Fitzpatrick: I suspect that it speaks volumes that we are looking across at each other to see whether anyone can answer.

The Convener: You took the words right out of my mouth. It would therefore be fair to say that Scottish Government support for outcome-based budgeting is a question that is yet to be answered. We will move on to delayed discharge.

George Adam (Paisley) (SNP): I know that everyone is committed to reducing the number of people who are waiting in wards to be moved to somewhere more suitable. I know that everyone is working towards that and I know that Audit Scotland has said that there have been improvements in the past couple of the years.

However, we have in front of us a table that has been provided by the Scottish Parliament information centre, which shows the rates of delayed-discharge bed days as a percentage of the population. The picture varies quite a lot throughout the country. For example, Inverclyde is at 2.5 per cent, Renfrewshire—my area—is at 3.3 per cent, Glasgow city is at 5.9 per cent, and East Ayrshire is at 4.8 per cent. At the other end of the scale, Aberdeen city is at 10.1 per cent, Highland is at 19.1 per cent, North Ayrshire is at 15.3 per cent, and West Lothian is at 13.5 per cent. There is quite a variation there. What is being done differently in those areas? Is it about demography, geography or both? Is it because in certain areas, there are new ways of working that are working extremely well, or is it simply all of the above?

Kenny O'Brien: I think that you probably covered the answer with the last statement. It is all of the above. I have not seen the table that you mentioned, but one of the good things about delayed-discharge data reporting is that it is quite granular. We do not just get the headline figure of the number of bed days lost, or the number of people who have been delayed. We can get quite deep into the reasons why a person's discharge has been delayed. On the ISD website, you will see on an Excel spreadsheet—which I am wont to do, although many people are not—that there is very good detail for each area on where there are still delays.

For example, you will find that in Aberdeen, which is my area, one of our biggest areas of delay still relates to care-home placement. That is partly because we have a smaller number of care homes available and accessible to us than in other areas. There have been improvements and there are other things that we can do to improve the flow out of the hospital. In some areas, it might be about demographics. In other areas, it will be about the labour market for social care with regard to recruiting home carers to allow people to go home.

One of the areas in which Aberdeen has done better than other areas is housing and adaptation-related delayed discharges, because we have been able to access more of the bricks and mortar to allow people to flow out to disabled access housing. There are a lot of things in play in regard to varying performance, but certainly there are things to learn from the areas that are doing exceptionally well.

Stephen Fitzpatrick: You asked about benchmarking. My sense is that Scotland compares very well with England and the rest of the United Kingdom. I think that there has been a real focus on tackling delayed discharge.

George Adam: I am glad that you said that, although I did not ask that question.

Stephen Fitzpatrick: I have always been patriotic about delayed discharges. [*Laughter*.]

Alan Gilmour and I are very wrapped up in the delayed-discharge issue—I think that all the other panel members are too. It is very much a shared priority across Scotland.

We tend to look at our own local area and we are very involved in whatever is happening locally. I stand ready to be corrected by the data, but my sense is that there has been a trend towards improvement across Scotland over recent years. We also compare well with the rest of the UK. However, there are significant contextual differences.

In Glasgow, one of our great assets is that we have a very responsive home-care service. Around 65 per cent of our referrals for home care are discharged from wards within 24 hours' notice of the referral, which has a very beneficial impact on our delayed discharge performance. In Edinburgh and other places, however, there are real challenges to do with the workforce, as Kenny O'Brien mentioned. The economic context can be different; care might be a more attractive employment option in Glasgow than it is in Aberdeen or Edinburgh, for example. We know that all those things have a practical bearing on our performance and on some performance differences. There is a quite complex explanation for the differences between areas, but generally the picture over time in Scotland is quite positive.

Jim Forrest: The factors to do with demographics and so on that have been mentioned are very important. From the West Lothian point of view, our performance on delayed discharges deteriorated quite significantly about 18 months to two years ago. We took a number of decisions to remodel the entire service, which we are now working through.

When it comes to seeking information from elsewhere, we sought information from Aberdeen city about the plan that it had at the time and the actions that it had put in place, and we have been in contact with our colleagues in Glasgow and various other places. We have made significant improvements, mostly in the past six months, as a number of those actions have come into play. There have been significant reductions in delayed discharges, occupied bed days and various other things, but there is still work to be done. We have learned from the previous framework agreement that we had for care-at-home services, and we are about to go out to procurement for a new framework agreement, which will be radically different from the previous one.

During that time, we also had a number of operational challenges that were outwith our control. In the care home market in West Lothian, for example, all our care home beds were full. We had no care home beds available and we were waiting for vacancies to arise. Therefore, we have worked closely with the care home providers to negotiate additional beds. In addition to the part of the care home sector that we procured and commissioned, about 25 per cent of it comprised people who were self-funders or beds that were purchased from other local authorities. We have tried to get some additional beds to give us a higher proportion of the number of care home beds. We are now starting to get those additional beds. We have worked very closely with the care home providers on that.

Another operational challenge that we faced with care homes was that a number of them were under investigation because their grades had dropped. When that happens, quite rightly, they do not take any new admissions. That does not sound like much, but such an investigation can mean 120 beds not being accessible for admission. It can take six months for a home to get the necessary assurance and be open for admissions again. We have had two or three care homes under investigation over the past two years. We have also had major challenges in the care-at-home sector. Unfortunately, our largest provider has been under investigation, and we have had to work very closely with it on an improvement plan before it could accept new cases.

All that, added to the change in demographics and the increase in demand, had a fundamentally negative effect on our performance. As well as working closely with the care home providers and the care-at-home providers, we have been remodelling our in-house service to address the negative performance. We have invested in our in-house service so that new cases for assessment and reablement, for example, come through that service before we ask a care-at-home provider or a care home provider to take them on. That is work in progress.

We have faced a number of significant operational challenges, which we will deal with. There will be a number of others, but it is a case of being flexible and dynamic in response to the challenges that arise.

George Adam: You have all mentioned care home provision as being one of the challenges that you face. According to the figures that we have, Fife is at the higher end when it comes to delayed-discharge bed days, with a figure of 9.7 per cent, yet I am led to believe that it has care home capacity. Why is that the case in Fife? I am not asking you to tell tales out of school; I just want to know why Fife, which has capacity, can still be at the higher end of the scale when it comes to delays with regard to care provision.

Jim Forrest: I am not sure that I can answer on Fife's performance, but I can say that, when there have been vacancies for care home provision,

whether in Fife, Glasgow or other parts of Lothian, my authority has made it clear to individuals who have been waiting for a place in a care home that if they would be interested in a place in a care home in another part of the country, they would be welcome to go and see it and we would provide the same level of funding that we would provide if it was in West Lothian.

We have made such offers and one or two people have sought them out, but we have not had many takers, mainly because people do not have a family connection in the area in question and it is more difficult for family to visit. When there has been a family connection, we have actively tried to explore that option and we have had co-operation from our other partnerships, but it has not been an option that has been attractive to families.

Kenny O'Brien: I cannot speak for Fife's data—

George Adam: I am just trying to understand whether there is capacity.

Kenny O'Brien: When it comes to delayed discharges, the point is that care homes are only one part of the puzzle. Fife might have vacancies and voids in its care home sector, but it is possible for any area to have vacancies and space in its care home sector and still have a significant level of delayed discharges. For example, there might an issue with the care home market, with housing and adaptations, with social work assessment and provision or with legal guardianship and court proceedings. An authority might well have 20 per cent of its care home capacity free and available, but if the people who are in hospital need support to get home rather than a place in a care home, but there are blocks and barriers in other areas, the authority could still have a significant issue with its delayed discharge performance overall, despite having capacity.

George Adam: I have one final question. In its submission, Glasgow city IJB says that there is too much focus on delayed discharges and that that detracts from investment in preventative interventions. I would like to explore what is meant by that.

Stephen Fitzpatrick: Over the past couple of months, we have presented that argument at various locations in our system. Over the past few years, Glasgow has made progress on delayed discharge. Back in 2011-12, our performance was the worst in Scotland, but we have progressively driven down our delays. Although that has been challenging in the past few years, we are still at a relatively low level. The argument is that we have already realised most of the opportunity that exists to improve the overall impact of delays on the system. We will continue to focus on getting to the lowest possible number of delays but, by definition, we have already generated most of the benefit over the past few years and the system still remains under huge pressure.

This week, our hospitals had 97 per cent occupancy, even though our delayed-discharge numbers, albeit that they were not helping, were not the main cause of the pressure. If we want to address the pressure, the strategic focus needs to move from the back door, where it has been for the past number of years, to the front door, because we think that that is where the main efficiencies are to be made. People who create demand by presenting at the front door could have their needs met somewhere else in the system. That is the argument that we have been making within our system—if we are too distracted by the back door, we will miss the opportunities that exist at the front door. That is where our strategic focus now needs to be.

Anas Sarwar (Glasgow) (Lab): When it comes to the long-term strategic outcomes, I completely agree that the focus needs to be on the front door and reducing the number of people who go into hospital and then need to stay there.

Returning to delayed discharges, Glasgow has successfully used an interim process—forgive me; I do not know the name of the process, but you will know it—for people who have come out of hospital, but who are not yet in a care home or a home setting. What is that?

Stephen Fitzpatrick: It is called intermediate care.

Anas Sarwar: Although that is welcome because it opens up a bed and reduces cost for the acute service, it still puts pressure on the council and the IJB, and it does not represent a definitive care plan for the individual involved. How much of the statistic on the reduction in delayed discharges in the acute setting relates to people receiving intermediate care but not getting final care packages?

10:30

Stephen Fitzpatrick: Alan Gilmour might be able to help with specific figures. I always think of the population who leave hospital as being in different cohorts. Ideally, the main cohort will consist of people who are going home without any need for continuing social care or healthcare involvement. We do not know what the numbers are. Home care is the next level. In Glasgow, by far the highest volume of people who come out of hospital with a care package will receive home care.

The people who enter intermediate care tend to be the most complex cases. They are the ones who require a social care assessment. The logic of introducing that model in Glasgow and elsewhere

was that assessing someone in hospital is the worst option. It involves creating an environment that is as close to home as possible. By definition, intermediate care is provided to quite a small minority of the population who are discharged from hospital. The intention in Glasgow was to maximise the opportunity for people to return home, because the intermediate care environment is closer to the home environment. It is not exactly the same as the home environment, but there is a focus on reablement and rehabilitation, which there was not in the traditional assessment for social care in complex circumstances that was carried out on the wards. All the evidence points to assessing people in what is, in effect, the least amenable environment being detrimental to the long-term outcome for people. The number of people who enter intermediate care is small, and the scheme has always been about maximising the prospects of their going home, as well as relieving pressure on the acute system.

Anas Sarwar: When you say that the number is small, do you mean in relation to all discharges?

Stephen Fitzpatrick: Yes, it is small as a proportion of all discharges.

Anas Sarwar: Obviously, the number will be small in relation to the total number of discharges, but if we look solely at those patients who are discharged who require a care package of some sort, how significant is the number of people who receive intermediate care?

Stephen Fitzpatrick: Alan Gilmour might be able to tell you. In terms of turnover, we have 90 intermediate care beds across the city and we are at close to 90 per cent-plus occupancy at all times. At any given time, we would expect to have upwards of 80 people in our intermediate care system, but there is obviously a turnover, so we operate to a four-week target. We do not always meet that target, but our intention is to maintain throughput, because we recognise that we cannot swap a delay for a hospital bed for a delay for an intermediate care bed. Throughput is a key performance measure on intermediate care.

However, across the performance measures that we attached to the intermediate care model when we first brought it in, we have been successful on throughput and returning people to their home environments. In the past, those people would have gone into a care home on a long-term basis, but we are getting quite a high proportion of people home from intermediate care.

Anas Sarwar: With regard to the controversy that has surrounded delayed discharge for a long time, the first issue is not having a bed available in the acute care setting, and the second is the huge cost of the acute care—it is more expensive to keep someone in hospital than it is to have them in another setting.

However, the controversy has also been about a failure to quickly deliver a social care package for someone who has been cleared to leave hospital but is stuck there because they cannot get a social care package. Those individuals might be stuck in hospital for days, weeks and even months. It is true that we might reduce the level of delayed discharge by putting those people into an intermediate care setting, but is it not also the truth that some people might get out of the acute setting only to be stuck in an intermediate care setting for days, weeks and months without getting a social care package?

That information does not appear in the national statistics. The number of people in intermediate care is taken off the delayed-discharge figure, but those people could have to wait weeks, if not months, for a social care package.

Stephen Fitzpatrick: We have a balanced scorecard. We have a lot of data coming through and we keep an eagle eye on our throughput. When people are beyond our 28-day target, we have the same performance focus in intermediate care. Our system could not achieve the performance on delays that it achieves—

Anas Sarwar: For someone who has been cleared to leave hospital to go home or into a social care setting, four weeks is still quite a long time to be in an intermediate care setting.

Stephen Fitzpatrick: We are talking about people who would have been assessed in hospital for at least four weeks. We have no evidence to indicate that it is taking longer to assess people in the intermediate care setting than it would have taken in hospital, but the intermediate care setting is more appropriate for their needs, and we are seeing outcomes where those people are being supported to return home in greater numbers. We have also seen a change in final destinations. The majority of people still go into long-term care, but we have seen a shift from nursing care and higher levels of long-term care to residential care, so the outcomes are beneficial in that, as well as the fact that a greater number of people are returning to their own homes, there are lower levels of long-term care. There have been a number of benefits from those assessments being carried out in the intermediate care setting.

Anas Sarwar: I am not disputing that, but if we look crudely at Glasgow's delayed-discharge figures, we see a reduction, but it is fair to say that that does not directly mean that people are getting their social care packages more quickly. That is a very crude way of looking at things. We cannot tell what is happening just by looking at the delayed discharge figures.

Stephen Fitzpatrick: If you were to assume that receiving intermediate care was equivalent to staying in a hospital bed, that would be right, but that would not be my assumption, because intermediate care is a social care service; it is not an NHS service.

Anas Sarwar: Intermediate care is also not a final destination, which involves having a care package at home or in a social care setting.

Stephen Fitzpatrick: Yes—it is not a final destination.

Anas Sarwar: I completely agree with Kenny O'Brien's point about it being possible to have capacity and still have high delayed discharge figures. Another element that is missing is money. An authority might have the capacity to fill a social care place, but if it does not have the money to put someone in that social care place, that place might remain vacant. How much of the issue is to do with local government and IJBs not having adequate budgets to be able to use the capacity that they have to deliver social care packages?

Kenny O'Brien: I can speak only about the local situation in Aberdeen, but that is certainly not the case there. I am operationally in charge of hospital social work. As a social worker, I handle the placements and the professional decision making in relation to people going back to their own home setting or into a care home setting, sheltered housing or any other setting, and in my period of time working there over the past four years, I have never had a situation in which I have had spare bed capacity or spare care home capacity and it has been restricted to me on budget grounds.

Anas Sarwar: Can the Glasgow representatives say the same?

Stephen Fitzpatrick: Like everyone else, we face significant pressures on our budgets. Our biggest budget is our purchased care home budget, but we have not had any delays for financial reasons for a number of years. No one has been delayed because the budget has not been available. However, last year, our care home budget was the most difficult that it has been for us to manage for a significant period of time. We overspent against that budget and, this year, we are already seeing significant pressure on the budget two months into the financial year. We are experiencing significant pressure on that budget.

Alex Cole-Hamilton (Edinburgh Western) (LD): I, too, want to ask about delayed discharge, not least because while I recognise that none of the witnesses is from Edinburgh, Miles Briggs and I, as Edinburgh members of the Scottish Parliament, were dismayed to see an increase of 6 per cent in delayed discharge in the capital last year.

I want to follow on from Anas Sarwar's question. Stephen Fitzpatrick referenced the different cohorts of people who might fall into the bracket of delayed discharge or the cohorts who are just leaving hospital. I want to ask about a fourth cohort that I believe exists. We often assume that delayed discharge concerns people who have been declared fit to go home and who are well enough to either go home or go to a care setting, but there is another class of people—those who are at the end of life. Hospital has done all that it can for that person, and it may be in the interests of both the individual and their family for the person to spend their remaining days at home.

I suggest that that is another category of delayed discharge and that, if there is insufficient hospice care to receive those people, or the clinicians are not supported to have the conversations that are required to support families to go home, we are creating another cohort of people who are otherwise taking up hospital beds. How would you respond to that?

Stephen Fitzpatrick: If you look at our data—I can comment only on our local data—supporting a higher proportion of people to die at home rather than in hospital is certainly a performance target for us. Alan Gilmour will correct me if I am wrong, but the proportion has been creeping up in the right way over a period of years. We are making progress.

Again, it comes back to the front door, and trying to avoid admissions for people with palliative and end-of-life diagnoses is a priority in the unscheduled care programme. When people are as gravely ill as that, there is a danger that the system will respond by drawing them into hospital when supporting them in a different way might be a more effective intervention.

We are looking at that for different populations, including people who are very close to the end of life, as well as others who have a terminal diagnosis but who are not close to the end of life and whose condition may be dynamic. What can we do differently to support them, other than admitting them? That is where most progress will be made, because we know that when people are admitted to hospital, that is probably the worst factor in determining their long-term outcomes. We try to effect as early and as positive a discharge as possible for that population once they are admitted, but I think that it is a twin-track approach—we try to stop people going in and we have a focus on that at this point in time.

One of the positives in Glasgow in the past couple of years is that we have taken on the management from the acute system of the two hospice contracts in the city. We are working very well with Marie Curie and the Prince & Princess of Wales hospice to try to expand that model away

from just a beds-based model, so that we can use their expertise and their value base in a way that helps us to create more pathways out of hospital and to support the population living within the community. We are actively looking at that.

Your point is well made. There is a danger that the system will fail that population and that they will remain in hospital until the end of their lives, when we could possibly do something else with them.

Alex Cole-Hamilton: You make a very good point. Culturally, primary care clinicians have sought to draw people into hospital when their situation is very grave, or life threatening or life ending. Catherine Calderwood, the chief medical officer for Scotland, set out a very interesting perspective in "Realistic Medicine". How is each of your organisations supporting clinicians to change that culture within the hospital and to say, "We could intervene, but it is probably better for everyone if we do not and we just support that person to go home and be comfortable"?

Kenny O'Brien: I agree with my colleague that we need to look at both ends of the spectrum. An element of realism is needed at the point of primary care and social care. It is not just about the general practitioner being in the room; it is about the GP making decisions in relation to realistic medicine and in relation to the thresholds of intervention for an individual with a life-limiting illness who is at the end of life. If the social care resource and the family support are not available to wrap around that clinical decision, the decision means nothing in the first place.

Work is certainly being done on that. Together with some of my colleagues from both acute and primary care, and the third sector, I am participating in workshops and strategic work on the palliative pathway; that work is being done Grampian-wide rather than just in Aberdeen city. However, it is also very much the case that we are trying to work with clinicians in hospitals on early case conferencing and doing a lot of work on anticipatory care planning for when someone leaves hospital.

Just yesterday, I chaired a case conference for an individual with a life-limiting illness, where there was agreement that the person had—to be fair, not inappropriately—bounced in and out of hospital a little bit; there had been admissions in and admissions out. We were taking stock and saying, "You know what, everyone—including the family—is in agreement that we now have to make a call. Is this a situation in which we will tolerate higher levels of dependency and medical instability within the community, because that is part of this person's journey and they wish to remain at home rather than bouncing in and out of hospital?"

As a partnership, we are trying to facilitate such things more with anticipatory care planning and, within that planning, moving much more seamlessly between, for example—as in the case yesterday—the consultant geriatrician on the ward, the community nursing staff and the GPs. We are even trying to do some cleverer stuff such as loading all that anticipatory care planning into the computer system so that the ambulance service can see it, too.

We are trying to move upstream, rather than reaching a crisis point at which we are talking about hospital admission and only then, in a bit of a pressurised situation, asking, "Will we do it or will we not?" We are trying to pull that decision point back a little bit, so that it is a bit more of a rational and reasoned decision, and taken when there is no pressure.

The Convener: That makes sense.

Alan Gilmour: To add to what Stephen Fitzpatrick has just said, as well as the relationship with the hospices, we have a palliative care pathway on which we work very closely with Macmillan Cancer Support. That is very much a community, home-based package. I reiterate that the big win here is around anticipatory care and that is about having all the stakeholders signed up to that understanding and being aware of that process, so that everybody is clear what to do in the event of somebody deteriorating. We have had lots of examples of the way in which the Macmillan response and support and the availability of our community support prevents people from going into hospital unnecessarily. That experience can be quite distressing.

We, and most other partnerships, probably recognise that cohort of people, whether the care is classed as end of life or palliative. We target that group and try to provide support where we can.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): Following on from Alex Cole-Hamilton's line of questioning, I should put on the record that I convene the cross-party group in the Scottish Parliament on palliative care and I have met palliative care consultants who are hospital based in the acute sector. I think that they would want me to speak on behalf of a small number of vulnerable patients who spend the last few weeks or days of their lives in an acute setting. The consultants put out an appeal to say that an acute setting should also be a high-quality, appropriate and sensitive place for people to spend the last few weeks of their lives and that sometimes that is the patient's and the family's choice. The consultants have been concerned over the years—quite rightly, given that the majority of people want to finish their lives at home, or in as homely a setting as possible—that we should not

forget about the quality of care that is required for the cohort in hospitals. I hope that you do not mind me taking the opportunity to say that; it would have been remiss of me not to do so.

10:45

Anas Sarwar made some very interesting points about the success that Glasgow has had. I want to look at the sustainability of that success, but we should flesh out a bit more the role of intermediate beds; I have always used the expression "step-down beds" rather than "intermediate beds". What I had in my head—I would like some reassurance on this; I might tend to agree with Anas Sarwar on the matter—is that for the step-down beds you are doing something a bit different from what happens with beds in the acute sector.

I would be looking for my constituents to have better access to physiotherapists and occupational therapists and more stimulation. I have done some constituency casework in this area and quite often it is not clear whether someone is fit to go home. Sometimes there is wrestling between an individual in Glasgow who does not want to go home, because they believe that they cannot be sustained at home and that they need a care solution, and Glasgow saying, "No, we think that we should support you at home." Sometimes the contrary is the case. The situation of when someone is ready and willing to go home is not always clear cut.

I return to those 90 intermediate or step-down beds in Glasgow. What reassurance can Glasgow give that it is doing something other than just taking 90 people out of an acute hospital bed and putting them into a step-down bed to change the figures a bit? What happens that is different in that intermediate or step-down setting?

Alan Gilmour: The 90 intermediate beds are very much a community rehabilitation mode. They are located in specific wings of care homes—that is quite important, because they are not part of the broader general care home population. There is very much a focus on the group of 15 individuals in each of the locations. Wrapped around the intermediate beds is a multidisciplinary team that includes our community rehabilitation colleagues; physiotherapy, occupational therapy, nursing staff and social care staff are also involved. The focus is on assessing the individual within that environment, but also on providing an opportunity for rehabilitation. In the hospital setting, the view might have been taken that those people would go to a long-term nursing home placement, but we have been pleasantly surprised by the number of people whom we have managed to rehabilitate to a stage at which they have gone to a residential placement or, alternatively, have gone home. The model lends itself to those opportunities.

The important thing is to understand the cohort and understand the individuals. The people concerned are some of the most complex and frail individuals. We are taking them from an acute setting, bringing them into a care home and allowing them time to be assessed; we look at various options, engage with the families and provide a range of physical and other support services to help the individuals to progress. Our driver is that we would like our default position to be home as an outcome of intermediate care, but the model allows us to make a more effective assessment of the individual and to look for any opportunities within the system to increase their independence and reduce their frailty.

Kenny O'Brien: In Aberdeen, we also have intermediate care, but we have divided its provision. We have 20 beds in a care home that deliver intermediate care with wraparound physiotherapy and OT, but we also have 19 flats that are designed to mimic a person's own front door and their own home; the idea is that there is OT and physiotherapy there, too. We find that exceptionally useful, especially in the borderline cases in which when someone is sitting in an acute hospital bed, we cannot tell whether it will be safe for them to go home or know exactly how much care or support they will require. When people are out of a hospital bed, and they have to get up and go to the bathroom or the kitchen by themselves and undertake significant activity—even if we are giving them support—we find that the baseline of what we think they might require before they go into intermediate care, and the amount of care, support and social care that they actually require when they leave intermediate care, tends to come down. That is a win for everybody, because social care is a scarce resource.

If we can use intermediate care to appropriately size and reduce to the minimum the level of social care that is safe and necessary for somebody to go home, we find that quite a win. We had one individual whom we did not think would ever get home—he had a complex brain injury—but we have managed to step him down into his own front door and he has surprised us all. That is the good-news story of intermediate care. It is not just about cohorting people who would otherwise have been in a hospital bed. It is about giving people the opportunity to show that they can do something, when they might not be able to demonstrate that when they are stuck in a hospital bed in a bay of six people.

Stephen Fitzpatrick: When we designed intermediate care models—or step-down models, which Mr Doris was right to say are principally the same thing—we were always very conscious that it was not just about relieving the pressure of delayed discharge and improving performance in

the acute system. There was an equally important target around supporting people, who in the past would always have gone into long-term care, to get home. As Alan Gilmour said, that population is very complex and, in the past in Glasgow, those people would invariably have gone into long-term care. The ethos of the system is driven by that dual target. Part of the discussion with colleagues in the acute system was around it being not just about relieving pressure there. We place a value on supporting people to get home, so intermediate care is something different.

Bob Doris: This question may be just left hanging, if you will be providing further information to the committee. The theory behind step-down beds being very different from the acute sector reassures me, but what we are hearing today is an assertion. I am merely passing through the committee as a substitute member, but I would be very interested to know the cost per patient per day in a step-down facility versus the cost in the acute sector, where the care might very well be more intensive and therefore more costly. However, as Mr O'Brien said, it might also be short-term intensive support to quicker enablement. The "Use it or lose it" theory behind enablement that I have seen with my constituents might be very beneficial. I would be interested to know the average duration of the stay of a patient in a step-down facility before they go to their eventual destination—be it long-term care, residential care or enablement at home.

I would also be interested to know how you monitor the outcomes. Do things break down after two or three weeks such that there has to be a follow-up acute admission, or is the number of such admissions reducing? I do not expect you to answer those questions right now. It is just an assertion that step-down care is very different from acute care: that is my experience, from my constituency case load. Unless we get some data, we cannot flesh any of that out.

The Convener: Do any of the witnesses briefly want to offer numbers?

Kenny O'Brien: I can give a bit of the numbers. Our intermediate beds in the social care sector cost approximately £900 per week. It is very difficult to put a price on the cost per bed per day in a hospital, because that cost depends on the specialty, the type of ward and other things. NHS Grampian, which is the board that I contribute to as part of the HSCP for Aberdeen city, has estimated a minimum bed-day cost of £270, I think. For other beds, depending on where they are, costs will be higher because of neurology provision, other specific diagnostic equipment and so on. If you compare £270 per day with £900 per week, the cost benefit analysis works well.

The Convener: That is a reduction in cost of at least 50 per cent.

Alan Gilmour: For context, you have to understand that there is also a cost to making the wrong decision. A rushed decision potentially pushes a person into a placement that is not what they want. There is a cost to that.

In the Glasgow model, we are very much on top of all aspects of throughput in terms of intermediate care. We look at the outcomes data, which includes numbers of people going to nursing homes, to residential care and being readmitted. Also included in the data is the development of clustered supported living, which has become a major benefit for the population of Glasgow. We work very closely with housing colleagues on developing that.

Regarding readmission rates, you have to understand the context of the client group, who are some of the most complex and most frail individuals. They are at risk of readmission from their placements: the rate is about 10 per cent. Our acute-care colleagues assess that readmission rate as being well within acceptable limits.

We look in detail at the reasons for readmissions: there is an audit process that sits underneath the data. We learn from that and look for themes that we can address in trying to prevent readmissions. Generally speaking, the reasons are to do with people being from our most complex and frail client group.

The Convener: Excellent—that is very helpful. If you can provide more numbers in due course, that will add to our knowledge.

Miles Briggs (Lothian) (Con): I want to follow on from what Alan Gilmour has just said, and to pursue the question of attitudes to hospital admissions and how we change them. There is almost a presumption against admission. IJBs around the country are progressing innovations. Of interest to me is how often people who are living with dementia are readmitted to hospital. I know that Aberdeenshire IJB has considered a dementia village to address that patient need. Do you have examples of other ways to avoid hospital being the end point for people in such care packages?

The Convener: Who would like to start on how to defer or avoid hospital admissions?

Sandra Ross: I can give examples from Aberdeen that are less about specific populations than they are about the prevention of admission agenda. We have tested and implemented acute care at home, which started off being geriatrician led, and through which people have either been coming out of hospital or have been turned around

at the front door. Due to issues with recruitment of consultants and so on, we have morphed the model slightly and are considering an advanced nurse practitioner led model to make sure that care is much more about the multidisciplinary team.

We are aligning that with our west locality visiting service and we are aligning our out-of-hours district nursing service and our 24-hour social care call-out service. Having started to join up all those areas across the system, which were working independently, we are starting to see that the GPs are much more confident about saying that they will maintain clinical oversight of people and prevent admissions. We are working closely with care homes and all areas across the system, and we are starting to see benefits as we reduce admissions.

Stephen Fitzpatrick: A number of approaches can be taken. We have had a dementia strategy for a number of years, and have been looking at preventing admissions by supporting people to live with dementia in the community for longer. We focus on the five pillars approach at the early stages of the illness; Glasgow has also helped to pilot the eight pillars approach for the more advanced stages. There is a big focus on sustaining family care and support, and on application of technology-enabled care using GPS and so on. Those things are all to try to reduce admissions.

We will review all our older people's mental health services because dementia is very often associated with older people's mental health in-patient beds rather than with the mainstream acute system. Much of our focus now is on how we might continue to shift the balance of care. I think we have shifted the balance of care from OPMH in-patient beds by maybe 15 per cent over the past six or seven years. We think there is scope to go further, and are in conversation with psychogeriatricians and other lead consultants on what the model might look like and how different it will be. That might allow some patients to be supported elsewhere.

Patients might be in their own homes or might be in an interim setting such as a care home, but that might have an impact on how the consultants' skills and resources are being deployed. For example, rather than the patient coming as an in-patient, the setting might be outward-facing and provide more of an outreach service. What might that look like? We are in the early stages of discussion about that at the moment. We have been doing some work. We had a meeting at the end of February at Stobhill hospital from which some ideas emerged on how we might make that a practical reality. We are looking at how we might support people without having them as in-patients. There are a range of approaches.

11:00

Jim Forrest: In West Lothian, particularly for people with dementia but also for older people in general, we seconded a GP to work with a nurse practitioner and go round all our care homes to look at how we would set anticipatory care planning for patients in care homes, including patients with dementia. The result has been that for the care homes and the GP practices that engaged—about 90 per cent of our GPs did so—we have reduced admissions to hospital fairly significantly.

In addition, we have put together a mental health team that is led by psychology colleagues. That team offers positive behavioural support for residents in care homes, by working with the care home staff to manage behaviours that people might have due to their illness.

We have been working quite successfully across care homes. The work has resulted in significant reductions in admissions and it has meant that care home staff feel equipped, and have been given the professional confidence, to deal with people as their condition worsens, which happens from time to time.

We also have in West Lothian a system of GP practices being attached to care homes. The GPs and district nursing team from the practice visit the care homes and do the equivalent of a ward round. The care homes have direct contact with that provision.

We have looked at increasing our post-diagnostic support for people who are newly diagnosed with dementia. We have increased that resource and are working on it. We have reconstituted community mental health teams for specific focus on the over-65s. It is a work in progress that has shown positive results.

An area that we all need to get into is the much younger age group who are diagnosed with forms of dementia, and how we support families to work with those young individuals. It is frightening for someone who is young and who retains a degree of understanding that their memory and other capacities are beginning to fail. There is a challenge in how to manage and deal with that. It is probably better managed in a home setting with a routine that is consistent and where the individual understands what is going on. We are working on that, at the moment. It is unfortunate that we are seeing a number of cases of fairly young people being diagnosed with the condition. How we deal with that is a challenge.

We have what we call a rapid elderly assessment care team. The idea is that we will provide acute care at home and the person will remain at home if we can deal with exacerbation of the condition. If their condition deteriorates and they have contact with hospital services, we admit them. The change in the dynamic is that before we had that people were sent to hospital for assessment and a decision about what we should do. The decision is now made at home whether the person will stay at home and we will manage the condition, or they need to be admitted to hospital because of their condition.

Miles Briggs: One of the key challenges that has been highlighted to us by other organisations is the sustainability of the care home sector. Scottish Care has highlighted what it is calling a "crisis" in provision. Certainly here in the capital, private homes are closing or going into administration. I think that I am right that Scottish Care estimates a need for another 2,000 beds across the country, and we are losing beds. I know your areas are very different in terms of the care sector—for example, Glasgow has a larger supply of council owned and operated provision. What is your reading of where we are going and sustainability of the care sector?

Jim Forrest: The care sector is fairly fragile and difficult. We have to be realistic. Deciding to have beds of any description is a very high-cost decision. People have to make best use of the assets that they have at the time. Most people will say that they want to remain at home with services coming to them with the least disruption for as long as possible. Some of the sustainability has to come from how we develop further our care-at-home models, and how we learn from the experiences of and differences between the various populations. There is no blueprint that you can pick off the shelf. There are some pointers available, but you have to modify them to your own population.

Public opinion would be that people want to remain in their own homes as long as possible. We have to develop a service model that allows that to happen, but which also delivers good-quality outcomes for the individuals and frees up capacity so that if the person needs to be in a care home, because that is the most appropriate way to meet their needs, they can access that care and do not have to wait five, six, seven or eight weeks to get it.

Regardless of whether care is at home, in a care home or in a hospital, the key is to deliver the intervention when the person needs it and for the time that they need it, and then to move on and change it from there. That is easy to describe, but it is a dynamic process that requires constant maintenance and constant development.

Sandra Ross: Sustainability of care homes and care at home requires some honest conversations. We are embarking on an approach in Aberdeen to commissioning in its real sense, and are looking at a co-production approach. We are meeting our procurement teams, our care managers and all our providers, and are having honest conversations in which we put the cards on the table and say what is facing us in terms of demographics, finances and the workforce. We are asking how we collectively, as a whole system, will deal with that. Until we work together as a whole system in genuine partnership, we will continue to have conflict and competition in the care home sector.

I feel that what we have done through procurement and different modelling has engendered an environment of competition among our providers. We have asked how we can get the cheapest, and how we can get the most, but we have not focused on outcomes and we have certainly not looked at sustainability. If we are to collaborate and use whole-system approaches, we have to start from co-production.

I totally respect the opinion of my colleague, but our perspective is that we are embarking on co-production. That will mean that we will take longer and that there will be some very difficult conversations, but honesty and the joint approach will bring about real sustainability.

Stephen Fitzpatrick: Glasgow is in a different position from that which Jim Forrest described for West Lothian. Historically, Glasgow has never had a problem with underprovision of care home places: the problem has been overprovision. That has been associated very much with speculative development from about 10, 15 or 20 years ago, which was sometimes to do with low land values in the east end of Glasgow. We have a concentration of provision that we did not commission, but which was there. The system responded by placing people because capacity existed. That was something that we wanted, at strategic level, to change, because we thought—there was a lot of evidence for this—that we were accelerating people's journey: they were going into care before they had to be there and, probably, against their wishes, sometimes.

We have over recent years sought to impose greater tests for admission to care, so we have seen a shift in the balance of care, with home placements having reduced by about 20 per cent over the past six or seven years. Some care homes in Glasgow have closed, probably because we were their biggest customer, but we think that we are probably closer to the right balance now. We might be reaching the end of that journey and are seeing demand picking up again. That relates to the pressure on the budget that I mentioned

earlier. We do not have an issue in Glasgow around sustainability, but we recognise that the situation is different in other parts of Scotland.

David Torrance (Kirkcaldy) (SNP): The panel members have talked a lot about shifts in the balance of care—for example, from hospital to community care. You have given various examples of how you have managed to achieve that. Is enough being done to share that good practice across all the integration authorities? You have all given us examples—is enough being done to share that good practice among yourselves?

Kenny O'Brien: That is not 100 per cent consistent across all the elements that we are working on. In my area of expertise, which is delayed discharge, there is quite a lot of sharing of good practice. There are conferences at which we all meet and there are Government-sponsored visits to high-performing authorities. Probably because of delayed discharge's visibility, a lot more is being pushed in regard to sharing of what is being done in other authorities, sharing of action plans and sharing of models of care. To be honest, I am not 100 per cent convinced that we are at that level of sharing across all the different elements of what we are doing.

The Convener: Is one area where more work is needed to do with the shift from hospital to community care?

Kenny O'Brien: I would say yes—probably because of the myriad different ways that you can shift that balance of care. In essence, a lot of it is about almost everything that we do now in regard to partnerships. If you want to deal with the issue of shifting that balance of care from hospitals to the community, partnerships have their fingers in the pie in relation to everything linked to that.

Yvonne Lawton: We talk about shifting the balance of care by moving it from the hospital to the community. In lots of ways, I feel that we should be looking at it from the other angle. If we presume that home is the first place that we want to be, how can we design our systems around maintaining someone at home for as long as possible? While we are dealing with the current challenges that we face, we also need to be thinking about whether longer-term planning needs to have a different focus, on that home-first approach and on building systems around individuals and community settings. Maybe we should be designing systems from that perspective rather than from the perspective of shifting the balance of care.

Stephen Fitzpatrick: I think that more can always be done. A lot is happening, as Kenny O'Brien has described, but there is always room for improvement because it is a complex problem. There is a lot of innovation out there and sometimes you happen upon it by accident. However, there is an onus on all agencies, including HSCPs, to look at the issue proactively.

It comes back to the benchmarking point. If you see another authority performing very well, that generally piques your interest. It is rare that a week goes past when we do not say, "How come Inverclyde is achieving this?" or, "Such and such an authority is achieving that. Let's go and find out more about it," because we need to dig under the numbers.

As I said earlier, in Glasgow we always try to look externally and to avoid the temptation to be too insular. Next week, for example, a delegation of senior managers is going down to Coventry because Coventry has managed to achieve budget sustainability around social care in the very straitened circumstances in England, while performing very well in acute care—in terms of delays and so on—and in its balance of care. We are always looking for other models out there. We can learn from other approaches that fit with our strategic priorities. We are trying to look outwards as well as at what is happening in our authority area.

David Torrance: Is a reduction in the resources that are allocated to hospital care realistic in the context of a rise in demand, demographic pressures and prescribing costs?

The Convener: That is a big question. Who would like to have a go at that?

Alan Gilmour: We can improve things and use what we have to the best of our ability, but eventually we get to a point at which capacity is being outstripped by demand and we cannot deny the changes in the population.

We can do a lot of things that are anticipatory in nature. If we can reinforce the health improvement agenda, we can try to get a better and healthier population. We can also put things in place that support decision making later. For example, being able to set up power of attorney and guardianship is a big win for Scotland. In Glasgow, we ran a couple of campaigns on the power of attorney; we have another one under way. We are looking at that with our acute care colleagues and we are supporting it through our carers agenda. Any opportunities to be anticipatory in nature will, I hope, ameliorate some of the issues.

Sandra Ross: The question that David Torrance poses is quite a difficult one to answer. As Yvonne Lawton said, it is about how we design our systems. We need to start looking at the whole system and thinking about how to shape the prevention agenda. How do we make sure that we will have fitter adults? We need to focus on our children, then we will have a less ill population in

the future. That prevention agenda will help to shift that balance. Given the demographics, it will be extremely difficult to maintain things if we continue with what we are doing at the moment.

11:15

Sandra White (Glasgow Kelvin) (SNP): Good morning, panel. Thank you for your written submissions, which I found really interesting, and for your evidence this morning, which has been very honest. I want to concentrate on the set-aside budgets. We are talking about budgets and lack of funding and so on. When we look at the set-aside budgets, it gets a bit problematic. I feel as though they are not operating as intended. Are the set-aside budgets operating as they should in your areas? If they are not, what is preventing them from working that way?

Sandra Ross: I should say that I am fairly new—I came into post in September. We have responsibility for strategic planning for services with the set-aside budget. The Aberdeenshire, Moray and Aberdeen city IJBs have been working quite closely with NHS Grampian. We have agreed to look at the matter from a whole-system perspective. We have started with mental health, care of the elderly and palliative care, which are all at different phases. We have agreed that whatever moneys are there will sit with those areas. We will have a range of workshops involving people across the third sector, people who use the services, and professionals within acute care, community care and so on. We are asking what our strategic direction and our aim should be.

We are almost at the end of looking at mental health; we have to start pulling our strategy together for June. That will dictate the direction of travel and the money should start to follow that. Otherwise, it is a case of working in siloed services and protecting them. The set-aside is about asking what the whole system looks like and how we can shift the whole system and move the service and, therefore, the finance to match it. It is a complex issue. It is a bit of a wicked system issue, but we are working collaboratively on how we do that.

Stephen Fitzpatrick: It is a complex issue and it goes to the heart of integration. In Glasgow, as you will see from our submission, our view is that the set-aside budget is not yet real. It is talked about in abstract terms, but our capacity for it not to be real will run out of road at some point in the not-too-distant future, given the pressures across the whole system.

To go back to David Torrance's question, we are looking at a potential shift in relation to people who are currently in hospital but do not have to be there. There have been a series of care audits across Glasgow and Scotland over recent years. Consistently, about 15 per cent of the people in our hospitals could be somewhere else. The other 85 per cent need to be in hospital. The opportunity is in respect of that 15 per cent. We will never get to zero, but somewhere between zero and 15 per cent is where the opportunity for the whole system lies and where there is potential to free up some of that set-aside budget. That is a key point for me.

We also have experience in Glasgow of changes to continuing care. We have taken a whole-system approach in recent years around continuing care off-site beds that have transferred from acute management into HSCP management. There is a very similar challenge there in moving from an in-patient model to a community-based model and how to do that across a whole system, with six HSCPs and an acute system that bears the risk if it does not work.

The acute system is the provider of last resort, so the driving concern for it is the idea that we might pass resource to the HSCPs and promise the earth, but if things do not happen as they should, the acute system has to find a way to meet the needs of that population. However, we have managed to do that. As we set out in our written evidence, we have managed to shift the balance. It is, in miniature, the same challenge as exists around the set-aside budget and shifting the balance of care. We have some direct lessons that we can learn from that experience.

Across NHS Greater Glasgow and Clyde, we are embarking on a commissioning planning process to try to move set-aside from the abstract to the specific, as we did with management of continuing care. Can we look at particular points in our system—winter beds or other aspects—and start to point to something tangible that we can do? If we say that we can reduce the number of beds in the acute system by 36, down to 90 beds, by putting something in place that gives us confidence that we can head off that demand, can we get agreement on that?

It is important to have whole system buy-in. We need to have that conversation with clinicians and acute managers and they need to be shaping it, rather than it being something that comes from the HSCP. It needs to be a whole-system approach. We have that experience from continuing care; it is not straightforward, but it has delivered some results for us.

Jim Forrest: I am in agreement with my colleagues that it is a complex issue. In terms of the experience that we have in West Lothian and NHS Lothian, I currently have the mental health budget. It is devolved to me and the partnership, which works well. The learning disabilities budget and the substance misuse budget have also been

devolved to us. Quite a number of things have been devolved to us.

Where the major challenge comes is in unscheduled care, and particularly the people who come in through the front door. There are four partnerships in Lothian and there are three acute hospital sites, so there is a complex issue, as there is for my Glasgow colleagues, regarding how we set real budgets in relation to activity and how that impacts on what we are doing. My finance officer for the IJB is heavily involved with the finance team at NHS Lothian, who are looking at how we develop budgeting, how the budgets are set this year and how, if we use a different funding model, that would look running in tandem with what has happened. That should give us some evidence for how we could make future changes to the unscheduled care budgets, in which we are very involved. We have been very closely involved with both parties with regard to the financial resource that we have, and we have worked as an integral part of the management teams in both parties to look for the efficiencies that are required. We have embarked on that over the past few years and we have a close working relationship, particularly with the finance team at NHS Lothian, in designing budgets.

From a West Lothian perspective, probably about 75 per cent of the unscheduled care activity goes through St John's. That gives us a better handle on what is required. We have the complicating factor that some of it does not go to St John's, but goes either to the Royal infirmary of Edinburgh or to the Western general hospital. The issue is how we find the balance that gives stability to the whole system and allows us to agree on the changes and adjustments that need to be made. That is work in progress for us.

Sandra White: Jim Forrest is the only person who has mentioned the NHS. Others have mentioned the integration boards and so on. We have heard evidence from professionals who say that the NHS seems to treat the set-aside money in the budget as its money and not the IJBs' money. Is there still that culture? You are talking about 14 per cent of the total budget. Why would you and others agree that the NHS keeps that money?

Stephen Fitzpatrick: It is a matter of debate at the moment. Speaking for Glasgow, I do not think there is an acceptance at all that that is the NHS board's money or acute care's money. The view is that we need to debate how we move as a whole system from "as is" to "to be", and to recognise the difficulties that are attached to that. If you are running an acute system in Glasgow that is running at 90-odd per cent occupancy, the notion of releasing some of that resource to invest in community alternatives is quite a scary prospect, and we need to respect that.

At the same time, the system cannot be sustained unless we look at the funding differently. We are absolutely committed to doing something different with the set-aside resources, but we recognise that we need a whole-system approach through which we build confidence on what the alternatives to the current use of that money would be.

Jim Forrest: I can reflect only on the Lothian experience. We have been very much part and parcel of the decisions that NHS Lothian has made on the financial position. We do not always agree, but we are part and parcel of that progressive way forward. There is a complicated issue with unscheduled care and the set-aside budget. What changes could we make that would be beneficial to the whole system and, more important, that would deliver the outcomes that we seek for individuals who use our services?

The other thing is that NHS Lothian has an unscheduled care committee, which I chair on behalf of NHS Lothian, that brings together all the acute campuses and all the HSCPs. It looks at unscheduled care operationally over the 12-month period and we meet monthly. We also use that forum for putting together our winter plan and for using any additional money that comes in. The outcomes that we are looking to deliver from any additional money are openly discussed, and that is tracked through the whole system—

Sandra White: I do not mean to interrupt you, but if you have a very bad winter with flu, for instance, the NHS will use that money, will it not? It will take that in, so although you can plan for certain things, if you do not have control of that 14 per cent—

Jim Forrest: It is not as straightforward as taking that money in. There are budgets for immunisation against flu, which is done across the whole system. We have had pretty good immunisation rates in Lothian, and we have worked collectively. Last winter was not particularly bad, but the winter before that was almost catastrophic for all kinds of reasons. I do not think that it was a case of, "We're taking that money back off you to do this, that or the other." We had to look collectively at pressures in the system and consider how we would fund additional activity and potential overspends in particular areas. That was not the relationship that we had with NHS Lothian and it is not the relationship that we have now.

Sandra Ross: I confirm that the approach that we are taking across Grampian—the three HSCPs along with NHS Grampian—is a whole-system approach. A key part of that is that we are not

saying, "That is your bit of the budget, that is our bit, and that bit goes there," but are looking at the budget as a collective. We are looking at the whole system and moving resources around. We do not want to start off from the position of needing to take money from here to put there. We want to ask where the resource can best be used for the whole system.

Sandra White: The evidence that we have is that a number of the IJBs would like to have a wee bit more control, because they get three years' funding and then have to plan, particularly with regard to drugs and alcohol. Do any of the panellists have evidence of money being overtly taken from set-aside budgets to be used specifically for acute care? Could anybody put their finger on an area of funding that is being shifted from the social care budget?

Jim Forrest: I have not had money shifted from the social care budget into acute care. In the main, the unscheduled care budget is about acute care. The issue is about reaching agreement on how to best use that resource, rather than moving it from one pot to the other. I have not had any pressure to fire money from social care to acute care.

Stephen Fitzpatrick: There is always a push-pull situation, and it is not as straightforward as saying that money will transfer from social care into acute care. However, the pressure that we experience on our care homes budget, for example, will relate to demand coming through from the acute system to relieve pressure there. Equally, the acute system will say, "Over time, as you reduce some of your social care budgets, that will impinge on our spend as well."

We have not fired any money from social care directly into acute care. We would absolutely resist that as being a counterstrategic move.

Bob Doris: This is an interesting line of questioning. I do not know whether my question will move it forward or will be duplication.

I read with interest in our briefing papers that Audit Scotland said, on integration, that there was

"a lack of collaborative leadership and different cultures ... affecting the pace of change".

Glasgow city health and social care partnership's evidence was also really helpful and quite enlightening. It states:

"The chief officer and the chief financial officer experienced very limited engagement with NHS Greater Glasgow and Clyde during 2018/19 in the lead up to budget offer being issued."

Glasgow also said:

"To date partner bodies budget process continue to operate in isolation ... Both sets of partners remain vested in the budget allocation which they delegate to the IJB and expect this to be used"

for

"their respective services."

The money is not losing its identity. I was sitting on this committee full time when integration was being put on a statutory basis. The only reason that the Government put it on a statutory basis was that when health boards, local authorities and services were asked to do it, they simply did not do it. It has now been put on a statutory basis, and you have no choice—not you personally; you are the leaders in the room today.

There is now a duty to get on with it. Despite some really good work that we have heard about today, Glasgow is still seeing that money not losing its identity. Where money is put in, people expect to get it back out of their side of the system again. Where is the leadership in the system to change all of this and can you point to examples of where that has happened and where there has been really good practice? Is there a lack of leadership in some quarters? I know it is very difficult to identify where you think there is a lack of leadership, but clearly there must be.

11:30

The Convener: Panellists should start with their understanding of their own position, but you can also speak about the wider issues you wish.

Sandra Ross: I can only give my view of the Aberdeen area. In my role as chief officer, I am part of the system leadership team within NHS Grampian, as are the other two chief officers from the integration authority. It is called a system leadership team because it has people from acute and the IJBs. There is a strong sense that we are a system and that we are moving forward as a whole—NHS Grampian with the three IJBs—and that we will only get there through collaboration.

There is a recognition of what was said in the Audit Scotland report, but there is also an understanding that the direction of travel is towards collaboration. My own leadership team is certainly anchoring back into the other areas and making sure that we have strong connections.

Bob Doris: I was trying to provoke a response—of course I was—in relation to that. Can you point to an example in Grampian where money put in by either a local authority or the health board has been used imaginatively and not just taken back out by the same partner to spend it on what they have always been spending it on?

The Convener: We will maybe come back to that, because clearly that will take a little thinking.

Stephen Fitzpatrick: It is a delicate question. Some of the issue is structural rather than personal—it is not about individuals and leaders in

the system. If you have a structure where the money flows through, for example, a city council and the health board, it is difficult to see how the accountability would not flow back out. There has been a conscious effort—this is reflected in our evidence—to lose the identity of the funding within the elements of the system that the partnership controls. For example, I have a view of our occupational therapy service, of which we inherited separate NHS and council components. We have brought that service together and brought the funding together and so on. That is something that is within our direct control.

There is a structural issue that is still to be remedied about how the money flows in and out, which places some constraints on the leadership. There is also a cultural point, in that it takes time to make a shift. We are on a cultural journey in the partnership and we are living that every day. If you are the council or you are the health board, however, and you are sitting outside that situation and are not exposed to it in the same way, you will still be inhabiting the same environment as you did before. Therefore, it is perhaps not realistic to expect that cultural change to take place on the same timescales. There is still a way to go. We have some concerns that the conditions do not yet exist to give full effect to the policy intentions of the legislation. We think that there is some work to do across the system.

Jim Forrest: Some of it hinges on the understanding of the legislation. If services are devolved, there is still a feeling from the funding parties that they are accountable for certain things, rather than another entity being accountable for them. We have had to work through that, and that is still work in progress. That is probably at the nub of where we need to shift the culture and attitude. We need good governance structures and oversight to allow that to happen. That is still an on-going development.

From my experience locally, from a local authority point of view and an NHS Lothian point of view, I have, with my chief finance officer, been very much part and parcel of the annual discussions. We were very much there at the beginning of setting out the five-year financial plan across all the local authority services. We were listened to: some of the funding ideas that we put forward were taken on board and that funding has been passed on to us. Although we do not quite have the same long-term view on NHS funding, similar discussions have happened there.

I have been able to take money that has come into the partnership and decide where in the community model we should spend it. For example, I have used money to fund additional community support workers for our reablement service. That does not all necessarily mean that that contribution has come from the local authority, even if it is local authority-employed staff. I have been able to use money across the whole system to allow that to happen.

Bob Doris: That is a useful concrete example. I was not deliberately trying to catch anyone out; I just genuinely wanted to get an idea or an example of where the money has lost its identity. That is helpful. Are you able to give an example, Kenny?

Kenny O'Brien: In Aberdeen, we have done an initiative as part of some of our delayed discharge work. Rather than just buying a wing of a care home and putting people there, we have been buying a cohort of beds in care homes that people would want to go to. Rather than people having to go somewhere they do not want to go, there is now reserved access from a hospital setting into an intermediate care setting with those care homes of choice.

I am employed by Aberdeen City Council, although I am a partnership manager and I work for the HSCP. Previously, there would have been all kinds of rammies, with GPs saying, "Why are these extra people going into these beds? We have to provide medical cover to them." All kinds of debates would have happened across different parts of the system that maybe would not have talked to each other so well prior to integration.

I have a shared budget now. It is not a council budget; it is not an NHS budget. It does not matter what is on the ledger. Consequently, I was very able to talk with our primary care colleagues and agree the appropriate contracts and service level agreements to support the medical cover and nursing cover and so on to allow the seamless flow and the turnover of people into those kinds of care home settings. Historically, we had spending that would have sat on the council side of the business, such as purchase of social care in the care home sector, and we had the more NHS side of the business, which was the community nursing, the GP medical cover and so on. We were able to sort that without lots of go-between, because it literally all came from my budget. The money lost its identity in that bit, because it was about delivering a goal as opposed to who got the council bit and who got the NHS bit of the pie.

The Convener: That is one of the things that we are keen to hear.

Bob Doris: That is helpful. It would be good to get more information on that, although not this morning, because of time constraints.

I pay tribute to David Williams, who is the accountable officer in Glasgow and who is hugely respected, but is it an issue when the accountable officer is the head of a section of the NHS or, in David Williams's case, the head of social work in

Glasgow? I am not asking specifically about Glasgow; that is just illustrative. Can it be an issue if the single go-to person who is in charge of everything is closely identified with the NHS or the local authority? Can that entrench some of the cultural issues that Mr Fitzpatrick and Mr Gilmour have talked about? Are there any thoughts on that?

Jim Forrest: We all have to be employed by someone, because the IJBs do not employ anybody. The short answer is yes, it could be an issue. However, taking my situation as an example, I am employed by the NHS, as I have been throughout my career, and I am based in the civic centre in West Lothian as part of the council's executive management team. I am responsible for all the social work services and I am the go-to person for those services. I like to think that, through the leadership of my team, the barriers have been taken down and we have been able to move things forward.

Bob Doris: I want to make sure that we cover all the bases but, if the other witnesses have a similar view, they should not feel the need to come in on that.

The Convener: I see lots of nodding heads from Aberdeen and Glasgow, so that is helpful.

Bob Doris: Over the years, I have had an interest in the money that is spent on housing adaptations. Previously, the Local Government and Communities Committee has considered the freezing of the budget of £10 million for adaptations in the social sector across Scotland. The budget has been retained, but there has been a real-terms cut over a number of years.

At constituency level, I have written to the Scottish Government and the integration joint board in Glasgow. The minister, Kevin Stewart, points to the budgets that IJBs have in relation to housing adaptations. I got some figures for Glasgow, which is why I was checking my phone earlier. David Williams told me that, in 2018-19, £2 million was used from the integration joint board for adaptations in Glasgow. I do not know what the figure is for 2019-20. When I wrote to the Government, it referred to the answer to a parliamentary question that another member asked on the issue back in March. That said that, for Scotland as a whole, IJBs used £38.4 million in 2016-17, which was the latest year for which the Government had figures.

It is difficult to ascertain whether there are any trends or patterns in relation to that but, all morning, we have talked about using the budget better to reduce delayed discharge, enabling people to live at home and doing preventative work. Adaptations are a good, robust and housing-tenure-neutral example of work that we can do to sustain people in their homes.

It would be nice to hear what the story has been in each of our witnesses' areas to date and whether you capture some of that information. A number is just a number—£2 million in Glasgow is fantastic, but £3 million is better than £2 million, obviously. For £3 million, what difference do we get? Do we get less delayed discharge or more people sustained in their homes? How do we measure outcomes for the money spent?

The Convener: As we are tight for time, I will add a question to that. Are there barriers to housing adaptations and are there things that we need to take up in order to address those barriers?

Yvonne Lawton: We have good relationships with our housing colleagues and we have developed a joint accommodation strategy to clearly set out our housing needs. It is true that it sometimes takes quite a long time for adaptations to be realised, so people can be delayed in hospital while the adaptations take place. One consideration is about what sort of interim arrangements can be put in place to facilitate discharge while adaptations are made. The issue is not so much that we have problems securing funding for the adaptations; it is more about the logistical aspects that are associated with that.

Kenny O'Brien: There is certainly pressure on budgets and increasing demand, and I have been involved in discussions on that in previous years. In regard to process and timeline, we have done relatively well in Aberdeen City. No matter how you cut it, if you are making structural adaptations to an individual's home, there will always be a lag of time from the identification of the need to completion, even just as a result of going from architect to plan to physical bricks and mortar. There will always be a gap, no matter how you cut it.

We are doing two things to try to minimise delay. First, we are trying hard to get upstream through embedding social work staff and the work that we have done in the discharge hubs. For example, if someone is going into surgery for an amputation and we know that they live in a tenement three floors up, rather than wait until they are referred, we get housing issues and other such things dealt with earlier. Before the person is anywhere near clinically ready for discharge, the wheels are turning. We have dedicated occupational therapy staff who are purely focused on this type of work, so that people have a pathway out. Our arm's-length company Bon Accord Care has a housing occupational therapist whose job it is to do such work and who has the expertise to try to cut through some of the flak.

Secondly, with our housing colleagues in Aberdeen, who we work with very well, the partnership has invested in taking on the tenancies of two disabled-access and wheelchair-accessible flats in the city. We have adapted them significantly so that they can work with a wide spectrum of individuals with different occupational therapy and adaptation needs. We try to constrain the time for which individuals are required to wait for adaptations and equipment—or sometimes even rehousing—but we have a place that is far more appropriate for people to go to than remaining in an acute hospital bed. That allows people to retain their skills and independence, and it allows the occupational therapist to try things in a more modular adapted setting, which helps, too.

11:45

Stephen Fitzpatrick: In Glasgow, as in other areas, our budget is, as ever, under pressure. We prioritise the issue and we have protected the budget over the years while social care budgets have been reducing. We have a strategic priority attached to our partnership with housing to try to shift the balance of care from long-term care in particular to supporting more people at home. As an outcome from that, we anticipate that pressure on the budget will accelerate over time, so we need to consider how we potentially grow it.

It is certainly a live issue in Glasgow. Two weeks ago, we had the launch of our joint protocol on adaptations and housing solutions, which was developed with the housing sector. We work with that sector to try to drive solutions and ensure that there is a culture across housing and the health and social care partnership to work together to make the most of the available resources.

The issue of adaptations is a marginal factor in delayed discharge in Glasgow and a marginal cause of unscheduled admissions to the acute system. The reason why we are considering the issue is more to do with the balance of care within the community.

The Convener: I thank all the witnesses for their evidence, which has been helpful. There are one or two items on which you offered to provide us with further information, and we look forward to receiving that in due course.

I briefly suspend the meeting. We will resume in public in two or three minutes.

11:46

Meeting suspended.

11:49

On resuming—

Subordinate Legislation

National Health Service (General Dental Services) (Scotland) Amendment Regulations 2019 (SSI 2019/174)

The Convener: Agenda item 2 is subordinate legislation. The Delegated Powers and Law Reform Committee considered the instrument earlier today and determined that it did not need to draw the attention of Parliament to the instrument on any grounds within its remit. Do members have any comments on the instrument?

Anas Sarwar: If the dentists are happy, I am okay with it. I should declare my interest as a former dentist, and I liked being a dentist.

The Convener: That counts as a succinct comment. If there are no further comments, is the committee agreed to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: We now move into private session.

11:50

Meeting continued in private until 12:02.

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