OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 5 June 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 5 June 2018

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HEALTH AND SPORT COMMITTEE
18th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Kate Forbes (Skye, Lochaber and Badenoch) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Catherine Calderwood (Scottish Government)
Paul Gray (Scottish Government)
Peter Johnston (Convention of Scottish Local Authorities)
Mike Liddle (Scottish Government)
Christine McLaughlin (Scottish Government)
Shona Robison (Cabinet Secretary for Health and Sport)
Shirley Rogers (Scottish Government)
Alison Taylor (Scottish Government)
John Wood (Convention of Scottish Local Authorities)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 5 June 2018

[The Convener opened the meeting in private at 09:02]

09:36

Meeting continued in public.

Subordinate Legislation

Ethical Standards in Public Life etc (Scotland) Act 2000 (ILF Scotland) Order 2018 (SSI 2018/148)

The Convener (Lewis Macdonald): Good morning, and welcome to the 18th meeting in 2018 of the Health and Sport Committee. We have already taken our first agenda item in private and will move on to item 2 in a moment. I ask everyone to ensure that mobile phones are switched off or to silent mode.

Item 2 is consideration of subordinate legislation. The first instrument is the Ethical Standards in Public Life etc (Scotland) Act 2000 (ILF Scotland) Order 2018. No motion to annul has been lodged and the Delegated Powers and Law Reform Committee has not made any comments on the instrument. As there are no comments or questions from members, does the committee agree to make no recommendations on the instrument?

Members *indicated agreement.*

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2018 (SSI 2018/151)

The Convener: No motion to annul the instrument has been lodged, and the Delegated Powers and Law Reform Committee has not made any comments on it. As there are no comments from members, does the committee agree to make no recommendations on the instrument?

Members *indicated agreement.*

Pre-budget Scrutiny (Budget 2019-20)

09:37

The Convener: We move on to the third and substantive item on the agenda, which is pre-budget scrutiny of the budget for 2019-20. I welcome to the committee Paul Gray, who is the director general of health and social care and the chief executive of NHS Scotland; Christine McLaughlin, who is the director of health finance, Shirley Rogers, who is the director of health workforce and strategic change, Dr Catherine Calderwood, who is the chief medical officer, and Alison Taylor, who is the head of integration division, all at the Scottish Government.

If the witnesses are content to do so, we will move directly to questions. I start by acknowledging the progress that has been made in providing financial information to the committee and in making it publicly available in the past few weeks. That is very welcome. However, we wish to continue to engage with officials over the content and format of the reports. It is new territory, in a sense, and we are keen to engage with you on what is most useful to us as a committee in scrutinising financial plans. The first area of questioning is financial plans.

Ivan McKee (Glasgow Provan) (SNP): Good morning. It is a nice early start and a nice easy subject. I want to talk through the longer-term projections in the budget. Clearly, we are moving into a different environment with the medium-term financial strategy in place. There have always been calls from the ground up—if you like—for more detail on multiyear budgets and so on, but there is clearly a lot of variability around that, which the medium-term financial strategy lays out fairly well.

It is interesting to look at some of the evidence that we had on that. People said that they know about 95 per cent—but not about the last 5 per cent—of the numbers in the medium-term financial forecast. The Government knows about 94 per cent, but there is nearly 6 per cent of variability in the numbers towards the end of that planning period.

I am interested to hear your thoughts about that process. How accurate do the numbers need to be for planning that far out? Can you work with the variability in the medium-term financial strategy or do you need more accurate data going out three, four and five years?

Paul Gray (Scottish Government): Accuracy and precision are always to be desired, but running a public service is not an absolutely

precise matter. For example, as the committee will know, we had a serious outbreak of influenza earlier this year—it started before Christmas and ran into the new year. We might not have one of those every year, but there are costs associated with such events. Therefore, it would be false to say that we can absolutely predict every element of demand. However, it is also important that public bodies, such as health boards and colleagues in local government who have responsibility for integration, have a degree of precision about what to expect.

We are always trying to walk the line between pretending that we know exactly what the future holds—which we do not—and having sufficient precision to allow people to plan effectively. Christine McLaughlin can say more about the detail.

Christine McLaughlin (Scottish Government): The main thing that the Scottish Government framework allows us to do is to come up with a reasonable set of assumptions, get agreement that they are the best set of assumptions at the time and then work out the level of risk. It allows us to see where the risks and opportunities lie. That, and the ability to flex it as we get more certainty on particular components, is the strength in it.

On health and social care, it also shows the importance of a healthy population for the economic outlook and the contribution of health and social care to the economy. It is clear that we cannot consider planning for health and social care in isolation; we need to think about the impacts on people's employability, the workforce and, for example, infrastructure development. The more that we can tie health in with policy areas such as education and justice in order to do that, the better the position that we will be in. That will allow us to join up all those considerations in a better way.

Ivan McKee: The total numbers in the budget turn up a couple of things. There is a figure of £2 billion for increasing the health budget in cash terms over this parliamentary session. Am I correct to say that that is as a consequence of the manifesto commitment?

Christine McLaughlin: Yes.

Ivan McKee: That nails that down. It is clear that the Scottish Government's budget could go either way—up or down—because we have the band as we go further out. Obviously, you will say that the health service could use more money if the budget increases. What scenario planning have you done for possible variability? I suppose that it would be on the upside, given the manifesto commitment.

Christine McLaughlin: You are correct that the £2 billion has been factored in because of the manifesto commitment. As you are aware, we will shortly publish the medium-term financial framework for health and social care. We have modelled it on the basis of that manifesto commitment. However, as Paul Gray said, that also demonstrates that we can make different decisions based on our funding position and what it means for our ability to invest more in transformation and reform. That is probably the biggest point, as well as the potential impact on our major infrastructure developments over the coming five to 10 years.

We are ready to build up scenarios. At the moment, we are trying to set out what we are able to do within the assumed funding levels for health and social care, rather than explicitly consider scenarios in which there is more or less money. The tie-in to consequentials is obviously different for the health budget than for other aspects of the budget so we need to be mindful of the fact that health and social care make up the largest proportion of the Scottish Government's budget.

Ivan McKee: Do you view the numbers in the medium-term financial strategy as the base? Is that the upside but not the downside?

Christine McLaughlin: That is the basis on which we have developed the financial framework for health and social care.

09:45

Ivan McKee: My final question is about whether Barnett consequentials are tied—I do not know whether you can answer that. One way to look at it is that, if health spending in England varies, the Barnett consequentials will vary. Another way is that the Scottish Government has insulated you to some extent from that variance because of the manifesto commitment, so the money goes into the big pot and is allocated depending on the Government's priorities. Is that how you see it?

Christine McLaughlin: Some of your points on matters about budget spend are for the cabinet secretary.

Ivan McKee: Of course.

Christine McLaughlin: The presumption to date has been that health consequentials from the United Kingdom Government settlement will be passed on, because resource consequentials are passed on. We have operated on that basis to date. If there is a scenario in which there is potentially more funding, that would be part of the wider Scottish Government plan.

Ivan McKee: However, on the other side of the downside from the consequentials, you would not

see that going into your minimum number, because that is guaranteed.

Christine McLaughlin: In so far as the manifesto commitment is a solid assumption—we are going on the basis that it is. As you have said, there is volatility in the plans going forward, but when you look at all the factors that are up front in the Scottish Government document for the medium-term financial outlook, the £2 billion investment is the first thing on the list. To me, that shows the priority that is given to it.

Ivan McKee: That is fine; we do not talk enough about the feedback loop from health spending that supports economic growth, which you commented on.

Christine McLaughlin: It is absolutely key.

Ivan McKee: We should maybe talk about it more.

The Convener: Can you confirm when the health and social care delivery financial framework will be published?

Paul Gray: That is a matter for the Cabinet to decide. We expect it to be published shortly, but it is a matter for the Cabinet.

The Convener: With regard to the questions about Barnett consequentials that Christine McLaughlin has just answered, am I correct to deduce that the Cabinet has not yet made a determination on the application of any future consequentials, over and above the additional £2 billion that has been described?

Paul Gray: Those matters are for the Cabinet, and I will take my direction from there.

The Convener: That is understood.

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): I have a brief supplementary to Ivan McKee's point about long-term planning. Has the UK Government given any indication when it will publish its long-term health funding plans, which I understand that it has promised in advance of this autumn's spending review?

Christine McLaughlin: We do not have a date and I have not seen any firm detail yet.

The Convener: We will move on to regionalisation and its consequences, and how it will affect future financial planning. One issue that became clear in the discussion at the recent Conveners Group meeting with the First Minister was that she believes that regional relationships should grow organically, but she also referred to there being different views on the matter. Is the matter simply evolving or is there a policy process with regard to finance that we should be aware of?

Paul Gray: We are already committed to regional planning and delivery, and a governance structure is in place—I want to be clear about that. Regional plans are in development and will be available once the financial framework is published. I ask Shirley Rogers to say a bit more about the planning and delivery process—I emphasise that the process is not just about planning; it is also about delivery.

Shirley Rogers (Scottish Government): That point is very important. The strategy for the delivery of health and social care has three elements—arguably, it has more than three. A number of things are delivered nationally because it makes sense to do that. A number are delivered regionally where there is an opportunity to look at regional specialties in a particular way. The thrust of the delivery planning methodology is to enable local delivery of the things that it makes most sense to deliver locally.

The other thing that the committee might be interested in is that, although there is governance around that regional structure, regions are quite porous structures. They have boundaries, and we are not necessarily going to make somebody who lives at the outer edge of a region travel a long distance when they could skip over the boundary. If we take Forth Valley as an example and Fife as another, some things go from Forth Valley into Glasgow and Edinburgh, if that makes sense, and a similar thing happens with Fife and Tayside or Lothian.

The strategy is really an attempt to look from the patient's perspective and ask what services it makes sense to deliver locally, what things is it sensible to do more collectively and consistently across a region, and what other things are so infrequent or highly specialist that it makes sense to deliver them nationally. Those things are emerging, and there is some governance to manage the process. We have appointed implementation leads in the regions, as the committee will be aware from earlier conversations.

It makes sense to trial developmental approaches in particular regions, and we might talk about that later when we look at the specifics of health challenges. The strategy is designed to look at the process that is required by patients and where it makes best sense for it to be delivered in Scotland.

The Convener: How does the Government anticipate that the lines of accountability for that will develop?

Paul Gray: There is an accountable officer in each health board; that situation stands. It is possible that, in the future, we might also see an element of regional accountability. However, as

Shirley Rogers has explained, the first thing that we want to do is get regional delivery in place. I have been discussing with the board chief executives and the cabinet secretary has been discussing with the chairs the extent to which that will then require us to refine the way in which we describe our accountabilities over time.

If I may, I will just stick to this year. Each of the chief executives remains an accountable officer and there is no immediate plan to change that.

Miles Briggs (Lothian) (Con): We welcome the fact that the Government has accepted the need for us to see monthly budgeting updates from the health boards and integration joint boards. However, knowing what is going on in some health boards has become more difficult for the committee. A couple of weeks ago, NHS Lothian said that it would need £31 million to carry on delivering, and the Cabinet Secretary for Health and Sport clarified that it did not. On Friday, NHS Lothian wrote to me to say that that is still its position.

Do you have confidence in the Scottish Government's financial monitoring of each board when we do not really know their true financial position?

Paul Gray: I have confidence in it. NHS Lothian has said that it estimates that it would need £31 million to continue to deliver as it was delivering at a similar point last year. However, the whole point of transformation is not to carry on doing the same thing. I have previously made that point to this committee and the Public Audit and Post-legislative Scrutiny Committee.

The sustainability of health and care services requires us to transform. The advances that we have made in treatment and care paths, and in the way in which care can now be delivered much more locally through telehealth and telecare, mean that simply saying that we need this much money to do what we did last year is not exactly taking a transformative approach. I am encouraging health boards to do as they are doing and engage fully with our transformation process. Part of that runs through the integration partnerships, which are making an enormous contribution. The clinical community is also making a contribution.

We need to take a more forward-looking approach to this rather than saying that, if we had this much money, we could deliver in the same way as we did last year.

Christine McLaughlin: I have confidence in the monitoring. I have spent a lot of time working with NHS Lothian, for example, on understanding its position. There is no doubt that every national health service board is its own organisation and that the way in which the financial reporting is done is slightly different in each board. The approaches have evolved and fit within the board reporting in each area. We look for the principles of transparency and simplicity so that people can understand the key messages and, in particular, the risks. From what I have seen, NHS Lothian provides that.

As Paul Gray said, the point about the particular issue in NHS Lothian is not that there is a deficit in its current financial planning; the figure is a quantification of the board continuing to deliver as it is, which is not what we have asked it to do. If that does not clarify, I am happy to follow up with any information that you feel that you need, but I have confidence in the way in which the board is reporting to us monthly.

Miles Briggs: Obviously, some boards, such as NHS Tayside, have received brokerage, and NHS Ayrshire and Arran has suggested that it may need brokerage. Are any other boards already making requests for that?

Christine McLaughlin: I am happy to give you information on that issue, which we clarified recently for the Public Audit and Post-legislative Scrutiny Committee. We are clear on the brokerage position for 2017-18, which has just been confirmed for the boards. There is £50.7 million of brokerage in 2017-18. In developing the monthly reporting from June, my intention is to show clearly which boards are signalling that there may be a brokerage requirement for 2018-19, so the committee will be able to see that clearly.

With the boards that are currently in deficit, we are working on the basis that recovery will take more than one year. We accept that, if we want to support them with performance and stability, it will take more than one year. I expect that, in 2018-19, we will have further brokerage requirements, but we need to firm that up with boards. We also accept that the position will change through the year. We might expect boards to be more prudent at the beginning of the year and then to make improvements through the year. To manage your expectations, I point out that we expect the number to move during the year. I think that you are asking for transparency about what the number is and to be able to see it regularly.

Alison Johnstone (Lothian) (Green): On that point, does the need for brokerage reflect temporary problems or structural deficits that require fundamental action?

Paul Gray: As the committee knows, boards have annualised budgets, and Audit Scotland and others often consider whether that is the right approach. Brokerage allows us to flex over the end of financial years in a way that we could not otherwise do if we simply said that the annualised budget was the end of it. We have been able to give some boards a bit of flexibility over the end of

a financial year in a way that has allowed them to plan ahead for what they need to do to recover.

You asked whether the use of brokerage implies some underlying structural issue. At this stage, I would not say that it does. Particular circumstances will come to light in some boards, given that they operate in different areas and serve different populations. However, at present, I do not have evidence to show that there is an underlying structural deficit in boards. One of the bases on which we provide brokerage is that the board has a plan to recover sustainable financial balance. We cannot really have one without the other.

The Convener: Does that mean that you anticipate that, where brokerage is arranged, the money will be repaid?

Paul Gray: That is the current situation.

The Convener: So the recovery plans are about getting back to balance and repaying the Government for the brokerage that has been received.

Paul Gray: That is correct.

Miles Briggs: When boards report that they cannot achieve the necessary level of efficiency savings—for example, NHS Greater Glasgow and Clyde reports that it expects its efficiency savings to be £44 million lower than planned—how do you factor that in? NHS Tayside, for example, is looking to make more than £250 million of efficiency savings over the next five years as part of its recovery plan, but boards that are not asking for brokerage are not achieving those targets.

10:00

Paul Gray: You raised the example of NHS Greater Glasgow and Clyde. I discussed its position with the chair, John Brown, last week. As Christine McLaughlin said, boards will make a set of prudent assumptions in the early part of the year, but they will continue to develop efficiency plans in the course of the year. That is what we expect them to do. I come back to the point that Mr McKee made. The capacity of anyone to make a perfect prediction at a particular point in time is fairly limited. I think that NHS Greater Glasgow and Clyde will find efficiencies in the course of the year that will defray the £44 million to a point at which it will come into financial balance. That was certainly the thrust of the discussion that I had with the chair.

Christine McLaughlin: To state the obvious, the process of setting a budget is not something that is done for a 12-month period, which then stops, only to begin again the next year. Boards continually look for efficiency savings, whether recurring or one-off. We need to recognise that there will always be a component of one-off savings. If you look at the figures for NHS Greater Glasgow and Clyde, you will see that the level of savings that it is achieving is not dissimilar to the level of savings that was achieved in previous years. That is also the case with NHS Lothian. A factor that I would look at is whether the level of savings that a board has achieved is very different from the level that it achieved in previous years.

Another point to make is that it is not possible to look at efficiency savings without looking at the transformational change plans because, in the longer term, the answer lies in the reform of services, in addition to achieving a core level of efficiency savings. The two need to be taken together. As you know, when it comes to the timeframe, the transformational change savings tend to have a longer tail, whereas boards will expect to achieve a minimum level of efficiency savings of 3 per cent in-year. It is necessary to look at the total picture.

The Convener: How will regional initiatives be funded? How will accountability operate in that context? Will that be done through partner boards?

Paul Gray: No. Within the budget, there is a transparent allocation of money to transformation. Shirley Rogers can say more about that.

Shirley Rogers: The transformational plans are not based only on hope. Significant support is being given to the boards to help them with that transformational journey, which is quite a difficult process. I will take the example of NHS Lothian, which Mr Briggs raised. I met the chief executive to discuss the provision of some expertise in that area only last week, and discussions are taking place this week about how we can support the board to take those transformational decisions.

There is transformational funding available to help to ease through certain things that will be transformative for the system. For example, there are transformational plans for a digital platform for patient records. That sounds like a mainly administrative development, but it will have a huge impact on things such as waiting times and so on. There is some funding available for that.

We are also mindful of the fact that we operate with a £13 billion budget. The real gains are to be made not simply by finding a bit of transformational funding for various things, but by looking through a transformational lens at all of that spend in the way that Christine McLaughlin outlined in relation to economic viability.

We now have plans from each of the regions, as well as a plan from the consolidated national boards, which are with us for consideration. A programme board approach will be taken, which will involve looking scientifically at which

transformations will give us the biggest return on investment and which things will truly transform the service for patients rather than just bring about a wee bit of change at the margins. The allocation of those financial packages will involve a rigorous process of impact assessment.

Clearly, some of those impacts will be long term, but some of them will not be. We are making sure that the financial allocations that are given to those programmes of work will actually achieve the things that are set out. That happens through the programme board and ultimately through the director general, who is the accountable officer for spend.

Ash Denham (Edinburgh Eastern) (SNP): Good morning. The public sector pay policy for 2018-19 has already been set out, but the Scottish Government has also committed to providing a pay deal for NHS staff that is at least as generous as the one in England, so the final pay deal in that sector might diverge a bit from the public sector pay policy. The Barnett consequentials for that are set at £78 million for 2018-19. Has modelling been done around any additional costs that might arise if there ends up being a more generous deal?

Christine McLaughlin: Yes. We have modelled on actual costs and on consequentials in order to understand the variation. It is also important to remember that there is a large chunk of staff for whom pay awards will not be associated with any consequentials, so we are modelling the entirety of pay for NHS staff and independent contractors. That is an important factor, but it is one of many when we look at pay impacts for 2018-19 and 2019-20.

Ash Denham: Do you have an estimate of what that additional cost might come to?

Christine McLaughlin: We have worked out various scenarios for where we might end up with the pay policy, and they factor in consequentials.

The Convener: Are you going to tell us what those are?

Christine McLaughlin: I was not going to. [*Laughter*.]

Shirley Rogers: We are in the process of negotiating that pay award as we speak, so we would rather not, if you do not mind.

The Convener: It is always important to ask the question. Sandra White is next.

Sandra White (Glasgow Kelvin) (SNP): Good morning. It has already been mentioned that the largest part of the budget is the part for health and social care, and integration is a huge part of that. We have received evidence from integration authorities: some say that it is working well, but others say that it is not. [*Interruption*.] Forgive me—this is the first time I have tried to use a tablet in committee rather than having lots of paper. I have now found the right page.

Basically, some people are questioning whether there is true integration. They worry that there are packages that are labelled “health” and packages that are labelled “social care” and that they seem not to meet in the middle. I have a number of questions about that, and about how efficient the integration authorities are.

First, is the leadership of the integration authorities sufficiently robust for them to be able to question why those labels still exist and whether there is true integration, or whether funding decisions are still dictated by health or by social care? Secondly, does the fact that the chief officers and finance officers are associated either with health boards or with local authorities lead to conflicts of interests?

I will throw those two questions out to you, then ask another couple, if that is okay.

Paul Gray: I will bring in Alison Taylor in a second, as she is the head of our integration division.

If integration was working perfectly evenly across Scotland only two years in, I would be very surprised indeed; I would think that people were misleading us. The fact that the position is not exactly the same in every place is what I would expect. On 5 July this year, we will celebrate the 70th anniversary of the NHS, and it is not perfect yet, so I would not expect integration to be perfect after two years.

However, I can certainly see evidence of where it is working well. In such places, staff who are delivering front-line services are being identified not with the NHS or with local government but with the service that they provide. For example, my mother benefited from the rapid elderly assessment care team in West Lothian. I deliberately asked her one day whether she knew where they were from, and she said, “It was just REACT.” Nobody had a local government badge or an NHS badge; they were simply the professionals whom she needed for the care that was appropriate for her.

Sandra White is right in that we are bringing together the two cultures of the health service and local government. From speaking to my colleagues at chief officer and chief executive level, it is very clear that there is real determination to ensure that the bringing together of the cultures is for the benefit of patient care and does not detract from it. Work is being done to support the leadership that is provided by chief officers.

Sandra White asked whether it is a problem whether the chief officer is employed by the local authority or the health board. Many chief officers are joint appointments. For example, the chief officer for Glasgow and the other chief officers in the area are executive directors on the health board, but also have a reporting line to the local authority through the partnership. We are doing all that we can to ensure that those senior posts have the right amount of power, authority, accountability and responsibility, consistent with what we are asking them to do.

Alison Taylor (Scottish Government): I will build on those points; I have been working on this for a few years. When we talk to people who work in local partnerships, particularly the integrated teams who are directly supporting people and their families who are using services—which is what it is all about—it is encouraging to hear what they say. They may say positive things to us, but they also say that because integration is high on the agenda, they have to work together and that that has made a real difference to how they approach working together.

In many places, integration is in the early stages. However, we did not start on a level playing field. Members will know that in some places people have been working in well-integrated ways for some time, but in others a lot more had to be done. There was quite an uneven starting position.

In monitoring progress at national level, it is really encouraging to see early quantifiable evidence of the shifts in the balance of care that we have been looking for. Those shifts are not without challenges. Paul Gray made the point about the joint accountability of the chief officers and the chief finance officers; that is key in terms of the structures of the systems that we have created. That does not get us past the fact that some of the decisions that need to be made are really difficult; reforming and reshaping services, as Christine McLaughlin and Shirley Rogers talked about, can involve challenging conversations with the public and professionals.

The key thing in the arrangements is that people make decisions together; we need to support them to work together and to lead together towards the sorts of opportunities that Christine McLaughlin described.

Sandra White: Are you saying that you do not see conflicts of interests when people from the local authority and from the health board sit together at that higher level, because of their experience?

Paul Gray: There certainly should not be conflicts of interests, because the appointments are deliberately designed as joint appointments, in that the health board and the local authority have equal say, and local elected members are on the integration joint boards to ensure that the local authority is represented at that level. To use the example of NHS Greater Glasgow and Clyde once again, I point out that there are several local elected members on the health board—as there are on other health boards.

I am not trying to put a counsel of perfection before the committee. We are on a journey and we are not at its end by a long stretch. However, we have put the right components in place to make the journey a success.

Sandra White: It is not all doom and gloom—some boards are working well, while others are not quite as integrated as we would like. We have heard evidence that integration joint boards should have their own direct funding—it was mentioned quite frequently during the meeting on 22 May. What are your thoughts on giving IJBs moneys direct from health and social care? Would that help? If not, should we stick with what we have and see it through, or is there another approach that could give integration authorities some direct funding?

10:15

Paul Gray: The legislation is set up in a particular way, but what lies behind it is the genuine and persistent ambition to ensure that health, local government and third sector partners have joint ownership of integration. It is a good thing that money that is first allocated to the health board goes into the partnership arrangement because that means that there is a sustained commitment from the health board to the success of that partnership. Integration cannot be described or thought of as something that is “over there” in some way—it is at the core of delivery of health and care services.

Similarly, in relation to local government, I am currently co-chairing a series of discussions with Sally Loudon from the Convention of Scottish Local Authorities, Joyce White and Andrew Kerr from local government, a number of chairs and chief executives, and elected members from integration partnerships to ensure that we see health and social care integration as a complete picture, and that it is not divorced from the business of local government or health. As I said, our third sector partners are an important component.

The Convener: I am keen to explore the issue of accountability, given that the meeting has a pre-budget scrutiny focus. Who is accountable, in the current scenario, for the funding of IJBs?

Alison Taylor: The Public Bodies (Joint Working) (Scotland) Act 2014 established the IJBs

as statutory bodies, as the committee knows, and the accountabilities for decision-making are set out clearly there. There are requirements on local authorities and their accountable officers, and on health boards and their accountable officers to fulfil their duties. What is done with the money once it is delegated to the IJB sits with the accountable officer of the IJB.

In that technical sense, the accountabilities are set out in the legislation. In fact, there was a large drive for the legislation to clarify those matters because under the previous arrangements, which had relied on voluntary joint working, the accountabilities were unclear and, to be frank, did not work. Some progress was made, but the system did not work as well as it needed to. Christine McLaughlin can speak about the financial management side of the question.

Christine McLaughlin: I have given a lot of consideration to the point that Sandra White raised. We have a finance development group that involves all the relevant parties; accountability is one of the things that we have considered. It is necessary to step back and draw a line somewhere if you give somebody a resource for which they are responsible. I do not think that anyone has yet come up with a way that feels better. There will always be pressure to understand what total resource you have, and it has to come from somewhere.

Even if we were to go down a different route—for instance, giving a budget direct to the integration authorities—there would probably still be a mechanism for agreeing increases and any additional funding for something else. You would also still have the reality that you might look to spend funding on different things.

The only way that integration is going to work is by people from the different sectors coming together. The fact that the resources come in from parent bodies should not, in itself, be the barrier. Sometimes, that is put up as a barrier; in the early years, it has felt as though it is a barrier, but we all need to try to move on from that.

There are things that we can do to make it easier: we could, for example, take away some of the complexity about individual allocations for various things and how they flow through. I accept that there is more that we can do, but I do not think that we have yet come up with a way that feels as though it takes away the issues about initial sources of funding.

The Convener: NHS Lothian told us that it remains accountable for the money that is spent, so there is a question about clarity of accountability for all concerned.

Paul Gray: I would explain the situation by saying that I am the accountable officer for the whole health budget, regardless of who spends it. It is my duty to ensure that there are systems of delegation in place that secure, first, the clear allocation of funds and the clear delegation of responsibilities. I then expect the health board chief executive, as the accountable officer, to ensure that he or she has a clear system of delegation in place in the health board and in relation to the moneys that are then delegated to the integration partnership. I know from speaking to local authority chief executive colleagues that they do the same. There is therefore a traceable line of delegation.

However, just as I remain accountable for the whole budget, I expect a health board chief executive to be accountable for everything that I delegate to them. Part of that accountability will be discharged by delegating further, but that does not erase their accountability.

The Convener: That is helpful. We will move on to set-aside budgets.

Emma Harper (South Scotland) (SNP): We took evidence at our meeting on 22 May about set-aside budgets, but I do not know whether I am any more clear about them even after reading the *Official Report* of that meeting again.

However, we heard about how some of the set-aside is hindering the processes for integration. One panel member at that meeting referred to set-aside as “a notional budget”. I am aware that the Dumfries and Galloway and the Argyll and Bute IJBs have chosen to allow the NHS boards to retain the set-aside, but technically the IJBs still direct where set-aside should be spent. Do you know of examples where set-aside budgets are working effectively? Do set-aside budgets support or hinder the process of integration? Should we be doing something different with set-asides, perhaps to make them more understandable and clear for everybody?

Paul Gray: I will say a couple of things and then bring in Christine McLaughlin and Alison Taylor, if I may. As we are talking about transparency, the transparent thing for me to say is that there is a set of principles around how the set-aside budget should work, but within health boards, local authorities and the integration partnerships there are genuinely contested views about how they should work in practice. That is one of the reasons why I convened the discussion with the Society of Local Authority Chief Executives and Senior Managers, COSLA, the IJBs and the chief officers, chief executives and chairs of the boards—it is something that we need to work through.

At the moment, I do not propose to try to impose an absolutely similar system in every area, because the whole point is to use local determination within the flexibilities that are

available. However, it is fair and transparent to acknowledge to the committee that the set-aside budget situation is something that we are still working through, so there will be differences in the views that are expressed to the committee. Christine McLaughlin and Alison Taylor might be able to say a bit more about that.

I record for the committee's benefit that the ministerial steering group that is jointly chaired by the Cabinet Secretary for Health and Sport and Peter Johnston, the health spokesperson in COSLA, is also taking a very close interest in the matter.

Christine McLaughlin: Set-aside budgets are managed in different ways because it is about resources that are within existing broader resources—for example, in a hospital it could be a budget for a ward or part of a ward that is part of a medical specialty. It is not about complete components of budgets, which is why money is established as a set-aside budget. However, that does not mean that it is notional. We are talking about real beds, real staff, real patients and real costs.

Where I have got to in this—I have been really helped by the finance development group and some of the people who came to give evidence on 22 May—is that the most important thing when integration authorities are setting out their plans for services is that they include the component that is in acute hospital care, which is a set-aside budget. If that happens, everything else flows from it. It has to be about more than just calculating a budget; it has to be something that features in their plans. We looked at Aberdeen city IJB as an example, and that is exactly what it does.

It gets harder when we start to look at how we would shift resources if we were to provide a service differently, but we are seeing examples in which that is starting to happen, so we know that it can. We can move away from set-aside budgets being described as "notional" through being able to see clearly that the acute component of care is included in plans. If we start from that, a valid question would be whether we can see it in every partnership. In all cases, the flow of money should be based on the service delivery plans; it should not be the other way around. I do not know whether that sufficiently answers the question. Alison Taylor might want to add to it.

Alison Taylor: The only thing I would add is that the question takes us back to what we are trying to do with this iteration of integration, which is building on years of attempts to bring health and social care closer together. One of the lessons that came from the community health partnership experience that preceded this round of work arose because those partnerships had within their span of control only the services that were already in the community; that was the maximum space within which they could reform anything. One of the challenges that we are trying to address now is the potentially avoidable use of institutional care in hospitals and care homes for frail older people and others, and we recognised that the only way that the new partnerships could get a grip of transforming that kind of care would be if they had some authority over aspects of it.

When Eddie Fraser gave evidence to the committee a couple of weeks ago, he explained that what is in the component of the hospital budget that Christine McLaughlin described is basically the types of hospital activity that are most often used because something else did not kick in earlier in the community that would deliver a better outcome.

It grieves me slightly that we end up talking about set-aside budgets so much. I completely understand why, but they are only a mechanism to shifting the balance of care by giving people that span of stuff to reform and improve that touches what we want to do less of, and what we want to do more of.

Paul Gray: In response to Emma Harper's question we could, if it would help, try to set out on no more than a couple of sides of A4 what we are trying to achieve through the set-aside budget approach. It is something that is oft debated, so I wonder whether it would help the committee if we tried to give you an outline.

The Convener: That is welcome: we would appreciate that.

Emma Harper: When we last took evidence, Judith Proctor said that, if cardiac and pulmonary rehab nurses delivered services in the community, the set-aside budget for acute care would help to support that transition. Would that part of the process be seen as a good example?

Alison Taylor: Yes, indeed. When we talk about shifting the balance of care, that takes us back to the earlier point that we need to see it as a joint responsibility. There is a pool of resource—human and financial—and a different service might be delivered by the same staff in a different place. That is shifting the balance of care, too, and it can greatly improve people's outcomes and experience of care. It is a good example.

Emma Harper: Okay, thanks.

The Convener: If an IJB reduces demand for hospital care through its activities, does the finance that is released by that go to the IJB through the budgetary arrangements? Are there any examples of that happening?

Paul Gray: In principle, the answer is yes. The difficulty—which is why there is a debate around the approach—is that the process is a bit more

complex than that. Imagine that a service is delivered in a hospital-based setting and some of that service is transferred into the community—quite properly, with proper clinical governance and so forth. Now imagine that that hospital consists of the one ward in which that service is delivered. We would not make a saving by removing the need for that hospital if we transferred only half of what the ward did out into the community. That is where some of the issue arises.

It might be absolutely the right thing to transfer some of the service into the community—it might be best for the patients and be clinically appropriate—but it would be hard to realise an efficiency saving if only a part of the service had been removed, with the other part remaining where it was. That is not to say that that would be impossible or that we should stop trying to do that, but that is where there is debate about where the budget lies. You cannot transfer half of the budget for a service into one place and leave the other half dangling. Those things need to be worked through, and that is what we are doing through transformation. It is not as simple as it may look on the surface.

10:30

The Convener: Thank you. I look forward to seeing the paper that you mentioned.

Kate Forbes: I understand that there is a requirement for the integration authorities to report budgets against outcomes, but we have previously heard questions about how successful that is. What support is the Scottish Government currently providing to integration authorities to help them to develop their reporting of budgets against outcomes?

Paul Gray: The high-level outcomes are set out in the legislation. We have been keen to help integration partnerships to have the necessary underpinning data to support their analysis both of what they should do, including the areas that they should prioritise, and of the outcomes that they achieve. Within NHS National Services Scotland, there is an organisation called the local intelligence support team, which can give local partnerships access to data that is very much focused on their own areas. In that way, they can identify particular areas where the patients use the most health and care funding because they have the highest and most acute need. Because we have some of that underpinning data already, we are able to support them by seeing whether those trends are moving and whether the highest-use patients are being given a better service nearer home that is reducing their usage.

Outcomes are not only objective; they are also subjective. In other words, whether the patient felt that the quality of care was good is just as important to me as whether we can, by some measurement, say that the quality of care was what it should have been.

Kate Forbes: There must be activities for which it is not meaningful to split budgets across a range of outcomes.

Alison Taylor: Do you mean particularly in relation to the requirement to report financially?

Kate Forbes: Yes.

Alison Taylor: I will add to what Paul Gray has said about support for local partnerships, and I will say a little bit about financial reporting. I will also invite Christine McLaughlin to contribute, if that is okay.

The local intelligence support teams are particularly well received by the partnerships. The fact that the analysts are embedded locally really helps. They have put quite a lot of effort into supporting clusters of general practitioners' practices as well as the social care teams, which is helping to knit together the idea of integrated planning and delivery. It is then a question of understanding what you are getting. They are using a data set that we have been developing over some years with the Information Services Division, which links health and social care data. That is potentially powerful, because it allows you to see patterns of service use, shifts and enormous variation.

The other layer, which is more recent, is the ministerial strategic group that Paul Gray mentioned. About 15 months ago, we wrote to every integration authority, asking them to share with us their historical and projected data against half a dozen key indicators such as unscheduled occupied bed use, which is a key issue in the delivery plan, and the balance of spend on palliative and end-of-life care. We have been gathering that data on a quarterly basis, and we have a working group for that. It is beginning to illustrate for the ministerial group some really interesting trends in terms of variation between areas both in how services are used and in the ambition of projections.

Paul Gray's point about what is quantifiable and what is more qualitative is on our minds a lot at the moment. When Janice Hewitt gave evidence to the committee a couple of weeks ago, she asked why we all tend to believe numbers but not narrative. That is a particularly powerful question when we think, for example, about our commitment to double the availability of palliative and end-of-life care in communities, as it is quite hard to quantify to any level of granularity what constitutes good palliative and end-of-life care. It is even hard to know what to count. A huge amount of work is going on around that, a key part of

which is the exchange that is under way between chief officers, integration managers and the local intelligence support team analysts, who are sharing experience to gain a better understanding of what is afoot.

When it comes to reporting financially against outcomes, I think that we have given ourselves a hard task. It is a good objective, but taking outcomes that, at their highest, are set out in statute and then filtering them down to the level of indicators risks producing a layer of granularity that is not very meaningful, as you suggested. Christine McLaughlin knows more about the practicalities of that bit of the system.

Christine McLaughlin: I can give you a bit more detail. We are starting by trying to get the building blocks in place, so we are looking at high-level expenditure—what we are spending on acute care, primary care, community mental health and so on. However, in the first report from the integration authorities, the attempt to show mental health spend demonstrates one of the issues, which is that spend in an area such as that crosses the whole sector, from primary care through to social care. As Alison Taylor said, it is important that we get that right.

From what we have seen so far, we think that not all our information systems allow us to do that, so we have started to invest—and we will have to continue to invest—in better costing information systems that will allow us to pull the information together. It is an example of the 80:20 rule. We can probably get about 80 per cent of the way without too much difficulty, but if we are to make the information meaningful on a real-time basis, which is what partnerships want—they do not want information that is 18 months out of date—we will have to invest.

We will start with the agreed national outcomes, looking at how the reduction in occupied bed days, for example, translates into financial terms. That is the best way to step into the process. However, we do not yet have a comprehensive programme budgeting approach across either health or social care.

Kate Forbes: There is always a danger that the existence of targets will distort behaviour. How can you ensure that that does not happen? Also, how do you enable good innovation when a proportion of integration authority budgets is fixed, at least in the short term? Feel free to take issue with any of my premises.

Paul Gray: We are very alert to the fact that, in certain contexts, targets can create perverse incentives, but I always take the view that the public are entitled to know what to expect from a health and care system. No one would do business with a shop that had no prices on any of its goods—if there is such a place, I have never been in it. The idea that we would somehow not be able to say what someone could expect from our health and care system is wrong.

The health and social care objectives have been set out in the legislation at a sufficiently high level to avoid the risk of perverse incentives. Also, each year, we review the plans from the integration partnerships and assure ourselves that they are deliverable and acceptable. We have a number of mechanisms for doing that.

I do not know whether you had anything in mind when you mentioned the risk of perverse incentives. Was it just a general comment?

Kate Forbes: I did not have anything particular in mind. Panellists made the comment to us in a previous meeting, last week or the week before, and I was giving you the opportunity to rebut or agree with the premise.

Paul Gray: I do not know how far you want me to go on the issue, convener, given the time.

The Convener: A brief response would be helpful, and then we will want to move on.

Paul Gray: You might ask what the 95 per cent accident and emergency waiting time performance target has got to do with integration, but what is outside the hospital makes a huge impact on what comes in through the front door and on whether people can get back out again quickly. Does that target create perverse incentives to behave in a particular way? No, because it is a clinically appropriate target; therefore, there are good clinical reasons behind it.

I would look at whether any target, objective or outcome was clinically appropriate and benefited the patient. It would be important to be able to answer yes to both those questions. I do not know whether Alison Taylor wants to add anything.

Alison Taylor: I will be very brief. A lot of the integration authorities have added their own objectives. I am not sure that they would call them targets, but they are certainly not working to the half dozen on which we are asking for data for the MSG. In some instances what they are doing is very interesting. Some are even talking with their communities about what constitute appropriate objectives and ambitions in their local system. Some of that work is very new—I would not describe it as bedded in—but such things matter as well. A centrally determined target can be offset by working on local objectives.

Alison Johnstone: Paul Gray's comment that a ward may still be needed, in response to the question of whether money would go back into the community, was quite helpful. It sounds as though you agree with Eddie Fraser of East Ayrshire health and social care partnership, who said:

"The demand on acute services would be much greater if we were not doing what we are doing."—[*Official Report, Health and Sport Committee*, 22 May 2018; c 25.]

Professor John Connell said that, when we look at the issue in the round, society

"probably needs to move away from the notion of saving money."

I would like to focus on the idea of shifting the balance of care. Is the aim of at least 50 per cent of spending taking place in the community health service ambitious enough, given that the data suggests that the level was 47.7 per cent in 2015-16? Are we setting a high enough target?

Paul Gray: We are making progress towards that target. The latest data suggests that the figure is now over 49 per cent. You ask whether the target is ambitious enough, and I would have no difficulty in discussing whether the target ought to be extended. I ask Catherine Calderwood, the chief medical officer, to say a bit about shifting the balance of care in the context of realistic medicine.

Dr Catherine Calderwood (Scottish Government): We need to remember that we are doing very well compared to other countries. In the United States of America, the balance of spending is 90 per cent on acute care and 10 per cent on community care. In a way, we are already far ahead.

It is absolutely right, when we have got so far, to look again at the spending percentages. As you are aware, we now have services such as hospital at home in all of our health boards, and I hear from general practitioners that the demand for those services is far greater than the capacity. We can definitely increase the capacity of some of those services. As you will know, hospital at home is much preferred by patients and their care givers. It reduces not only prescription but readmission to acute hospitals. It is also a service that people prefer, so it is a win-win all round, including in cost savings.

Alison Johnstone: It sounds as though there is not enough capacity at the moment for hospital at home. Is that a resource issue? Is there enough funding for the transition?

Dr Calderwood: I think that people are becoming more ambitious. Over the winter, I visited the hospital at home service in NHS Lanarkshire, which has space for 60 people at any one time. Because of the pressures on the hospital, the health board upped the capacity so that the service could care for 90 people. It did not know that it could achieve that, but it did, so it is now routinely caring for many more than 60 people.

10:45

People have really gained confidence in such services, so the teams are getting bigger and more staff are being recruited. The previous attitude to hospital at home focused on its being new and on whether the patients would like it. People thought that they needed to be in hospital, and they could not see how they could possibly get antibiotics that would be as effective at home. There was concern and conservatism about whether such care could be as good as care in a hospital bed. Of course, we now have the data to prove that it is.

Alison Johnstone: Is preventing a future shift towards more spending on acute services an achievement in itself, or are you looking for something more concrete than that?

Catherine Calderwood: We need to look at patient preferences and, as we have already heard from Alison Taylor, the difficulty with those is measuring them. We do not have robust ways of measuring how important patient preferences are, although we know that the outcomes can be changed by people having the option of different types of care. Worldwide, we are struggling to find even proxy means of seeing how patient experience can be measured in a meaningful way so that we can adjust our services. However, we are working on that, which is where the measurement of realistic medicine with patient priorities comes in. Audiences always ask me how I am going to measure that, and I do not think that we have a concrete answer. At the moment, we are using proxy measures. As we gain confidence in the patient experience being such an influence, we need to work out ways of collecting data and using it.

Alison Johnstone: On shifting the balance of care, our briefing paper suggests that there have been modest shifts in budget allocations over the three years of operation of the integrated authorities and that family health, prescribing and social care budgets have reduced as a percentage of the total budget. Would our witnesses like to comment on that? Does the decline in spending on family health reflect the principle of shifting the balance of care to the community sector?

Paul Gray: As I said, the overall shift, as counted, shows an increase. The proposed extra investment in primary care, in particular—which would bring that up to 11 per cent of the budget over time—will be another important component of that. Christine McLaughlin might want to say a bit more about the individual components.

Christine McLaughlin: This is one of the areas that we hope to set out very clearly in the financial framework. The issue is really about differential growth rather than seeing overall reductions.

However, prescribing is a good example of an area in which, over the past few years, we have seen effective efficiencies such as polypharmacy reviews, which have allowed us to avoid the increases that we have previously seen in primary care prescribing. In the past few years, in some areas, hospital prescribing has seen around 10 per cent inflationary growth. That partly reflects some fairly big increases in the hospital sector, so maintaining that proportion of spend is a challenge in itself. However, getting to 50 per cent of spend being in the community would take more than a just a marginal increase; it would require us to keep the focus on both shifting and making efficiencies in areas where we can. The committee might expect me to say that I would not want to stop anybody from generating efficiencies in overall spend where they can. If we had taken that out of the equation, we would probably have seen a greater overall growth in volumes.

David Stewart (Highlands and Islands) (Lab): I want to ask about spending on mental health. As the panel will know, there has been a lot of interest in that from members across the Parliament. Without being too simplistic, mental health care has historically been seen as a Cinderella service compared with physical care. In considering the evidence from integration authorities, I was struck by the variation in spend across them. For example, there was a reduction of 3.5 per cent in mental health spending in the Borders, but an increase of nearly 30 per cent in Shetland. I am interested in hearing the panel's views on why there is such a huge variation.

Paul Gray: Out-of-hospital spend on mental health is an essential component of ensuring that people can have good quality of life in their communities. On David Stewart's point about mental health being a Cinderella service, that is recognised and it is not right. The fact that the Government has appointed a Minister for Mental Health, the 10-year mental health strategy and the increasing mental health funding are clear signals of intent.

An individual is a complete person. They have physical health and mental health, and the two interact with each other: they are not separate, and one inevitably affects the other.

We work with a wide range of partners to ensure that, when people present with issues that are related to their mental health, we are able to help them at the point of need. For example, I and many others work closely with Police Scotland and the Scottish Prison Service on people who present in police station custody suites and Prison Service settings. Police officers often deal with what they call "distress calls" that are related to individuals' mental health rather than to crimes that have been committed. We want to enhance our resources in those areas. I understand that there is significant additional investment of £35 million over the next five years, and we are working towards involving 800 extra workers in mental health. The service has been undervalued, and we are trying very hard—not only symbolically but practically, with the input of money and people—to turn it into a valued service, because it is essential to people's welfare.

Dr Calderwood: I entirely agree with that summary. There is a long list of reasons why mental health issues have not been taken as seriously as other issues and have not received the spend for care. My summary is that we now recognise that everybody has mental health and wellbeing. Before, we just talked about people who had mental health problems or mental health illness. There is a far greater recognition across society that mental health is an aspect of everybody's lives.

Paul Gray spoke about distress calls to the police. Twenty-five per cent of the distress calls to the police are caused not by crimes but by people with mental health issues. People need to understand how to deal with those calls. The police are not, of course, the right people to deal with somebody who is in a mental health crisis.

With our increased knowledge of the burden—I do not like that term—of disease, our public health colleagues have recently published a nice graph that I will share with the committee. It is in my recent report, which talks about the burden of disease across Scotland. The committee will recognise that cardiovascular disease and cancer are right up there at the top, and that the burden of those diseases is premature mortality—early death—living with them, and the disability to people's lives that they cause. Members may be surprised to hear that, after them, mental health issues and substance abuse are the third-largest quantity of the burden of disease as we measure it in Scotland. I do not think that that has been recognised. If we were to place a map of the finance across that burden of disease graph, the spend would not match that at all.

David Stewart: That is very interesting. The issue that you raised about the effect of stigma in mental health is very worrying. I remember that, in the 1980s, the Health Education Council had a poster that said:

> "Six months after Mary had a nervous breakdown, her friends are still recovering."

I thought that that was a very interesting way to put the issue of stigma and its effect on health.

Paul Gray mentioned the appointment of 800 mental health workers in Scotland over a five-year period. Will you give an outline of where we are with that?

Paul Gray: Again, I would be happy to write to the committee with more details of that. Obviously, we are beginning that process just now. We are keen to stress that we are not saying that we will appoint 800 doctors or nurses for mental health. We will need more doctors and nurses and other clinical professionals, but there is also important investment at the front line in counselling services and in the work that we are doing in schools. If the committee would find it helpful, I would be happy to give a more detailed exposition in writing rather than try to do that at length here.

The Convener: That would be helpful.

David Stewart: I am conscious of time, so I will ask a final question, which is on a related issue. You mentioned the important issue of transformational spending. How important is that in relation to mental health, and how do you work out how effective each £1 of spending is across integration authorities?

Paul Gray: It begins with knowing what works—that is the base. There are some things that we know work in relation to mental health issues—for example, in some cases, it is early access to talking therapies. There is strong evidence that that works, so it is important to make those therapies available.

Shirley Rogers might want to say something about transformational spend as it relates to mental health.

Shirley Rogers: That is the critical point. With the multidisciplinary teams, we are trying to ensure that early intervention prevents escalation. That means that the point about the effectiveness of the spend becomes even more complicated, because we look for an achievement from that early intervention and try to calculate what any failure to intervene appropriately at an early stage means for the clinical condition thereafter.

Sandra White: It has been raised with us that there is a gap when it comes to the transition between child and adolescent mental health services and adult services. Will you look at that issue, particularly in relation to finance? If you can send a written answer, that would be fine, but that has been raised with us.

Paul Gray: That is a very important clinical issue. We can provide more information in writing, but if you want a very brief answer, I ask the CMO to give it.

Dr Calderwood: That is another issue that has not been recognised previously. We have traditional child and adolescent services and then adult services and, as with some physical health services, the need for an active transition and a plan has not been recognised. However, we have recognised that now.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel. I was struck by Dr Calderwood's assessment that the third biggest strain on the health service comes from substance misuse and mental health issues. I am concerned that, given that reality, the £27 million uplift that the Scottish Government has announced for mental health services will not even wash the face of the 800 link workers whom we have to appoint, let alone deliver a transformational uplift.

I want to focus on substance misuse. One of the most alarming outcomes that we have talked about and drilled down into is the increase in drug-related deaths and the fact that we are now the worst in western Europe in that regard, with not many signs of improvement. There is no direct causal relationship with the loss in alcohol and drug partnership funding. I have tried to make that stand up, but we cannot say that the issues are definitely related. However, that surely did not help. I am gratified to see the Government acting on that with £20 million of funding, but there will be lost institutional memory and experienced staff will have gone out of the door as a result of the closure of services because of the cuts. Have any decisions been made about allocation of the £20 million? How will the efficacy of its impact on drug-related deaths be measured?

Christine McLaughlin: We can provide more details. We are working on the basis that the majority of the £20 million will go from health boards to integration authorities, with a component being held back as a kind of investment fund. That will support the new strategy on substance misuse, which is due out in the summer. There is a refreshed approach. We are looking for the money to be invested in a way that gets the biggest impact rather than just for it to go back to fund the programmes that were there in the past.

I am sure that you will have heard from the team that a lot of its work so far has been about looking at how we can get the best services across the country and a level of consistency that maybe was not there in the past. That is the broad approach.

I understand that a funding letter has gone out to partnerships and boards in the past week. We can ensure that members have a copy of that and provide any further information on what will happen between now and the strategy being published.

11:00

Alex Cole-Hamilton: If that £20 million is being washed through integration authorities, how will it be protected for drug and alcohol services? Obviously, there are competing demands in IJBs.

Christine McLaughlin: It is probably important to note that there are areas in which we have been

directive about protecting both mental health spend and ADP spend. We expect the spend to be over and above the core spend, particularly in mental health. We have said that we expect the additional funds for mental health to be over and above real-terms increases in base budgets.

With regard to your picture of 2016-17 into 2017-18, we are not expecting to see that when we look at the 2018-19 figures. I will have to come back to members on that once we have the data, but that is the evidence that we will be looking for through the year.

Alex Cole-Hamilton: What will happen if IJBs do not protect the money? We saw previously that they were told to protect the money when the original 23 per cent cut happened, but in Edinburgh there was a £1.3 million cut to ADP services.

Christine McLaughlin: We will be looking at the team to understand the extent to which the strategy is being implemented. To be fair, we also need to understand whether an area has been able to deliver what it needs to deliver with fewer funds. If it is a case of a reduction in spend and not delivering outcomes, you would expect us to take the same action that we would take for any area of performance. However, you can be assured that the area is one of real priority and that we will focus on understanding how that money is invested.

Brian Whittle (South Scotland) (Con): On the alcohol and drug funding, a lot of the services are delivered through the third sector. I suppose that we could say the same about mental health, as well. As that money washes through, will NHS services and the third sector work together?

Paul Gray: I am in no doubt that third sector services are absolutely essential for the delivery of appropriate mental health interventions. That is partly to do with those services being trusted in communities; they also probably have access to areas in which, frankly, statutory services would be less trusted and people would be much less likely to access them. I have a strong expectation that the integration partnerships will work with local services, some of which might be quite small. We therefore want to ensure that they have certainty about the resources that are available to them so that they can continue to provide local services.

The Convener: I thank the witnesses for that evidence session. You have already volunteered to provide further information on a number of items. That is always welcome. However, we might drop you a line if the committee requires further assistance with other items.

I suspend the meeting for five minutes.

11:03

Meeting suspended.

11:08

On resuming—

Subordinate Legislation

Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No 2) Regulations 2018

The Convener: We move on to consideration of instruments that are subject to affirmative procedure. The first instrument is the Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No 2) Regulations 2018.

We will hear from our colleagues from the Convention of Scottish Local Authorities in just a moment, and then from the Cabinet Secretary for Health and Sport and her advisers. Following a question session with the witnesses we will move directly to a debate on the instrument.

With us today from COSLA we have Councillor Peter Johnston, who is its health and social care spokesperson; John Wood, who is a chief officer for health and social care; and Morag Johnston, who is the director of financial and business services at Glasgow City Council.

I ask Peter Johnston to lay out COSLA's views on the instrument, its approach to the principle and any particular issues to which COSLA wishes to draw the committee's attention.

Peter Johnston (Convention of Scottish Local Authorities): Thank you for inviting COSLA to give evidence today. As I hope is clear from our written submission, COSLA is happy to provide support for the extension of free personal care to under-65s, although we believe that it cannot be done successfully without the co-operation of local authorities.

In previous written submissions, COSLA has suggested that staged implementation might be worth consideration. This morning, I want to make it clear that COSLA absolutely accepts the desire of ministers to have full implementation by April 2019 and I stress that we commit to making that timetable a reality.

Before we take detailed questions, it is perhaps worth our while to reflect on the views of the COSLA health and social care board, which has agreed to uphold the principle of charging for some social care services on the basis that it is fair and that people who can afford to pay a charge or contribution towards the cost of care services that they receive should do so.

We believe that co-payment encourages ownership and empowers people to make choices with regard to the care that they receive. Furthermore, the ability to use income that is raised through charges to invest in social care services is key to providing local authorities with the flexibility to focus resources on local priorities and needs.

I understand that COSLA officials are working with civil servants and partner organisations to develop the detail of implementation. We have some areas of concern, which we hope can be addressed prior to implementation. First, the policy must be fully funded, with new money to service current service levels and the increased number of assessments that will be required, together with unmet need that will be identified as the policy begins to be implemented.

Secondly, the policy must not come at any detriment to councils' decision to charge for non-personal care, in line with the COSLA charging policy. We strongly argue that councils' current autonomy must be maintained. Finally, the implementation should be closely monitored with an agreement to reflect any increase in demand in future financial settlements.

COSLA gives its full support to the Scottish Government's policy intent of removing the current discrimination and extending free personal care entitlement to adults under 65 who are assessed as needing personal care.

That was a whirlwind tour of the COSLA policy statements.

Miles Briggs: Good morning. Thank you for your submission, which provides helpful background information. It is about a year since I tried to introduce a member's bill on the issue in Parliament. I am pleased to see that progress has been made and I hope that we will agree to the necessary statutory instrument today.

On costing, I am still not clear where the Government has found the figure of £10 million. From your work with local authorities on meeting the unmet need that will arise from the policy, how much do you think it will cost?

John Wood (Convention of Scottish Local Authorities): The figure of £10 million to £11 million has been mooted. That is based on removing the current charges that apply for under-65s and on nothing else. The figure does not take into consideration the potential increased demand that would flow from charges being removed. We are working with civil servants to bottom out what the costs would be. We anticipate that they would go beyond the £11 million figure.

We hope to get clarity on that over the next couple of months through the implementation advisory group. Initial estimates suggest that it will be at least three times the figure of £11 million. We need to do more detailed work to have confidence in any figure.

Miles Briggs: That is very helpful. Some of the work that I did on the bill suggested a costing of about £40 million to £60 million at that point. What work has already been undertaken by local authorities in scoping unmet need?

John Wood: We have done work in conjunction with civil servants. It has been a collaborative exercise and I would not say that it was just us that did that scoping work. We have modelled it on the trends that emerged after free personal care for those aged 65 and over was introduced in 2002 and we have applied those trends to the current figures for under-65s. That does not necessarily flow as a direct comparison so there has been some modelling to temper the increase that would be predicted if we applied exactly the same trajectory. Over the next few months, we want to do some more detailed work on those figures to get better clarity.

Miles Briggs: In your submission, you raised some concerns about extra assessments and administrative costs. Are you still confident that we can put the policy in place for everyone in Scotland by April 2019? That is what the Government is looking for.

John Wood: That is certainly what we are working towards.

11:15

Peter Johnston: COSLA has worked with the Government on several similar policies. The principle of the policy being fully funded is core. However, at least in health and social care, we have always managed to work such things through and reach the desired outcome. We are confident that we can do likewise in this case.

The Convener: Do I take it that the funding includes the funding that will be required for staff to make assessments of people who are not currently identified as being in need of personal care?

John Wood: That is certainly what we will be pressing for. Councillor Johnston's point about the additional burden flowing from the assessments needs to be taken into consideration.

The Convener: Thank you for attending the committee and giving us your input. It has been very useful for the committee to get an understanding of your position as it has evolved—as such things often do. As committee members have no further questions, we will suspend briefly to allow for a change of witnesses.

11:15

Meeting suspended.

11:18

On resuming—

The Convener: I am pleased to welcome the Cabinet Secretary for Health and Sport, who is accompanied by Mike Liddle from the Government's adult social care policy team, and Ann Davies, who is a Government solicitor. The cabinet secretary will make a brief statement about the regulations.

The Cabinet Secretary for Health and Sport (Shona Robison): Good morning, convener. Thank you for giving me the opportunity to speak briefly to the committee about the Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No 2) Regulations 2018, which will introduce provision of free personal care to adults under the age of 65 from 1 April 2019 by removing the age requirement that is set out in the current regulations.

The affirmative instrument that is before the committee reflects our continued commitment to removing the differentiation in treatment of people under the age of 65 with regard to the provision of free personal care. I am sure that the committee will want to join me in recognising Amanda Kopel's tireless campaigning to bring about Frank's law.

In Scotland, free personal care already benefits about 78,000 older people in their own homes and in care homes. It enables them to receive, free of charge, hands-on care including help with washing, dressing and shaving, and assistance with preparation of food, but it does not include wider social care elements, such as day care.

From 1 April 2019, personal care will be made available across Scotland, free of charge, to everyone who requires it. For people on the lowest incomes and with the smallest levels of assets, personal care is already provided free, and that will continue to be the case. We recognise that people with substantial packages of non-personal care will still pay towards those elements of their care packages, but they will continue to have access to the social care resources that they receive at the moment.

We are aware that a range of opinions exist on the charging policies of local authorities, but we must balance the best outcome with the appropriate timing for implementing the legislation. Therefore, we have asked for the regulations to be considered significantly ahead of the date on which they will come into force—1 April 2019—to enable local authorities to plan for necessary changes to their processes and systems for care and financial assessments.

In preparation for the extension, an implementation advisory group has been set up, which is making use of expertise from local authorities, health and social care partnerships, COSLA, care providers and service users, in order to ensure that implementation takes into account the impact of the change on local authority systems. Those areas will require to be reviewed by local authorities to ensure that changes to the systems are made in a manner that is sensitive to the needs of service users and their choices about their care and support, and in a manner that aids local authorities.

The implementation advisory group is also looking at models for monitoring and review of the policy that will help the Scottish Government and local authorities to budget for future costs of the extension of free personal care.

I am happy to take questions on the regulations.

The Convener: Thank you very much, cabinet secretary. The reference that you made to the costs of implementation is important. Earlier, we heard from Councillor Peter Johnston of COSLA, who indicated how keen local authorities are to work with the Government on implementation according to the timetable that has been set out. Would you like to comment on the estimated costs of implementation which, in COSLA's view, reflect existing need but not any unmet need that has yet to be identified?

Shona Robison: As COSLA said, such matters are being discussed by the implementation advisory group, whose deliberations will be brought to a conclusion over the next few months. It is recognised that it will cost between £10 million and £11 million to provide free personal care to existing service users. Estimating the unmet need is more challenging, which is why we are working through the implementation advisory group to obtain the best estimate and thereby to ensure that, in the future, local authorities can be properly supported in implementing the policy. Those discussions will reach a conclusion well in advance of the implementation date.

The Convener: Does the Government, in principle, fully support the principle of fully funded implementation that COSLA laid out?

Shona Robison: Yes, but we need to have a discussion about what that means and what the costs are. We need to land that accurately, and the figure needs to be reviewed to make sure that it is accurate. Once we establish what the actual levels of unmet need are, we will make sure that the resources that have been provided are in line with that. We need to have proper monitoring of the policy as it is implemented.

The Convener: Thank you very much.

Alex Cole-Hamilton: I have a quick question on a subject that I asked about when we discussed the Government's uplift to the cost of free personal care for the elderly during our scrutiny of the budget. I think that the figure is about 1.8 per cent in a year in which all public sector workers are to get a 3 per cent uplift. My concern is that we are not attaching to care work the value that we should be attaching to it and that, as a result, we are not incentivising people to enter the profession. What is your view on that?

Shona Robison: I do not agree with that. The latest figure for the resources that we have put into social care more generally is about £550 million. On top of the uplift for the free personal and nursing care policy, additional resources have been put into delivering the living wage to about 40,000 social care workers. That spend has to be considered in the round. It is a significant investment in social care, but demand continues to increase.

Scotland is the only part of the UK to have implemented free personal care for older people, and will be the only part to implement it for people under 65. All in all, we have a system that, although it is not perfect, is much fairer. The next instalment of extending free personal care will make the system even fairer. As I said earlier, we need to make sure that we resource personal care properly as we take it forward. That is a discussion that we will continue to have.

Alison Johnstone: I certainly welcome this step forward. The cabinet secretary will be aware that the Scotland against the care tax campaign group still has concerns. It is concerned that not all parts of a person's support package will be covered by free personal care, and it would like there to be a personal care rebate, which would help to reduce the overall costs of their whole support package for people under 65. Is that something that the Government will consider in a review?

Shona Robison: It is important to separate the elements. This is about extension of free personal and nursing care to people under 65 to bring it into line with the arrangements for people aged 65 and over.

I recognise that Scotland against the care tax wants a discussion about care charging more generally and has made a proposal about removing charges across the board. Obviously, that would carry a significant cost.

The discussion around charging policy and the cost of that is separate from the discussion that we are having today. We recognise the need to ensure that when free personal care is implemented for people under 65, there is not a rise in charges for non-personal care, for example.

That is part of the discussions that are being had in the implementation advisory group. It is important that there is fairness, and that the system does not give with one hand and take away with the other.

As part of making charging fairer, we took the decision previously—at a cost of £11 million—to raise the threshold for charging. That applies to non-personal care as well. That has benefited people on lower incomes. There are also changes for veterans, through disregarding war pensions.

Mike Liddle (Scottish Government): There are also changes to the armed forces compensation scheme.

Shona Robison: The armed forces compensation scheme assists veterans with personal and non-personal care. We have taken additional steps. We recognise the issues that have been raised, but they are for a separate discussion.

Miles Briggs: The cabinet secretary will know of my personal interest in this issue, in that I wanted to introduce a bill on it. I am pleased that we have reached this position today, in less than a year since that bill was proposed. I hope that today is a good day not only for Parliament but for the people in Scotland who need this. Cross-party support for the proposal has been important.

On implementing the proposal, it is important that we have heard from COSLA, because it has suggested that we will need three times the amount of money that is currently proposed. It also highlighted concerns about the full costs of administration.

I say to the Government and the cabinet secretary that I hope that we are able to make sure that there is flexibility on the additional funding that will be needed. I hope that we will not see this being done on the cheap. It is important that the unmet need, which we are all now aware of, is met and is scoped as soon as possible.

I would like some clarity on the two points that COSLA made about the full assessments that will be needed and the additional administrative costs that councils will face.

Shona Robison: As part of its work, the implementation advisory group, as well as looking at the estimates of unmet need, will of course look at the cost of implementation, including whether there is a requirement for additional staffing for assessment and administration.

At the end of that process, we will agree with COSLA the global resources that will be required to implement the policy fully and successfully from 1 April 2019. We will then propose a budget to Parliament. I hope that we get the same cross-party support for the budget that will actually deliver this policy. That will be important when we get to that stage.

11:30

Miles Briggs: Do you have a timetable for when that figure will be announced?

Shona Robison: Work is being done on it. We hope to conclude the discussions during the summer. It is important to get this right: if additional work is required, it is important that we have the best estimate. As COSLA said, progress is being made and we hope that we will have figures nailed down during the next few weeks, and certainly well before implementation of the policy on 1 April 2019. I am happy to furnish the committee with that information once it becomes available from the implementation advisory group.

The Convener: That would be helpful, thank you.

Sandra White: My question is almost the same as Miles Briggs's question. It is about on-going funding and how it affects local authorities. However, I want to go a wee bit further than that and seek some clarification. We have taken evidence on health and social care integration and the regulations will obviously have a knock-on effect on that. How will that be implemented in the funding that local authorities are asking for? Will health and social care integration have a part to play in the policy?

Shona Robison: The success of implementation of the policy will be in health and social care integration. Many service users will receive a range of services that span health and social care, so it is important that the packages of support that people receive are knitted together well across health and social care. Integration has helped to get us away from the old debates about whether a bath is a medical bath or a social bath; what is important is the package of care that is required. Resources flow into the integration joint boards to deliver those services, and the same will be true of the resources that are associated with this policy.

It is as important for free personal and nursing care for people aged 65 and over as it will be for the under-65s that the delivery of services to people in their own homes is seen through the lens of integration.

Sandra White: My question was more about the budget, but you answered that.

The Convener: As there are no further questions, we will move to the formal debate on the instrument. There will be no questions to the cabinet secretary and there will be no contributions from officials. I invite the cabinet

secretary to begin the debate by moving the motion.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 be approved.—[*Shona Robison*]

The Convener: I invite any members who wish to, to contribute to the debate.

Alison Johnstone: Having led a Green Party members' business debate on social care in April 2017, when I called for social care to be free at the point of need, regardless of age or condition, and funded through progressive taxation, I welcome the amendment to the community care regulations. However, is important to put on the record that we could and should go further.

I welcome the cabinet secretary's recognition of the issue that there will be some people whose social care charges will not end. Scotland against the care tax continues to call for an end to all social care charges. In its submission, it informs us that

"only this will remove the current discrimination against disabled people whereby they are charged for the essential support they need to enjoy the same human rights as anyone else."

Providing free personal care to under-65s as it is done currently will still leave the majority of younger adults facing significant charges to receive the social care that they need for independent living. I welcome this morning's progress, which is a step in the right direction, but we can and should go further.

The Convener: I see that no other colleagues wish to contribute to the debate, so I ask the cabinet secretary to sum up.

Shona Robison: I thank Alison Johnstone for her contribution. I recognise the wider issues, but it is important to note that Scotland has continued to provide support through the independent living fund, for example, which we will discuss in a moment, and that has not been the case elsewhere. The ILF programme was stopped in England, and it has just been stopped in Wales. The ILF is an important source of support, particularly for young disabled adults, because it enables them to live full and independent lives in their own homes. We should not see the issue in isolation: we provide other forms of support that are not provided elsewhere to help people to maintain their independence.

Motion agreed to,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 [draft] be approved.

The Convener: I suspend the meeting for a change of witnesses.

11:36

Meeting suspended.

11:37

On resuming—

Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2018 [Draft]

ILF Scotland (Miscellaneous Listings) Order 2018 [Draft]

The Convener: I welcome again the cabinet secretary. She is joined by Ann Davies, who is a Government solicitor. Before we move to questions on the two instruments, which are subject to affirmative procedure, I invite the cabinet secretary to make a brief opening statement.

Shona Robison: The instruments are largely technical, but I will provide a bit of background and context on their purpose. As the committee will be aware, the independent living fund was a UK scheme that made care payments to severely disabled people. The scheme was closed to new applicants in April 2010 and ceased to operate on 30 June 2015.

The Scottish Government made a commitment to maintain ILF payments in Scotland and it established ILF Scotland from 1 July 2015. That fund makes payments to all persons in Scotland who remain eligible and who received funding from the ILF before its closure. Recipients use the funding for services that offer the flexibility that they might not otherwise have to live in their own home and to take up employment or education, and the funding helps to reduce social isolation.

An agreement has been reached for ILF Scotland to distribute packages of ILF support, on the Northern Ireland Executive's behalf, to existing ILF recipients who live in Northern Ireland.

In addition to supporting existing ILF users, the Scottish ministers have committed a total of £5 million annually to extending the ILF's reach in Scotland. In December 2017, the ILF Scotland transition fund opened to new users. The new fund supports young people aged 16 to 21 who are living with disabilities to be more independent during their transition from education and children's services. Since opening access to the payments, 200 applications have been received, with a total liability of around £600,000.

When ILF Scotland was established in 2015, it was decided that it should be a company limited by guarantee in order to meet the very tight timeframe for delivery and to ensure that payments were protected. At that time, there was insufficient time to list ILF Scotland in various pieces of legislation as a public body.

In discussion with the Scottish Government legal directorate and officials of public bodies, we have identified a number of pieces of legislation in which we consider that ILF Scotland should be listed in order to ensure that it operates in line with other public bodies in Scotland.

The two instruments that are being considered today—the ILF Scotland (Miscellaneous Listings) Order 2018 and the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2018—will achieve that, along with a third instrument that is not being considered today, the Ethical Standards in Public Life etc (Scotland) Act 2000 (ILF Scotland) Order 2018, which is subject to negative procedure. I will provide brief details of the two instruments that are being considered today.

The ILF Scotland (Miscellaneous Listings) Order 2018 lists ILF Scotland in a number of pieces of legislation. First, it will be listed in schedule 1 of the Freedom of Information (Scotland) Act 2002. Although ILF Scotland is already bound by the act, listing it makes it subject to the duties relating to climate change that are contained in part 4 of the Climate Change (Scotland) Act 2009.

ILF Scotland will be included in schedule 2 of the Public Appointments and Public Bodies etc (Scotland) Act 2003. The purpose of listing it is to regulate appointments that are made by the Scottish ministers to the ILF Scotland board by requiring that the Scottish ministers comply with the code of practice for ministerial appointments to public bodies in Scotland.

ILF Scotland will be listed in part 3 of schedule 19 of the Equality Act 2010 so that it is required to comply with the public sector equality duty.

ILF Scotland will also be listed in the schedule of the Public Records (Scotland) Act 2011, which will require it to manage its public records in accordance with a records management plan that has been agreed by the keeper of the records of Scotland.

Lastly, ILF Scotland will be in schedules 1, 3 and 4 of the Children and Young People (Scotland) Act 2014. Being listed in those schedules means that it will be subject to the duties of public authorities in relation to the United Nations Convention on the Rights of the Child, and it will become a listed authority in relation to children's plans, and a corporate parent.

The purpose of the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2018 is to add ILF Scotland to the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012. That will make ILF Scotland subject to various duties, including assessing the impact of new or revised policies and practice on the needs that are set out in the public sector equality duty, reporting on mainstreaming equality, publishing information on the gender pay gap and equal pay, and taking account of the equality duty in the context of procurement.

I am happy to answer questions.

The Convener: Thank you for that comprehensive run-through of the purposes of the two orders. The cabinet secretary will be pleased to know that we considered the negative instrument earlier this morning and it was agreed to.

As members have no questions on either of the affirmative instruments that the cabinet secretary described, we will move on to consider them formally. The same procedure applies as before.

Motions moved,

That the Health and Sport Committee recommends that the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2018 [draft] be approved.

That the Health and Sport Committee recommends that the ILF Scotland (Miscellaneous Listings) Order 2018 [draft] be approved.—[*Shona Robison*]

Motions agreed to.

The Convener: I thank the cabinet secretary for her attendance.

11:44

Meeting continued in private until 12:44.

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