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Health, Social Care and Sport Committee

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
22nd Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor David Bell (University of Stirling)
Caroline Cameron (North Ayrshire Integration Joint Board)
Michael Kellet (Public Health Scotland)
Kathrine Sibbald (Audit Scotland)
Pat Togher (Edinburgh Integration Joint Board)
Sharon Wearing (Chartered Institute of Public Finance and Accountancy Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 3 September 2024

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 22nd meeting in 2024 of the Health, Social Care and Sport Committee. I have received no apologies.

The first agenda item is a decision on whether to take items 3, 4, 5 and 6 in private. Do members agree to do so?

Members *indicated agreement.*

Pre-budget Scrutiny 2025-26

09:15

The Convener: The next item on our agenda is an evidence session as part of our pre-budget scrutiny for 2025-26, focusing on the financial position of integration joint boards. I welcome to the committee Professor David Bell, professor of economics from the University of Stirling; Michael Kellet, director of strategy, governance and performance from Public Health Scotland; and Kathrine Sibbald, senior manager at Audit Scotland.

We will move straight to questions. The Accounts Commission's report "Integration Joint Boards: Finance and performance 2024" notes that IJBs are often not informed of their allocations from national health service boards ahead of the start of the financial year. How could that situation be improved and what impact does that have on financial planning?

Professor David Bell (University of Stirling): Most of the bodies that are commenting on the performance of the IJBs have argued for the need for longer-term planning, but that is rendered very difficult when one-year budgeting is in force. That stems in part from the way that budgeting is run at both Scottish and United Kingdom Government levels. Obviously, it is not helpful to local authorities not to have a clear view of the allocations that they receive from the NHS. Incidentally, I was looking at the proportion of funding that IJBs get from the NHS and it varies quite a lot across the different IJBs. To be honest, I could not understand why there was such a big variation.

Kathrine Sibbald (Audit Scotland): All that I would add to Professor Bell's point is that delay can have an impact on IJBs making decisions about savings and planning their budgets. Therefore, it will clearly have an impact on the management of budget-setting arrangements for IJBs.

That variation is not something that we have particularly delved into in the piece of work that we have done for the 2024 IJB report. However, some of the variation might be to do with the range of services that different IJBs provide, given that some also cover acute services. Therefore, there will be quite significant variation in the services that are provided, but I do not think that that accounts for all the variation, so we might look at that as part of this work in the future.

Michael Kellet (Public Health Scotland): I do not have much to add to what my fellow panel members have said. However, I want to recognise that, as for any public body, late notice of the

funding that is to be delivered makes planning more difficult. Our focus in Public Health Scotland is on supporting public bodies—particularly health and social care delivery agencies such as IJBs—to take a long-term approach, and late notice of budgets clearly frustrates their ability to do that.

The Convener: What would be the ideal scenario for budget setting? Would it be direct funding for IJBs, for example, or another model?

Kathrine Sibbald: As I am representing Audit Scotland, I certainly would not be in a position to comment on that, as I think that that is a policy decision. However, as Michael Kellet said, having the funding and the details around the funding early enough will support better planning for individual IJBs and across the sector.

Professor Bell: The lack of foresight on budgets makes it particularly difficult to plan capital spending. It is also important to recognise that the private sector plays a pretty significant role in the provision of social care services, in particular, and requires some kind of assurance if it is to make longer-term investments. Having the budgeting decided year by year is not helpful for that.

Michael Kellet: Public Health Scotland does not have a position on the policy matter of how funding is conveyed to IJBs.

The Convener: Kathrine Sibbald, my last question is specifically about what Audit Scotland has looked at, which you referenced. Is there a plan to look in more depth at IJB funding in the future—at the disparity between the amounts that health boards fund, taking into account the differences in the services that are delivered across the country?

Kathrine Sibbald: We are in the very early stages of thinking through the scope for a piece of work for the coming year. In doing the work for the 2024 report, we have recognised that, given that the remit of the report was only that of the Accounts Commission, there was a limit to how far and into how much depth we could go in some areas. The plan as we go forward is for the report to be joint between the Accounts Commission and the Auditor General for Scotland. That gives us much more scope for the areas that we can comment on.

As I said, we have not yet scoped out that work, but we will take on board the comments of the committee and of a wide range of stakeholders to consider what we should focus on in the report next year.

Emma Harper (South Scotland) (SNP): Good morning to you all. My questioning is on the same theme—financial planning—but is about sustainability. Before I get to my first main question, I wonder what the legacy of Covid is. I think that we are still recovering. I have a simple question: are we still recovering from the global pandemic?

Michael Kellet: Public Health Scotland's perspective is that we, as an organisation, and the wider health and social care system are certainly doing that. We are learning from the pandemic, taking into account the work of the public inquiries and preparing for potential future threats. That is part of our day-to-day work in Public Health Scotland, I know that it is the case across the rest of the NHS, and I am sure that it is the case in IJBs as well.

Kathrine Sibbald: This is more anecdotal than what we reported in the 2024 report but, in the work that we did—certainly, in discussions with stakeholders—there was a sense that an element of recovery work is still being undergone in IJBs' partner bodies.

Emma Harper: Is there anything that we should be doing on multiyear funding commitments? That issue comes up a lot in evidence. Can IJBs do anything to support sustainable planning as we move forward?

Professor Bell: Certainly, on the social care side, one key element is the workforce, which turns over at a huge rate. Often, outside opportunities are better than those within the sector. This is not at all a new message, but the more that can be done to develop a sustainable workforce in the social care service, the better. That is becoming increasingly difficult, because a lot of social care workers are already quite old and there does not seem to be the same readiness in the new generation to join the social care workforce. That is creating huge difficulty and it impacts slightly on discussions about migration.

Michael Kellet: From our perspective in Public Health Scotland, sustainability is absolutely key. We are concerned about work that we have done on the burden of disease, which shows that, if we do nothing in terms of our arrangements to get upstream and focus on prevention, the predicted future demand on health and social care services will increase by 21 per cent by 2043. Our work with IJBs and other partners across health and social care and the public sector suggests that we need to focus more on prevention and on tackling inequalities both nationally and locally. Few would argue against the merits of prevention, but doing it is the really difficult thing, particularly at the moment, when finances are so pressed.

We therefore have a couple of suggestions that we think would be relevant to IJBs and the wider system. The first relates to the thinking that has been kicked off by Demos and other think tanks on the question whether it would be helpful, in terms

of guaranteeing a shift to prevention, to create a "preventative" category of public spending that would establish a baseline for prevention work and help to ensure greater accountability. Secondly, and married to that, we think that there is a need for improved scrutiny and performance measurement around prevention. That would mean clearer accountability for progress on prevention and tackling inequality—in short, measuring what matters.

Finally, we believe that the refreshed national performance framework and emerging legislation such as the proposed wellbeing and sustainable development bill potentially provide a focus on strengthening our collaboration as well as a focus on prevention, so that we can get upstream and make public services—particularly health and social care services—more sustainable in the long term.

Professor Bell: Perhaps I could come back in on that, because I have just realised that I omitted one very important category: unpaid carers. They play a huge and often unrecognised role in providing care, and they—along with the voluntary sector, who are also important players in this regard—need to be sustained in a way that allows them to continue to provide their valuable services.

Kathrine Sibbald: I concur with colleagues on the panel, but I just want to add a point about workforce and prevention. In our report, we have tried to get across the need for a collaborative approach to learning and developing national-level planning in some of these areas. I just wanted to agree with other panel members on those issues.

Emma Harper: I have one final question. In your submission, Professor Bell, you talk about the NHS and how funding for boards varies widely. You say that that

"is difficult to explain in relation to markers such as deprivation or rurality."

Dumfries and Galloway IJB is 79.4 per cent funded by the NHS, for example, whereas the figure for the north-east—Aberdeenshire—is 53.9 per cent. Can you explain why there is such variation in how the IJBs are funded?

Professor Bell: I do not have an immediate answer to that question, but Kathrine Sibbald referred to that when she said that there will be some variation in the services that IJBs provide, although perhaps that is not the full story with regard to this important division of allocations. Obviously, in almost all circumstances, NHS boards are the ones with the largest wallets for providing these services, whereas local authorities are, in financial terms, the bit players. However, from what Kathrine Sibbald has said, there might be a case for looking more closely at that in the future.

Emma Harper: Thanks.

Tess White (North East Scotland) (Con): Professor Bell, thank you for your written submission, which I found particularly helpful. You highlight the Scottish Fiscal Commission's concerns over the financial impact of the Scottish Government's public sector pay assumptions. Can you talk us through the anticipated impact of the in-year budget cuts for IJBs that you outline in your submission?

Professor Bell: This is quite a long story, and there is also a UK-level aspect to it. It appears to be the case that possibly both the UK Government and the Scottish Government underestimated the increase in wages that they were going to pay out during this financial year, so they did not build in to their budgets sufficient headroom for the kinds of pay settlements that have been announced.

09:30

A consequence of that is that, as we understand it, the UK Chancellor of the Exchequer has said that some more money will be available at the UK level but the NHS in England will have to absorb some of the increased costs that are associated with the increase in wages. A consequence of that is that NHS funding in England will not increase at the same rate as the wages in England. Because of that, the Barnett consequentials that will follow from this slightly lower increase than the wage increase south of the border are resulting in strong pressures on the Scottish Government, which had also made a perhaps too optimistic assumption about the increase in pay in the NHS that would be needed. The consequence of that is that we are now confronted with a pretty difficult situation in that we might have to make in-year adjustments to the budget.

Tess White: That relates to pay and your view on pay. In relation to staffing, your written submission highlights that the Scottish Government assumes 1 per cent growth in staffing over five years from 2022 while the English NHS workforce plan assumes growth of 20 to 21 per cent over the same period. In your view, what are the implications for Scotland of that divergence in staffing and the underpinning assumptions?

Professor Bell: That is a five-year horizon for workforce planning. If errors are made at the start, they can possibly be recovered from later. All the commentators seem to suggest that there will be an increase in the demand for health services of 3 to 4 per cent per annum. If there was no massive increase in productivity in the health service, the consequence would be that you would need to increase the workforce at a rate of 3 to 4 per cent.

Over a five-year period, that would obviously build up.

There is clearly an issue around productivity in the health service, which is a bit related to the earlier discussion around Covid. However, in essence, that is what has happened. It seems to me that an assumption of 1 per cent growth would need to be accompanied by an optimistic assumption around growth in productivity, and it would be interesting to know how exactly that might come about.

Tess White: I will make a comment rather than ask a question, as I know that we will cover data later. If you are talking about improving performance, it is almost about doing more with less rather than saying that there is a fundamental problem with the assumption on staffing.

Professor Bell: Productivity would be about doing more with the same or not much more. In effect, that is what we are saying. We have to define what we mean by "doing more". What are we actually trying to achieve in the NHS and social care? I guess that that is in the national health and wellbeing outcomes framework, which I mention in the paper. I am sure that we will come to data later, but there seems to be some broad agreement that that is where we should be going.

Tess White: Can I just go back to your point about pay?

The Convener: Briefly.

Tess White: Very briefly.

You are almost saying that it is due to the Barnett consequentials rather than the Scottish Government having the levers in relation to the decisions on pay increases. Could you just clarify that point before we move on?

Professor Bell: Clearly, the Scottish Government negotiates with the NHS in Scotland, so it is up to it to make that decision. The Scottish Government will make assumptions in its budget as to what those outcomes might be. It can do that and cut back on other services—it does not have to follow whatever increases are being made south of the border. Obviously, given that there is quite a lot of cross-border movement of NHS staff, having things massively out of kilter with what is happening south of the border would potentially cause workforce problems.

The Convener: Before I move to Ruth Maguire, I should put on record my entry in the register of members' interests. I hold a bank staff-nurse contract with NHS Greater Glasgow and Clyde.

Ruth Maguire (Cunninghame South) (SNP): Thank you, convener. I will just draw attention to my entry in the register. I was a serving North Ayrshire councillor at the time of integration in 2012, and was a member of the IJB.

I thank the witnesses for being with us. Michael Kellet touched on this point in his answer to my colleague Emma Harper. It is about Public Health Scotland's recommendations in relation to the focus on prevention. My declaration of an interest will let you know where I am coming from. It feels quite strange, 12 years down the line, to still be talking about how we can focus on prevention. Can you just flesh out a bit more your recommendations in that regard? It would be particularly interesting to hear about what is stopping that shared focus. What are the barriers? What needs to change?

Michael Kellet: I am not sure whether I need to make a formal declaration of interests, convener, but formerly, in a previous life, I was a chief officer of the IJB in Fife, so I bring that experience to bear. I just wanted to get that on the record.

The question is a really good one. Since the Christie commission, the language around prevention has been generally accepted in public services and public policy in Scotland, yet we have made little progress across the system. We have examined the reasons for that.

The focus on short-term funding is a real challenge to the ability of public services to work on prevention. When public services try to work in partnership on prevention, that shared agenda can sometimes be frustrated by the way that systems are established and how reporting mechanisms work. In some areas, such as the Ayrshires, community planning partnerships are working really well and are genuinely advancing prevention.

However, one of the views that has been expressed, including in the Demos report that I referred to earlier, is that although pilots and small-scale preventative interventions are very important and there are really good examples of them right across Scotland—including in the Ayrshires, in Fife, where I worked, and beyond—they do not add up to a big enough shift towards prevention. Hence the suggestion that we made in our submission, and which I have made again this morning, about exploring whether—in the same way as we moved, in the late 1990s, to a split between capital and resource expenditure in public services across the UK—there is value in thinking about adding a third category around prevention, and therefore holding public bodies and Governments to account for the spend in the categories of resource, capital and preventative interventions. That is one practical suggestion to change things.

Ruth Maguire: I am sorry to interrupt. On that note, one of the biggest challenges is that

everyone agrees in principle that prevention is better than mopping up stuff afterwards, but it is always very hard to shift resource. What is it about having a preventative spending category that Public Health Scotland feels might assist with that?

Michael Kellet: I think that the suggestion is primarily about accountability. The spend would become transparent to those who run the services, to those who hold them to account and to the public, and it could be tracked over time. That extra category of spending might put extra focus on accountability. I am not pretending that it is the only thing that could be done, but I think that it would be important. There is a point to accountability and to tracking, through a national performance framework, that would measure preventative intervention and support it, and there is a point to public bodies being held to account for their performance on prevention in a way that, largely, does not happen at the moment because the focus is, understandably, concentrated on service delivery.

Ruth Maguire: I will bring in other witnesses in a minute. Another frustration is about budgets not being seen as being truly integrated, if you like: they often come with a "health" label or a "social care" label. Although it was a wee while ago now, one of my huge frustrations when I was a board member was on hearing the phrases "from a health perspective," or "from a council perspective," when, really, the purpose of integration is that it should be seen from a service user's perspective. What is being done, or what more can be done, to try to ensure that the budgets lose their identity as council money or NHS money?

Michael Kellet: That is a very good question. That is certainly what I experienced in Fife. I am sure that you will hear later from a number of chief officers, who I imagine might say that that is still a challenge for them. A genuinely whole-system approach, both locally and nationally, is really important.

This is just one example, but one of the things that we in Public Health Scotland are doing is work with Michael Marmot's Institute of Health Equity. We are seeking to bring some of the learning from the Marmot principles to places north of the border. We hope to identify, later this year, three areas in Scotland where we will work. Part of that focus will be on bringing public services, the voluntary sector and even the private sector together in their local areas to think about how they can pool resources in order to genuinely tackle some of the Marmot principles, which are all about getting upstream and supporting the health and wellbeing of the population. That is one small initiative from which we think there might be good learning that will help with that sense of shared endeavour.

Ruth Maguire: Do any other panel members want to come in?

Professor Bell: For a long time in Scotland, we have talked about preventative spend. It certainly goes back to before the Christie commission. Measuring outcomes is one of the difficulties that always besets it. How do you measure the effect of a preventative outcome 10 years down the line, when other things will have happened?

I have just, along with David Blanchflower at Dartmouth College and Alex Bryson at University College London, published a paper on declining mental health. There has been a pretty rapid decline in mental health in the UK and Scotland over the past 15 years or thereabouts. There might have been preventative interventions that would offset that, but all kinds of other stuff has been going on, including the effects of mobile phones and Covid on mental health. Picking out what we would call the signal, or the effect, of preventative spend has always been a real bugbear, and it can be done properly only if you get very serious about the way in which you collect statistics on health, social care and wellbeing in general.

Kathrine Sibbald: I support those points. One of the key themes in the 2024 IJB report that we have recently produced is collaborative working and working towards a common national strategy that includes commentary on prevention and the way forward, and how that fits with a wider strategy. Part of that is collaborative working to look at data and what data is collected to support that. I agree with the points that have been made by Professor Bell and Michael Kellet.

09:45

Ruth Maguire: In other committee work, on scrutiny of self-directed support, we have heard evidence that sufficient time and resource are not given to enable policy and legislation to embed before more structural change is introduced. It does not take much imagination to understand how workers on the front line who are delivering services feel when more changes come along. Do panel members have a view on whether integration in its current format has been given enough time to bed in?

Michael Kellet: I have a personal view, but I am speaking behalf of PHS today and we do not have a view. Our job in PHS is to work with the NHS and IJBs, and the wider system, particularly with the Convention of Scottish Local Authorities and local authorities, to support the work and the focus on prevention. On the integration agenda, I do not

think that it would be appropriate for me to express my personal view.

Professor Bell: My view comes mainly from the metrics. They have their deficiencies, but Audit Scotland's reports have not suggested that there has been the massive seismic move that was maybe hoped for at the time when IJBs were set up, so it could still reasonably be described as work in progress.

Kathrine Sibbald: Professor Bell has stolen my thunder on that. I agree with that.

Paul Sweeney (Glasgow) (Lab): I have a quick question to put to Professor Bell. You note in your submission that the short-term decisions that IJBs make might reduce spend at the front end but can prove to be more expensive in the longer run, in the whole system. How can we ensure that IJBs make a fuller assessment of any long-term detrimental impact on health outcomes before taking such decisions on budgets?

Professor Bell: There is an organisational point that might be partly about leadership—having in place leaders who understand the consequence of making short-term decisions and the potential negative effect that they might have in the longer term.

I will steal a bit more of Audit Scotland's thunder and say that there has been too much turnover as far as the leadership of IJBs is concerned. As organisations, they have not been that stable.

That is one aspect, but I keep coming back to the fact that you must know where you are—you have to have data that show whether a decision that you are making in the short term will have detrimental long-term effects. You cannot do that without good data.

David Torrance (Kirkcaldy) (SNP): What is required to simplify, streamline and co-ordinate governance and accountability, as was called for by the Christie commission, for constructive integration and relationships between partners to develop? How might the creation of a national care service contribute to that goal?

Kathrine Sibbald: I am happy to come in on that one. Again, I go back to the need for collaborative working and working towards a common objective, and setting out a national health and social care strategy that everyone can be commonly working to.

I do not want to comment specifically on the national care service; neither the Auditor General for Scotland nor the Accounts Commission has set out a particular position on the national care service. However, this also requires a common strategy and common goals, and collaborative working to ensure that there is the right data to support that.

Michael Kellet: PHS does not have a position on the NCS, either. We are working closely with Government and other colleagues on supporting the improvement of data on social care, because we think that that will be hugely important moving forward, whatever the structure or governance arrangements are for social care in Scotland. That is a priority for us. In the current year, 2024-25, we are focusing with our partners on improving the data on care homes. Generally, we are focusing on working in partnership to improve the data on social care.

Professor Bell: I made a point in my submission about capacity. Some IJBs have much greater capacity than others to encourage collaborative working, simply because they have the expertise and the people on the ground. It seems to me that a local authority such as Glasgow City Council is in a completely different position from much smaller authorities.

On the national care service, we have to acknowledge that, ultimately, we will be limited by resources. It will be an interesting challenge for the national care service to share those resources equitably. I certainly do not have a strong feel for the overheads that will be necessary to put that organisation in place, or for what will be saved in local authority costs through it because their decision-making powers will, to some extent, be moved to Edinburgh, or wherever the NCS will be located.

I would like some more information on the NCS, partly because it is my view that a social care organisation would be quite a lot more complex than the NHS. As I said earlier, there is involvement from a large private sector, the voluntary sector and unpaid carers, as well as the professionals who provide and organise social care.

David Torrance: In preparation for the proposed national care service, what opportunities does amendment of the Public Bodies Act 2011 offer to examine, amend and simplify the governance of IJBs?

Michael Kellet: We do not, from a Public Health Scotland perspective, have a position on the governance arrangements. However, we think that there is an opportunity in the legislation to consider the data legislative environment. One of the frustrations across the system around health and social care data is organisations' inability, in order to protect privacy, to share data. We think that there is an opportunity, on which we are working with colleagues and Government, to ensure that we take a progressive approach to legislation on data collection, data use and data protection.

Kathrine Sibbald: Similarly, I cannot comment.

David Torrance: I have a final short question. Professor Bell touched on the high turnover of leadership in IJBs. What do we need to do to stabilise that?

Professor Bell: I cannot back this up with a lot of evidence, but I am casually aware of it. I sometimes wonder whether we give enough training to the kinds of people who are likely to have important roles in our IJBs or, more generally, across the health service. Turnover within social care is a perennial challenge: the answer is about making people feel valued and paying them a competitive wage. This all relates to the remarks about wages that were made at the start. Nevertheless, if you are going to have a successfully operating workforce within social care, you need people who are motivated, well trained and have a willingness or desire to stay in the profession. I think that, at the moment, the average stay is around two years.

Gillian Mackay (Central Scotland) (Green): Good morning. I feel that we have talked about data for years—what we should be collecting, what we are not collecting and what we could be collecting. Is it the case that, sometimes, we need to talk about collecting different data, rather than simply more, and joining it up to ensure that it covers priorities across health and social care as a whole, to deliver outcomes for people as a whole? How do we get there from where we are now? What do we need to encourage IJBs and others to do to ensure that we can get to that reality, where data can be used in a rounded way?

I see Michael Kellet nodding, so I will pick on him first.

Michael Kellet: I am happy to start the answer to that.

I agree that collecting the right data is really important. I am not the data lead in our executive team in Public Health Scotland, but one of the projects that we are working on with the Government and other partners, including COSLA, is called the care and wellbeing dashboard. It is still in its infancy, but it is an attempt to collect data that genuinely shows at local and national levels progress against outcomes—which brings us back to what Professor Bell said earlier. It involves a basket of measures that genuinely show not just how the system is performing in terms of service delivery but what changes we are making in terms of outcomes. It feels exactly like the right way to make progress.

One of the challenges that we face, which I am sure the committee will have heard about, is the data around primary care, given the way in which our primary care system is set up in Scotland. That is a challenge, but there is real shared ownership of the fact that we need to make progress. We in Public Health Scotland are keen to play a leading part in that holistic whole-system approach to data, but there is a considerable amount of work still to do.

Professor Bell: I have been involved for several years with national surveys, with a particular focus on older people aged 50-plus. Michael Marmot was one of the first people to be involved in such a study down in England—the English longitudinal survey of ageing—and it has added to the direct health and social care measurements a lot of contextual information about family structure, family income and whether they are in a place of high deprivation.

For several years now, I and a colleague have been trying to get a similar survey done in Scotland. That has not proved to be easy, but—and this will surprise you—I have applied to the US Government for $7 million to put in place such a survey in Scotland, which would involve fairly elaborate health measurements.

Kathrine Sibbald: I totally agree with Michael Kellet's point about a whole-system approach. Certainly, one of the conclusions of our work is that it is really important to have connectivity of the data and to be able to paint a picture of what is happening across the system.

Gillian Mackay: Given the whole range of priorities, frameworks, performance metrics and all those things for IJBs, with limited resource, how can we support IJBs in collecting the good and useful data that can drive some of those outcomes? IJBs have so many performance and measurement frameworks that they legally have to report on, while, as a whole system, we are trying to drive better data, but there are only so many people to do all that work.

10:00

Michael Kellet: I will start. This is not a complete solution to your question, but one of the things that we think is really important is the work of what we call our local improvement support—LIS—teams. They are analysts, largely, who work for Public Health Scotland but who are embedded in local partnerships to support their data gathering and the whole-system approach that I talked about earlier. We think that they are a really important resource, and they are valued by IJB leads.

One challenge that we are thinking about is whether we could make that information more available to the wider community planning partnership, not just the IJB, to support the type of joint work that we talked about earlier. The LIS teams are an important asset in improving the data landscape around CPPs and IJBs.

Professor Bell: This is more in terms of blue-sky thinking, but artificial intelligence, if corralled effectively, provides us with huge opportunities to collect more data and use it more effectively. There is a case for arguing that, as far as artificial intelligence is concerned, a pretty thorough investigation of the potential should take place, which might make productivity and the production of data a lot better.

Kathrine Sibbald: I have nothing to add.

Gillian Mackay: That was great. Thanks.

The Convener: I call Paul Sweeney.

Paul Sweeney: I thank the witnesses for their contributions so far.

I want to turn to commissioning and procurement. How can we promote a more ethical and productive approach to those things? Is it the current approach to strategic commissioning that needs to be revised, or is it the processes themselves—or is it both?

Kathrine Sibbald: We have done a small bit of work on commissioning and procurement for the "Integration Joint Boards: Finance and performance 2024" report, and we have concluded that there is a long way to go to improve the approach to commissioning in order to be more focused on collaborative approaches as well as ethical commissioning.

We refer to the areas where that is beginning to happen, with a number of IJBs working closely with the Institute for Research and Innovation in Social Services to progress that work. It all comes back to what I have referred to several times now: the need for collaborative working and ensuring that that message is spread more across all the IJBs, with support for them to take that work forward. A lot of work is clearly on-going, but it is in the early days of development.

Professor Bell: I would also just mention rural areas, where getting a market is, effectively, extremely difficult. There is huge pressure on the workforce as far as our more remote rural areas are concerned.

Paul Sweeney: That is an interesting point. Some strong examples of innovation and efforts to improve the commissioning and contracting of services have been highlighted in the Accounts Commission report. How can those efforts be further supported and the pace of change improved? Are there practical opportunities to do that?

Kathrine Sibbald: I am not sure about improving the pace. It all comes back to learning from individual IJBs as the work progresses; having the support network behind all of that, which Iriss is providing; reviewing and analysing improvement as the pieces of work progress with the change in approach; and sharing that learning across the sector to support the pace of improvement across the board.

Paul Sweeney: Is that currently a barrier to improvement? Does it inhibit opportunities to improve service delivery? Is that identified as a key blocker? Have you identified any other blockers or barriers to be overcome?

Kathrine Sibbald: In the report, we set out the challenges that have been created by the current approach, with its focus on finances, budget and the provision of services in the most economical way rather than on outcomes and the quality of services for individuals. When we put those two different points together, I think that, yes, there is an issue there to be addressed.

Paul Sweeney: Noting Professor Bell's point about resource, particularly in rural areas, does that drive towards lowest-cost tenders militate against efficiency and good-quality service delivery? Have you noted that tendency? Does that model of chasing the lowest-cost solution need to be changed?

Kathrine Sibbald: I suggest that that is the point that we make in the report.

Joe FitzPatrick (Dundee City West) (SNP): My question has largely been covered, but I wanted to ask about the wider issue of improving sustainability in the context of increasing demand and fiscal pressures. Kathrine, you mentioned collaboration as being key to getting there, which comes as no surprise to me as a former health minister. That is what we have been trying to do across the system.

I want to push a bit on how can we do that better. Paul Sweeney mentioned the short-term situation in which an IJB looks at its budget and sees that it can save money, but that often means additional pressure being put elsewhere in the system. Can you widen that out from IJBs and the health boards to third sector partners, unpaid carers and the wider workforce? How can we get a collaboration that brings in the whole system?

I will bring in Kathrine Sibbald, as she has been talking most about collaboration.

Kathrine Sibbald: I agree that collaboration is about having communication across the board, with all the key stakeholders involved. However, I do not have anything specific to add to what I have already said about having a clear strategy, engaging all the key stakeholders in conversation about planning throughout the stages of the process and identifying data and how it can be used more efficiently.

Professor Bell: It is particularly difficult to do that sort of thing with unpaid carers. It is possible

to bring some long-term unpaid carers into the system, but for many, the provision of unpaid care is of a relatively short duration. They do that work anonymously, without all that much help. Self-directed support, which I have been involved with, has been quite a useful adjunct in this area, but it would be particularly difficult to bring unpaid carers into some collaborative whole-system approach.

Joe FitzPatrick: Do you think that they are being considered as part of that approach, or is it just a case of thinking, “This will not cost any money, because they will just do the work”?

Professor Bell: There are knock-on effects for people who are unpaid carers. For example, there are costs in terms of their mental health, or they might have to give up work in order to provide the unpaid care. They are a very difficult group to integrate into the system. Innovative ways of thinking about that would, I am sure, be very welcome, but, as yet, it seems pretty difficult to me.

Michael Kellet: On a slightly different, but relevant, tangent, Public Health Scotland has partnered with Police Scotland and the University of Edinburgh on something called the Scottish prevention hub, which is located at the Edinburgh Futures Institute in the old royal infirmary building in Edinburgh. One of the challenges that we have been thinking about is leadership, and putting in place the sort of collaboration that you have talked about is really important.

One of the challenges for public sector leaders is that their attention, time and capacity get sucked up in dealing with the immediate pressures of running day-to-day services, and their capacity to step back and engage with unpaid carers and others is very limited. That was my personal experience when I was a chief officer, and it is the experience of public sector leaders across the board. The prevention hub has been thinking about what “different”—and “better”—would look like in order to protect the time and capacity to be genuinely collaborative. However, given the financial pressures and the pressures on service delivery, it is a real challenge to have a system that is genuinely collaborative and which is able to engage with and support the communities that it serves.

Kathrine Sibbald: I just want to come back in briefly to flag the issue of the resources of third sector representative bodies that represent individual groups of people. It is extremely important that we bring that issue into the conversation, as the likes of the Health and Social Care Alliance Scotland are, frankly, valuable resources to utilise in this scenario.

Emma Harper: I have one final quick question. I know that the NHS Highland model is the only lead model that is used with regard to the integration of joint boards. I find it interesting that the NHS has taken on that lead role, and I see that it has been talking about reducing overlap, improving care and having better co-ordination, which I suppose brings us back to collaboration. Has any modelling or assessment been done on the finance and efficiency opportunity of a lead model versus an integration model?

Kathrine Sibbald: Audit Scotland has certainly not done that piece of work.

Michael Kellet: I am not aware of any such modelling or assessment, but it is not an area that Public Health Scotland would focus on.

Emma Harper: I am just thinking about the 79.4 per cent of NHS funding that goes towards integration in Dumfries and Galloway. That is a big pot of money and already represents a big chunk of what they are doing.

Professor Bell: I have not come across or know of any evaluation of the Highland experiment, but it seems to me that it would be useful to have a clear view of the success or otherwise of that model.

The Convener: I thank the witnesses for their evidence, and I am very grateful for their time.

I now suspend the meeting for a change of panels.

10:11

Meeting suspended.

10:19

On resuming—

The Convener: We continue our pre-budget scrutiny with a second panel of witnesses. I welcome Caroline Cameron, chief officer of North Ayrshire integration joint board; Pat Togher, chief officer of Edinburgh integration joint board; and Sharon Wearing, chair of the integrated joint boards chief finance officer section in the Chartered Institute of Public Finance and Accountancy. Professor Soumen Sengupta, chief officer of South Lanarkshire integration joint board, is unfortunately no longer able to join us this morning.

We will move straight to questions.

Tess White: My first question is to Caroline Cameron.

With the funding gap for IJBs set to triple for 2023-24, it is clear that they are facing an alarming financial crisis. What is the impact of those intense budgetary pressures on the delivery of primary care services, including phase 2 of the 2018

general medical services contract, which has still not been delivered?

Caroline Cameron (North Ayrshire Integration Joint Board): Thank you very much for your question. Clearly, there is a huge impact for our health and social care services across the community. The demand that we have seen in primary care and across other settings has been quite stark, particularly post pandemic, including in primary care in general practitioner practices.

In Ayrshire and Arran, we are quite far forward with the implementation of the GP contract, and we are one of the demonstrator sites that will take forward the full implementation of the primary care GP contract. There are particular areas that we have not been able to invest in due to some of the funding not flowing through, such as mental health practitioners in general practice settings. That is having a significant impact on our wider community mental health services, including our community mental health teams and our specialists in mental health services, because that robust tier of support in primary care settings has not been fully implemented on the ground.

Primary care and following through with the contract are really crucial. It is a core linchpin in our community services that supports every other part of the pathway. It is the first point of contact and port of call for individuals who are struggling in the community, and if there is no capacity to provide a response there, it impacts on every other part of our system and services. We see that person appear in a different part of the system because they have not been able to get an early intervention response from their GP. It is hugely challenging and a core fundamental issue that we need to address to support the wider system.

Tess White: Thank you. That is very helpful.

My second question is for Pat Togher. The Accounts Commission report highlights that IJBs were intended to shift the balance of care out of hospital to the community, but that has not happened in practice, and we are seeing decreased funding and decreased patient satisfaction instead. With the significant budgetary shortfalls, do you believe that it is still possible to achieve that shift?

Pat Togher (Edinburgh Integration Joint Board): It is possible—of course it is—if it is adequately funded. The Audit Scotland report has highlighted that really well. I think that, across all of the IJBs, there is an overwhelming view on shifting the balance of care and sustaining more people at home longer and reducing hospital admission, including emergency admission. In some of those areas, some of the integration indicators are quite strong, but the question is about the longer-term sustainability.

Packages of care that support people in the community are extremely expensive, and issues such as population growth, complexity and need, more needs and the volatile recruitment market all play into the longer-term financial viability of those arrangements. Therefore, that shift is achievable, but there are many challenges that still need to be addressed regarding not only the longer-term financial viability, but the providers that provide the care—we have some major issues there.

Tess White: Thank you. This is my third and final question. You talk about the cost pressures of providing care in the community. What do you anticipate the impact of the Scottish Government's in-year budget cuts will be? We will start off with Sharon Wearing, then maybe the other panel members can give a view.

Sharon Wearing (Chartered Institute of Public Finance and Accountancy Scotland): From where we are starting, right now, we are having to look at significant reductions in our budget. The information that the IJBs have from the 28 responses that we have had tells us that we have budget gaps of £513 million. That, added to the in-year cuts, will just make that challenge even harder and it will impact on the services that we are able to provide.

We are already looking at recovery plans to try to reduce that gap, but not everybody has fully developed plans; that is highlighted in the Accounts Commission report. IJBs are struggling to identify all their budget options and some of them are using reserves to reduce that gap. There is no doubt that putting anything else on top of that will have further impact on the services that we deliver.

Caroline Cameron: My comments will be similar to Sharon Wearing's. There is no doubt that those cuts would compound some of the issues that we are currently facing. My own health and social care partnership is projecting an overspend for this year, so we are already in financial recovery mode and looking at how we prioritise services and try to reduce spend in year. Further cuts on top of that would be really challenging and there is absolutely no doubt that they would impact on vulnerable people, whether they are passed through to IJBs or to local authorities, health boards, third sector and other partners and agencies that we work with closely on a whole-system basis to support individuals.

One of the other challenges that we face is that where we have had in-year funding or funding for specific investments, that funding has not been inflation proofed. Where we have a static allocation of funding to implement a policy area or investment, that loses value over time because of the costs of inflation with regard to pay and other things across services. There is absolutely no

doubt that that would be difficult to manage alongside the financial challenges that we currently face.

Pat Togher: In Edinburgh, we started the financial year with a £60 million gap and a requirement to produce and approve a £48 million savings plan. That gives a fair indication of what this would mean for us moving forward with delivering services within the IJB and the delegated services. There would be a requirement for us to focus—as we are focusing at the moment—on our most vulnerable people and our statutory requirements, and that is often to the detriment of early intervention and prevention. We are faced with significant financial pressures, and those tend to be the go-to places. We are therefore not preparing for upstreaming and the ability to address earlier intervention and prevention, while taking growth into account.

Growth has varied across Scotland, whether because of population growth or poverty and deprivation. There is so much variation across Scotland. That, as well as what I have already said about recruitment and retention in a city such as Edinburgh, play into a major challenge for us.

Tess White: I have a quick follow-up question for Pat Togher about the voluntary sector. There is a squeeze on the council-run care homes because the cost of care homes is increasing, and that is having a huge knock-on effect on the voluntary sector. Could you comment on that? I say that to Pat but I notice that Caroline Cameron is also nodding. I ask Pat and Caroline to comment on that, then that will be me.

Pat Togher: As you can probably imagine, in a city such as Edinburgh, it is becoming extremely difficult to secure care home placements at national care home rate. The finances just do not stretch to that, and that is playing a part in the issue. Care homes operating within a national care home rate is, by definition, very challenging. In recent months, a care home in Edinburgh closed, which placed additional pressures on us so that we had to re-provision care for more than 40 people, and those 40 people were in a placement where the national care home rate was being complied with. If we take that number out of the system, we are left with additional financial pressures.

Care at home provision is also a particularly volatile market, given where we are financially, and the cost of living crisis, especially living in a city such as Edinburgh, for example, plays into that. An average package of care should not be underestimated: it is considerable. It costs about £30,000 in Edinburgh, and a care home costs about £1,200 per week—and that is with an estimated population growth among adults of about 30 per cent in Edinburgh alone between now and 2030. That is particularly pronounced in the over-80 population, which is set to increase by as much as 40 per cent. There are major challenges there.

10:30

Caroline Cameron: There is a quite different context in North Ayrshire. We do not have the same challenges with competing for care home places with residents who are self-funding. We have a very different demographic profile.

We have one care home that we operate in house, which is on the island of Arran. We do that because, from the point of view of economies of scale and cost, it would not be an attractive proposition for an independent care home provider to operate on the island.

Three care homes have closed in our area over the past three years, but the issues with them have predominantly been about quality of care, rather than financial sustainability. However, there is no doubt that the financial constraints of operating a care home impact on quality as well.

Our challenges include recruitment and retention for care home staff, continuing to rely on premium and agency staff, and having a number of smaller care homes. There are not the same economies of scale to make things financially viable when we have a lot of smaller care homes. There are different challenges across different areas.

The national care home contract is great for having a national standard for what we expect a care home to deliver, and for having a national rate. It removes local negotiation, although it does not always reflect the reality of what it costs to deliver the service.

There has been a huge increase in the complexity of the individuals that care homes are now supporting. There is a very different profile of residents who are now choosing to go into care homes. There has been an 8 per cent reduction in the number of people moving into care homes over the past couple of years, with a massive increase in demand for care at home services. There has been a real shift to supporting people with more complex needs in the community, but that inevitably means that there are more complex residents in care homes, for shorter stays. There is a very different demographic profile for care home residents.

Joe FitzPatrick: Sharon, you mentioned IJBs using reserves. What is the state of reserves across IJBs? What kind of money has built up that has not been used from previous years?

Sharon Wearing: We have a depleting level of general reserves, which is the area of reserves

that we can use to help balance the budget. A number of IJBs do not have any reserves left. When we started the financial year, after setting the budget, 13 of the IJBs had no general reserves left. We estimate that, by the end of this financial year, 15 of them will not have any general reserves. That means that half of all the IJBs that can hold general reserves will not have any left. That is a worrying concern.

You will see in the Accounts Commission report that the numbers are going down, and we are seeing that across the piece. Earmarked reserves are for specific purposes, and they cannot necessarily be used to offset budget pressures. A lot of those reserves are tied to primary care funding or action 15 funding for mental health, for example. That money has to be spent for that specific purpose. There is a trend of there being very little left now.

Emma Harper: Good morning. I asked the previous panel about recovery from Covid, as we are still recovering from a global pandemic. I am interested to know, for instance, about the on-going financial costs of dealing with post-pandemic vaccinations and long-term care, which were unanticipated prior to the pandemic. Has the pandemic had an impact on on-going planning for finances? How has that impacted ye?

I am looking at you to answer first, Sharon, because your heid is up.

Sharon Wearing: There are a couple of areas where we still have pressures, and vaccination programmes is definitely one of them. The Covid funding has obviously stopped and, although we have an allocation of funding, the question is whether it goes far enough. There is still a bit of a challenge around the allocation of funding, particularly for vaccination programmes.

We are also working our way through some other challenges. Our biggest challenge relates to the complexity of people's needs following Covid, which creates a big financial challenge for us. There is not only an increase in demand, but complexity that goes with that, so it is a double dunt for us. We see more of that following Covid.

Emma Harper: Is that complexity caused by there being more people with more than one long-term condition?

Sharon Wearing: There is that, but there is also the fact that a lot of people did not necessarily seek help during Covid. Since Covid, a lot more people are coming forward who did not do so at that point in time, which means that they have greater and more complex needs and that they need more services. We see that across the piece, including in mental health services. There is a big increase not just in the number of people coming forward but in the complexity around services. That creates a significant financial challenge across the board for all of us right now.

Emma Harper: Caroline Cameron mentioned mental health in her first response. There can be one-off or initial funding for many such programmes, or funding can be annual. In relation to sustainability, what would be a different approach to tackling mental health issues, for example?

Sharon Wearing: We have asked for more recurring funding to be built into our baseline budgets. Just now, an awful lot of our funding, particularly on the health side, comes through each year. We do not yet have funding allocation letters for quite a few areas, although we have them for some of the bigger areas. When there are annual allocations, it is very hard to recruit staff on a recurring basis, because you do not know what funding you will get in future years.

There are also challenges relating to pay uplifts. In the past couple of years, we got uplifts in the level of funding for pay, but we did not get those in the early years. We would like some security, where possible, in relation to direct allocations. We know that there is a changing picture, but we would like there to be baselining of funding and some confirmation about future levels of funding, so that we can have security when we recruit staff. It is very hard to employ staff right now. We need to employ staff on a permanent basis, so if we do not have security of funding, it is a real risk for us.

Ruth Maguire: Further to my declaration of interests during the first session, for clarity, I should probably say that, although the chief officer for the IJB in my area is here, we have not worked together, but we absolutely will have corresponded on constituency issues.

I have questions about performance, shifting the balance of care and outcomes. We all appreciate that the situation with diminishing funds and increasing demand is challenging, but the data that is held does not show a marked shift in the balance of care, which was one of the main aims of integration. Do structural changes need to take place to help to shift the balance?

Further to that, what is being done, or what more can be done, to ensure that budgets lose their identity and are truly integrated? I mentioned to the first witnesses that, when I was on the IJB, one of my great frustrations was hearing phrases such as "from a health perspective" or "from a council perspective", because I know that all of us want to talk about things from our neighbour's perspective, from our granny's perspective or from the perspective of the person who needs the services.

Those are a couple of questions to start with.

Sharon Wearing: I will address the last one, and I will leave Caroline Cameron and Pat Togher to address the other one.

The phrase “budgets losing their identity” has been used right from the start. However, while we work in two ledgers—one from the council and one from the health board—budgets will never lose their identity. I have said previously to committees that, to get true integration of budgets, things need to be done in one ledger. They cannot be done in two, because what happens is that our health performance is reported through the health board and comes up through the Scottish Government, and the social work bit is reported through the council. To allow budgets to lose their identity, there needs to be a completely different approach, in which we all work in one ledger and the budget is all in one ledger.

Ruth Maguire: On that specific issue, Public Health Scotland talked this morning about having a new category of spending, which would be a preventative spending category, in the same way that we have capital and revenue categories. Do you have a view on the helpfulness of that?

Sharon Wearing: There is a lot of preventative spending at the moment and, although we cannot capture all of that information, we can capture a lot of it. Part of the challenge is that some of our services have more than one purpose, so not everything that is being done in terms of preventative spending would necessarily be captured in that separate category. We have had a similar discussion in relation to carers. We can capture information about services that go only to carers but, if services are going to carers and an individual, it is not easy to capture that information separately—we are not good at that separation of reporting. At this stage, my view is that I do not see the benefit of the proposal. I think that it is more important to capture the spend in one ledger to try to ensure that loss of identity and allow those shifts towards preventative spend to happen more easily.

Pat Togher: I completely agree with your first point, about the structural changes that you described. Given where we are with integration, eight years down the line, there are some reflections to be had on exactly how it has been applied and interpreted and the language that has been used, which is often not particularly helpful. It is true that, as Sharon Wearing said, the budget loses its sense of identity. However, when we are faced with the financial pressures that we are faced with at the moment, there then comes a question about an overspend at the end of the financial year. We have not quite reconciled that consistently across Scotland, and that is definitely something that we could address structurally. We could genuinely tighten up in that regard, and take stock and reflect on what we have done in the past eight years.

On the issue of the preventative spend category, I would say that, by definition, it is often difficult to determine precisely what prevention is. A lot of services, including internal services and third sector services, categorise their intervention as early intervention and prevention, for example, but what really needs to be running through the middle of that is a strong evidence base for that categorisation and a consistency about what it is. If there was a specific funding arrangement for preventative spend, there would need to be a consistent interpretation of exactly what it is for in terms of prevention and early intervention.

At the moment, we have a budget in which we are constantly offsetting prevention and early intervention for core statutory duties, and we are dependent on that approach. If there was an option in that regard, it would have to contain a degree of flexibility to enable us to use those budgets accordingly.

Caroline Cameron: I would make a similar point. The progress in making the money lose its identity is perhaps going backwards somewhat because of the financial pressures that we face. Part of that relates to risk exposure, with the local authorities and the health boards being accountable for the resource that they are putting into the system and wanting to see what is delivered with that, and then being exposed to the financial risk when there is an overspend or an underspend on the part of health or social care services. It is difficult to co-ordinate that in a way that ensures that the money loses its identity and is spent in the best possible way when both partners are exposed to different risks around that.

10:45

When it comes to progress on shifting the balance of care, we often think of that only in relation to how we are shifting activity from acute hospitals into the community, which has been really challenging. The pandemic has also had on our hospitals a huge impact which they have not yet recovered from. In our own system, in acute hospitals lots of additional beds were opened that it has not been possible to close, which is an additional cost. It is difficult to see when we will be in a position to transfer resource into the community.

However, we have been more successful at shifting the balance of care and improving outcomes across other services—for example, our mental health and learning disability services. We have significantly reduced the number of hospital beds that we have for mental health and learning

disabilities and we have provided support within the community.

In North Ayrshire, we have worked closely with housing staff on supported accommodation models to provide independent living environments in the community for people who were in hospital for a long period of time. Similarly, in children's services, with the prevention agenda through the Promise and the whole family wellbeing fund, we have seen reductions in our child protection registrations and in the number of young people coming into care, and we are supporting young people in the community. We need to focus on the principle of shifting the balance of care across the range of services that we deliver.

When it comes to the acute side in particular, right from the outset, we knew that it was always going to be difficult to deliver a shift. I understand the principle and there is merit in it—absolutely—but the investment did not come along with it to allow us to double-run and pump-prime our community services in order to facilitate that shift at the outset of integration. As I described, it feels really difficult to achieve that now given how pressured the acute hospital settings are.

Ruth Maguire: Thank you. I have heard from all of you this morning—and I think that we all understand this—that, when pressures come in, resource gets put to what you are legally obliged to do and to those who are most in need.

Some—in particular, a number of third sector organisations that have a special interest in various conditions—would see ring fencing of funding as being protective of certain services. What impact has ring fencing had on reforming services and also on how you respond to local needs, which will differ greatly between North Ayrshire and Edinburgh, for example?

Caroline Cameron: When we have experienced ring-fenced funding before, it has been to deliver a specific strategy or priority. One particular area where that has been positive is the ring-fenced resource that we have had for more specialist mental health services, including child and adolescent mental health services, psychological therapies and other such services. That has been positive in enabling us to focus investment in those areas and it probably gave people more confidence that there would be a recurring investment and they would be able to deliver improved performance, so there is definitely a place for ring fencing that can deliver positive and focused efforts to improve performance.

The challenge comes when, in a local area, we receive ring-fenced funding for a number of different things and they do not necessarily all align with our local priorities. If we had a pot of resource for investment in local priorities, that might be slightly different from how the ring-fenced funding comes through. The challenge is that, although we see ring fencing and any additional resource as positive, it is difficult to join that up when we are cutting services in other areas. We need to manage it carefully so that we are not creating a gold-star service through a ring-fenced opportunity but unable to prioritise other important priorities locally. There is definitely a place for ring fencing, but it needs to be carefully managed and considered alongside our local priorities.

Pat Togher: We would take a very similar position, having managed services where funding has been ring fenced—for example, for services in relation to Ukraine. Overall, it can be seen as quite effective. However, given where we are now financially, as Caroline Cameron touched on, it cannot be to the detriment of the other services that are not ring fenced. That would be my only caveat.

Sharon Wearing: I would like to see some direct funding coming into the IJBs, but I would like to see that flexibility so that the IJBs can determine locally what they need to prioritise in relation to services—that is key. We need to look at our community's needs and deal with the pressures that are there just now, so that is the priority from our point of view.

Ruth Maguire: The committee has undertaken scrutiny of self-directed support, and one of the things that we have heard quite consistently is that policy and legislation are not really given time to bed in before the next change comes along. That message has come across clearly, particularly from front-line workers. To what extent does integration simply need more time to bed in, or are different performance indicators required to measure the impact of changes that are happening?

Pat Togher: I completely agree with the question—it is a really valid one. We have not allowed integration to properly bed in. The recent research from the Centre for Excellence for Children's Care and Protection confirmed that it is relatively inconclusive right now. There are exceptional examples of integration across Scotland, certainly in the IJBs and health and social care partnerships that I have worked in. There are fantastic examples that we can draw on. However, integration itself clearly needs more time, given that, since 2016, we have also had the Covid pandemic, and it feels that we are not giving it the proper chance to breathe.

You touched on policy and legislation in your question, and there are examples of policy and legislation that have been introduced over the past eight years or so that have not been adequately

funded in the long term, which is playing into a fairly chronic financial picture. Where there are decisions around changes to policy and, certainly, changes to legislation, increased legislative responsibilities need to be carefully considered and thought through with regard to the short and longer-term costs.

Sharon Wearing: We are in danger of creating a huge amount of disruption, and I am not necessarily seeing what benefits will come from that. More time is needed, and it would be good to see a bit more consistency right across the IJBs, because we all have different services delegated to us. However, the existing legislation allows for a lot more, and there are also reserved powers that have never been tapped into. Therefore, there is more opportunity to drive through what we have rather than bringing in new legislation to do something that I am not, at this stage, seeing the benefits of.

Caroline Cameron: I absolutely agree that this scale of change takes a significant period of time to deliver—we all understand that. As Pat Togher noted, we are just coming out the other end of a global pandemic, which happened in the middle of that period. There are additional levers that could support integration to be more successful. There has been lots of learning from different areas since the outset of integration. Sharon Wearing described the complexity of the services with different IJBs having different delegations, and there could be improvements around that. I think—

Ruth Maguire: I am sorry, but I am just going to jump in so that I can sneakily get an extra question in. Can you give us an example of those levers?

Caroline Cameron: From an IJB perspective, integration works well with regard to strategic commissioning and decision making around resources at local level. It is more difficult at operational level within a health and social care partnership, where you have staff who work for two employers, funding that comes in from two sources and systems that do not talk to each other—we do not have integrated systems and we continually have workarounds for all those issues. It would be helpful if we could be far more proactive about saying, "Yes, we will continue to have two organisations that are employers and different funding routes," but looking at whether there are mechanisms that we can use to make that feel more integrated from an operational point of view on the ground.

Sharon Wearing described the relationships and buy-in for integration, and support for it is key on the ground. This morning, we have discussed the financial constraints, and it is very clear that, with regard to integration from a financial point of view, we were really challenged in terms of delivering savings right from the outset. Having to make unpopular decisions and the difficulties around that at a local level has not set us up to succeed from the outset, so there are levers that we could use to support integration to be more successful without a complete restructure.

David Torrance: Good morning to the panel members. What obstacles do IJBs face in seeking to place binding directions on their partners and settle on shared priorities for their communities?

Sharon Wearing: I work as a chief financial officer in Glasgow, and right from the start we did directions. We got a bit of resistance at the start, but directions are well embedded in our system and work well, and people understand the consequences around directions. We try to ensure that our partners see beforehand anything that is particularly controversial or challenging, so that no surprises come their way. As I said, we have embedded directions from the start, and that works well for us.

Pat Togher: I agree with Sharon Wearing. Likewise, in Edinburgh, it is probably fair to say that the directions process works fairly well. Where it does not is when it comes into the core business of competing demands and other priorities. Clearly, our partners—the NHS and the council—have their own competing demands, and they play a really important role in this.

The budgetary constraints are not specific to the IJB; they exist across the board. There is an interdependence, if you like, in the financial pressures that can often play out, and sometimes that can play into the ability to make decisions.

That is a bit like what Sharon Wearing just mentioned. We have a lot of discussions, communication and dialogue—sometimes well in advance, for example, of an IJB meeting—to ensure that people feel equipped for and informed about the decision-making processes. That includes integrated impact assessments for such decisions, whenever that is necessary.

Caroline Cameron: The situation is very similar in North Ayrshire; I do not see dealing with directions as a particular obstacle. Before we take decisions to the IJB, we do a lot of work with the council and the NHS board. Since the IJB was formed, we have never needed to take a vote on any decision. There has always been a consensus in the room, which is a testament to the groundwork that is done not only with partners but with IJB members. We work through any really complex issues and decisions with them before we take something forward to a decision. In my system, I do not see any particular obstacles to directions.

David Torrance: I asked the previous witnesses this question. What could we do to stop or stabilise the high turnover of leadership in IJBs?

Caroline Cameron: The roles are really difficult. Chief officers and other colleagues who are working in the senior leadership space across IJBs really value the peer support that we get from our colleagues. We have strength in our own networks, too.

Lots of aspects of the role are challenging. I do not think that the issue is about pay, grading and recognition, because I do not think that any of us goes into those roles particularly for those reasons. We need to feel valued and to feel that the work that we are doing—that the IJBs and the health and social care partnerships are doing—is valued.

We tend to focus a lot on the things that go wrong and the negatives, instead of celebrating the positives in the work that we are taking forward. One of the more positive experiences that I have in my role is when I am spending time with my team celebrating the good work that is being taken forward. There is a disproportionate focus on some negative aspects.

Pat Togher: I would second some of that. It would be helpful to develop more of an informed position about the reasons why, for example, there has been an increase in the number of chief officers moving on or retiring earlier. That is not specific to IJBs and relates to wider leadership throughout many councils in Scotland.

As Caroline Cameron mentioned, the job is extremely difficult and challenging. There is a strong political dimension to it, of course. It can be an extremely rewarding position, and I second what Caroline Cameron said—the issue is not always about the pay and the terms and conditions.

11:00

IJBs face such enormous challenges right now, and maintaining an IJB's financial position is often difficult. That is not just about where we are currently. If you look at where we are going—there has been discussion today about the future, including the future financial position of IJBs and their sustainability, and there was the discussion earlier about the national care service and the related upheaval and diversion of our focus and attention—you will see that this is an extremely complicated working environment to be in when, in fact, most chief officers would say that what they really want to get on with is the business of integration.

Sharon Wearing: I will come at the question from the CFO perspective. There is a variety of reasons why there has been quite a large turnover, but some CFOs have simply said, "Enough's enough," because of the difficult position that they have been put in.

Working between two partners can be challenging, particularly when some of the budget offers that IJBs receive do not necessarily comply with what was expected. There have also been issues with pay awards not being passed on and with conditions in Scottish Government budget letters not being complied with.

Because of the positions that some CFOs find themselves in, they might think that going elsewhere is a better option. That is not the case for all of them, but there have been areas where people have moved on because of really challenging situations. It is about getting to a situation where there is a fairer share for all and where, from a professional point of view, staff are not put in these tricky financial positions.

Gillian Mackay: Good morning. According to the stakeholders whom the Accounts Commission spoke to, current data does not provide good evidence across the whole system or show how one part impacts another, and data does not help to inform improvements for better outcomes. There is too much focus on data that is used by individual bodies for their governance and operational purposes rather than on collective and joint priorities, and there is no whole-system approach to performance management and reporting. Given the variability in the capacity of IJBs, what can be developed to guide data collection and reporting to enable more accurate comparisons and benchmarking and to move towards a whole-system approach to performance management and reporting?

Pat Togher: I agree that, depending on what we are reporting on, consistency in reporting is varied. I would go as far as to say that, in some circumstances, the situation feels unfair, because the data that we report on and how we report does not necessarily take into account the genuine complexity and variables that exist across the whole of Scotland. Earlier, we touched on the fact that it does not really provide a true account of where IJBs are sitting with the unique challenges that they face. The data reporting does not reflect that—it does not draw on the specific challenges that are associated with poverty and deprivation in Scottish index of multiple deprivation 1 and 2 areas, for example, or in more rural areas, which include challenges with recruitment and services that are and are not delegated.

Homelessness probably provides a very good example. Only two IJBs have responsibility for homelessness delegated to them. However, all IJBs are affected by homelessness in one way or another, given that addiction and mental health issues are fairly prevalent in a transient homeless population.

There are genuine inconsistencies and, first of all, that needs to be understood. How we move

forward needs to take into account all the differences to ensure that there is genuine fairness in how we report in the future.

Caroline Cameron: There is lots and lots of data—we are almost overwhelmed by it—and it is key that we focus on measuring the right things that tell us how the systems are working. There is a tendency to look back at historical data rather than to use data proactively for planning.

The situation has improved, particularly from a social care point of view. Previously, social care data was nowhere near as good as the health data that we held but, as we recover from the pandemic, we are getting far smarter in how we use social care data for planning for services.

There are definitely opportunities that are being grasped. For example, the national centre for sustainable delivery is looking at the whole system of unscheduled care and bringing a different perspective to looking at data and finding solutions. The key part is that, when we use that data, in some ways it just reaffirms how we think that the system is operating, but as we implement change, we can look at how that impacts on the data.

The key point is that, right now, it feels as if we are overwhelmed by data and obsessed with numbers. We need to focus on the key areas and do more forward planning for the improvement trajectories that are attached to that.

Gillian Mackay: With the previous panel, we heard about local improvement support team—LIST—analysts in IJBs. Do your IJBs have those posts? What value do they add to the IJBs? What other measures could be put in place to support IJBs with data gathering, given the range of performance management frameworks to which the IJBs have to contribute? How do we get the shift to recording the right things for integration across the piece?

Given what Pat Togher said about different IJBs having different things in place, how do we ensure that we do not overcomplicate the picture for the IJBs that may or may not have some of those things delegated to them?

Caroline Cameron: Absolutely—on the point about delegation, that does not necessarily need to drive what we measure, because it is a whole-system approach. We do not have full control over some of the data and the measures that we use, as we work with a range of whole-system partners around that.

We have LIST analysts who are aligned with each of the partnerships. For example, our LIST analyst prepares our strategic needs assessment, which drives forward our strategic plan and enables us to measure performance against that.

More recently, there have been a lot of discussions about how we take that to the next stage, in particular around joining up some of our social care and health data for individuals. That would enable us to get a real understanding of hospital pressures and what journey or pathway a patient has taken before they reach the point of admission, as well as post discharge from hospital. LIST analysts can support us with the key role of looking at how we join up our social care and health data so that we get a whole picture of individuals.

Some of the other public health work is focused on prevention, in particular in areas with high levels of poverty and deprivation. How do we target our finite resources at the individuals who are most vulnerable, and how do we use some of the information and data that we hold in order to do that? There are a lot of opportunities there.

A lot of exciting opportunities are also being explored by the Digital Health and Care Innovation Centre; I know that the centre is working with a few areas, including Moray, on pilot projects. There are good opportunities to use technology and grasp that data alongside it.

Pat Togher: Edinburgh IJB is going through a transition. We are changing our system to make it much more up to date and contemporary, and we are seeking to adopt an approach that will involve much more digitally enabled decision making. That should allow us to redesign services in a much better and much more informed way that takes into account what is specifically delegated to us and how we can redesign that as we move forward. That will ensure that our position is much more informed, with a stronger evidence base attached to it. That is where we are in Edinburgh.

Sharon Wearing: We have LIST analysts locally, but one opportunity that we all recognise is that we really need our information technology systems to talk to each other. We want our staff to be able to access information on our service users and patients just once—we do not want people having to repeat all their information to different parts of the team over and over again. The focus should be on how we get our systems to talk and pool that information, so that we can see in front of us all the information that is there for a particular patient or service user, and do that just once.

There is a lot of technology that can allow us to do that, and it would be better for us to do it collectively rather than all trying to do it individually. There is scope there to make significant improvements, and that should be a focus.

Gillian Mackay: I absolutely agree.

Paul Sweeney: I thank the witnesses for their points so far. I turn to commissioning and

procurement. What would promote a more ethical and productive approach to that? Is the current approach to strategic commissioning the source of the problem and does that need to be revised, or is it the processes themselves, or is it both? I invite the IJB leads to offer their thoughts.

Caroline Cameron: We try to take an approach of ethical commissioning and procurement, particularly when we are commissioning social care services. As we all know, there is always a balance to be found between cost and quality. When we commission care services, a much heavier weight is placed on the quality of care that is delivered. We can further promote that approach by working with our commission providers, particularly around the fair work agenda and how they support their workforce. The key challenges are around recruitment and retention, making sure that the workforce is being paid appropriately in line with the Scottish living wage, and ensuring that staff are getting support with training and meeting their needs.

In North Ayrshire, we took the decision to bring all our care-at-home services in-house, and that was finally completed earlier this year. We decided to do that because of fragility in the market, inequity of access to support for individuals and our really wanting to proactively control our care at home services. We still work with a range of other providers across a number of other services, including supports for adult and community care homes and other providers. There is probably still lots of work that we can take forward to promote that ethical approach in how providers deliver care, but I think that we will never get away from a procurement process that balances cost and quality. The real driver needs to be that, when we procure our contracts related to care, the quality aspects of the delivery of care need to be heavily weighted alongside the costs.

Pat Togher: The challenges that we are experiencing in Edinburgh are more related to the cost efficiencies, the evidence-informed approach, and the demand for and availability of providers. They are also related to the constraints around our longer-term budget and funding arrangements that could give a form of stability.

Similarly to Caroline Cameron's board, we are taking a much more ethical approach to commissioning and procurement. We are well informed and our relationships and partnerships remain strong, particularly with the community-based providers that we have in Edinburgh. For example, any decisions that we have to make in advance of budget setting incur an awful lot of partnership and engagement work well in advance. We are taking an approach that works and works well for us just now, but, needless to say, moving forward will be challenging for us in terms of longer-term financial sustainability.

Paul Sweeney: Sharon, do you have any points to make?

Sharon Wearing: We use a lot of people with lived experience as part of the process when we go out to commission. Their contribution is very much valued and they are very much part of that process. I definitely think that we need to follow that direction of travel more, because those people and their experiences are what really matter to ensure that we get the right services for people. Taking in and using people's experiences of service delivery, what they would like to see and what they think works as part of the process is really key.

Paul Sweeney: Thanks for that point.

The Accounts Commission report highlights strong examples of innovation, but how could innovation efforts be better supported? Are there barriers to benchmarking, learning from other IJBs, levelling up—if you like—and promoting the best practice across the country as standard? How does that function at present? Are there too many silos and too much fragmentation?

Caroline Cameron: Speaking from an IJB perspective, it does not feel as if we operate in silos. We proactively go out and look to those areas that are taking forward improvements in order to learn from them. Our teams frequently link with colleagues from other partnership areas to do exactly that. The other support that we get is from our colleagues close by. In North Ayrshire, we work closely with our IJB colleagues in East and South Ayrshire in order to share learning, and to collaborate where that is appropriate.

We deliver and take forward projects and initiatives together rather than going at it alone all the time. There is probably more that we could do—there always is, as there will be across any organisation. There are still opportunities to learn, and areas continue to innovate and take forward different transformation programmes that we will continue to link with. I provide a reassurance that we do so proactively. We seek out learning from others on how we can implement that locally—where appropriate, because it is not always appropriate for our local need or services.

11:15

Pat Togher: I note the comments in the report that there is potential for collaboration to be somewhat stymied given the pressures that people are under. I recognise some of that, but I do not completely recognise that there is a lack of collaborative working across chief officers. We now have more of a requirement than ever to be

much more outward looking. Excellent examples exist of how we are doing that across Scotland. In Edinburgh, we are looking at redesigning the front door of and access point to the service, and the model that we will come up with will not simply be based on an executive team sitting in a room in Edinburgh and coming up with those suggestions; it will be about looking more widely and taking advantage of what has worked well elsewhere, not just across Scotland but also in parts of England, where the redesign of the front door has been really effective.

Models of care and intervention outwith Scotland have been taken into account across IJBs—national models, such as the alcohol and drug partnerships, drug services and alcohol services. Those are not just specific models that have been born in Scotland; they are nationally recognised models of care.

As chief officers, we are fairly outward looking. Now is the time to be more outward looking than ever and to take those opportunities.

Sharon Wearing: We are quite ambitious in a lot of the commissioning of services that we are trying to do. We share a lot of practice and learning across the board.

Benchmarking is always kind of tricky, because we do not always include the same things. Going back to the home care unit cost benchmarking that we try to do, I note that we never get a consistent picture, because variations always exist with regard to what is and what is not included locally. However, we are trying to deliver a lot of ambitious new services and we need to keep doing that. Caroline Cameron talked about the work in Ayrshire, and we share a lot and work collectively across Greater Glasgow and Clyde. We share what others are doing and, where appropriate, others look at that work and deliver it. It is really important to try to do that.

Paul Sweeney: We have discussed the pressures on prevention. Given the financial constraints that GPs face, it is a challenge to reconcile the different elements, as has been discussed. Commissioning decisions are often based on which provider offers the lowest cost, but that can have a deadening effect on quality and innovation. The answer from the previous witnesses was to get more resource, particularly in rural areas, which can be quite challenging.

Do you have other views on how we can empower IJBs to look beyond cost and consider the longer-term benefits of investing in innovation and prevention as part of budget decisions? For example, in Glasgow, there was a decision to cut a transition from custody service, which will result in back-up in the prisons and cost the country more money in the long run. How do we avoid those short-termist reactionary decisions in future planning?

Caroline Cameron: To be honest, it will be really difficult to do so in the financial climate in which we are operating. As I described, our IJB is in the process of further developing and refining a recovery plan, which will see us take a significant amount of resource out of our care-at-home service even though we have people in the community on a waiting list who meet the threshold and criteria. We have delayed discharges as well, which I would not class as an early intervention and prevention service.

It feels like the opportunities around efficiencies and some early intervention approaches have been passed up in previous years, and we now are at a critical point. From a leadership perspective, it is really for us as chief officers to ensure that our IJBs understand the implications of some of the decisions that will be required to reach financial balance. It is about deciding on the priority of meeting our financial pressures and the pressures on our communities.

The missed opportunities are not lost on us. We celebrate the early intervention approaches and the outcomes that they deliver for people, but when it comes to providing life-and-limb, critical and substantial-needs services to individuals, those are the elements that we have a choice about delivering. That is the hard reality that we are all facing just now.

Paul Sweeney: On the point about empowerment, how do you articulate the absurdity, if you like, of the decision that you are being faced with? How do you communicate that to the wider system? Is that something that we could improve?

Caroline Cameron: Some comments were made earlier about the implementation gap for SDS. We could use that as an example and look at whether people see that as having been successful or not. There is a level of expectation in our communities about initiatives such as SDS and what they mean for the availability of care, for example. The reality is that the resources that we have to deliver care compared with the level of demand mean that we are not necessarily able to provide everything that people would like. We are all in a really difficult space and, practically, we are talking about rationing care.

We need to have really difficult discussions with our IJBs about which services we absolutely need to protect and cannot touch because of the unintended consequences that there could be. The services that I have discussed with my IJB include respite services, because of the impact that they have on vulnerable people as well as their carers, and our carer support services. We

are in really difficult territory where we have to have discussions about what we can afford to protect and what we cannot. I do not think that any of us is comfortable in that space, but it is the stark reality of the financial pressures.

The Convener: We have gone over our time and another member still has questions. Will you be concise, Ms Wearing?

Sharon Wearing: There are examples such as the family support services in Glasgow that prevent children from going into a higher level of care, which would cost us more money. It will be key for us to do more of that work going forward.

The Convener: I appreciate your brevity.

Sharon Wearing: You are welcome.

Joe FitzPatrick: Paul Sweeney strayed into the area that I was looking to talk about, which is longer-term sustainability and ensuring that there is collaboration, which we heard from the previous panel is key. Caroline Cameron touched on carers, which I also wanted to make sure that we touched on. I want to ensure that, when we talk about collaboration, we are not just talking about the IJB, the council and the health board but also recognise that the third sector, the voluntary sector and unpaid carers are important parts of the system.

How do we ensure that we are collaborating in a joined-up way? The pressures that the system is facing are only going to get more challenging as the population gets older and has more complex needs. I would be grateful if you could answer briefly.

Caroline Cameron: It is about ensuring that all those entities are round the table when we are having those discussions so that the possible impact of any potential decisions, as well as the positive impacts of the services, are well understood and we can build a case for what we need to do in the future.

Pat Togher: I touched on this earlier, but the scale of the savings plan for Edinburgh required an enormous amount of work and collaboration. I do not think that we would have had a budget approved to that extent had we not demonstrated sound collaboration—and not just with the delegated services, because there is a suite of non-delegated services including our carers and third sector partners. There is collaboration with all those bodies well in advance of those decisions being made, because they have an impact.

Joe FitzPatrick: Maybe Sharon Wearing can answer my other question. We have talked a lot about finances for long-term sustainability, but the other side of that is workforce planning and the challenges with that. The services were really impacted by Brexit. Are we getting over that and managing to start recruiting or is it still a real challenge that we are unable to have the full range of people who want to work?

Sharon Wearing: It is still a real challenge. If anything, from where we are sitting, it has gotten worse post-Covid. It is really challenging to recruit and retain staff at present.

The Convener: I thank the members of the panel for staying on slightly longer than was anticipated. I appreciate that you have very busy jobs and I appreciate your evidence to the committee.

At our meeting next week, we will undertake scrutiny of the Scottish Government's current review of the national outcomes as part of the national performance framework.

That concludes the public part of our meeting.

11:24

Meeting continued in private until 12:12.

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