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The Scottish Parliament
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Health and Sport Committee
Comataidh Slàinte is Spòrs

Looking ahead to the Scottish Government - Health Budget 2020-21: When is Hospital bad for your health?

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Health and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

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Introduction

1. At the start of the Parliamentary Session, the Committee agreed to adopt a full year budgeting approach, building an element of budget scrutiny into all aspects of its work, as detailed in its 2nd report, 2016 (Session 5) Health and Social Care Integration Budgets .

2. In 2018, the Committee undertook pre-budget scrutiny in May/June and published a report in October 2018 aimed to feed into the budget process, rather than responding to the Budget when published. The Scottish Government provided a detailed response shortly after the Budget was published, in December 2018. As such, the Budget Process Review Group recommendations were reflected in the Committee's approach.

3. In recent years, the focus of the Committee's budget scrutiny has been on Integration Authorities (IAs). The Public Bodies (Joint Working) (Scotland) Act 2014 required local authorities and NHS boards to form partnerships called integration authorities by 1 April 2016. The aim of the policy was -

> To improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older. [1]

4. IA budgets totalled £8.9 billion in 2018-19, of which £6.3 billion was delegated from the NHS budget. IAs therefore direct almost half of the total health and sport budget. The Committee agreed a continued focus on IA budgets in the pre-budget scrutiny for 2020-21, particularly in light of the ongoing concerns raised by the Committee in respect of the progress of integration.

5. The 2018 Audit Scotland report identified that Integration Authorities (IAs) are "operating in an extremely challenging environment and there is much more to be done". It made a number of recommendations in six areas -

- **Commitment to collaborative leadership and building relationships;**
- **Effective strategic planning for improvement;**
- **Integrated finances and financial planning;**
- **Agreed governance and accountability arrangements;**
- **Ability and willingness to share information; and**
- **Meaningful and sustained engagement.** [2]

The Ministerial Strategic Group for Health and Community Care (MSG), Review of Progress with Integration of Health and Social Care - Final Report, agreed with the Audit Scotland recommendations and comments that the recommendations should be acted upon in full by the statutory health and social care partners in Scotland. It

also acknowledges that "the pace and effectiveness of integration need to increase." [3]

6. To inform our work, we held informal sessions, in private, with Scottish Government officials and Audit Scotland. We also invited selected Integration Authority chief officers to give evidence to the Committee on 21 May and 4 June 2019. These meetings focussed on budget setting challenges, reporting against outcomes, operation of the set aside budget, performance data specifically in respect of delayed discharge and unscheduled care hospital admissions.

7. The timing of this report, in advance of the publication of the Scottish Government's budget, is to provide the Scottish Government with time to consider the implementation of our recommendations in its forthcoming budget 2020-21.

Budget setting process

8. Integration authorities direct health board and local authority funding. IA budgets consist of two elements, which may vary in size and scope depending on the functions delegated to the integration authority[i] -

   - Health care (including primary and community health, as well as relevant hospital services); and
   - Social care.

9. To set IA budgets, the integration authority, NHS and local authority partners work together to determine how much is required to deliver the delegated services and how much each partner will contribute to these identified costs. This budget is then directed to the integration authority. [4]

10. An issue the Committee has pursued vigorously over recent years is access to comprehensive and timely information on IA budgets. In response to Committee recommendations, the Scottish Government is now providing quarterly financial updates. While this is welcome, there is a time lag in reporting. This means that in May/June 2019, when the Committee was undertaking pre-budget scrutiny, no information was available on the budgets agreed for 2019/20. Through the normal reporting timescales, this information would not be available until September – six months into the financial year to which they relate. Therefore, whilst some progress has been made and welcomed, there remains a considerable delay in accessing information on budgets agreed at the start of the financial year.

11. We have previously been informed the reason for the delay in IAs agreeing budgets was due to the difference in financial planning timeframes in local authorities and health boards which has impacted on the agreement of budgets in advance of the start of the financial year. In response to this the MSG report recommended budgets be agreed by the end of March 2019 and, in response to a question in the Chamber, the Cabinet Secretary indicated she expected this timetable to be met. [5] It is understood that budgets are now being agreed more timeously. However, it remains challenging to access this information on a consistent and comparable basis until well into the financial year.

12. At our evidence session on 4 June 2019, we asked witnesses if there was a particular reason why timely financial information can not be provided to the Parliament. We received an overwhelmingly positive response from chief officers. Stephen Fitzpatrick, assistant chief officer for Glasgow Integration Joint Board (IJB) stated, “we set our budget at our March meeting, just over two months ago. It would be straightforward to find a mechanism to share that information with the Parliament. I’m sure that would not be problematic.” [6] This position was reiterated by Aberdeen City IJB and West Lothian IJB at the meeting.

13. **Scottish Government Response**

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i The Scottish Parliament Information Centre briefing, 'Health and social care integration: spending and performance update', page 16

The Scottish Government has indicated the challenge in reporting agreed budgets for IAs relates to the timing of IA board meetings, at which the release of financial information needs to be agreed by all partners. Although this is currently an obstacle to the provision of budget information, the positive reaction of those giving evidence to the Committee suggests it would be feasible to agree earlier release of budget information. This would ensure more timely access to budget information to inform partners, recipients and crucially to permit more informed parliamentary scrutiny.

14. We recommend the Scottish Government works with IAs to deliver more timely release of information on agreed budgets.

Link between budgets and outcomes

15. Integrated Authorities have a statutory duty to report against nine national health and wellbeing outcomes . In our budget report of 2016, we first raised concerns over the IAs' awareness of these reporting requirements and the apparent lack of progress towards publishing budget information of this nature. [7] Our 2018 report highlighted continued challenges with IAs adopting this approach. We concluded –

> The Scottish Government must, in advance of the publication of the budget, provide reassurance that developing budget information against outcomes is a top priority, advise when this information will be available and provide further information on the work that is being undertaken with the deadlines set for delivery. [8]

16. **Scottish Government View**

In response to the recommendation in our 2018 report, the Cabinet Secretary stated -

> We recognise the importance of linking expenditure to outcomes, and that it will enable us to establish the value of expenditure on services in terms of people's experience of care. Integration Authorities are making progress using the data provided via the Source system (managed by NHS National Services Scotland) and analytical support for strategic commissioning provided via the LIST (Local Intelligence Support Team) provided by NHS National Services Scotland. The processes for planning and reporting under integration – strategic commissioning plans that span three years, annual financial plans, and annual performance reports and financial statements – all provide important mechanisms to set out local expectations and experience of the relationship between spending and outcomes. [9]

17. It is our understanding that the Scottish Government is working with the Integration Authority Chief Finance Officer Network to provide guidance on linking budgets to outcomes. Reflecting on our 2016 and 2018 reports, we were keen to hear from witnesses what progress had been made.

18. However, when asked on 4 June 2019 what support the Scottish Government provides for developing budgeting relating to outcomes, limited information was given. The question was repeated again in written correspondence and we received the following responses –

> Aberdeen City have not received any support from the Scottish Government in this regard. (Aberdeen City IJB) [10]
>
> There has been limited support to date provided by the Scottish Government on outcome based budgeting. (West Lothian IJB) [11]
>
> The Scottish Government has been in discussion with the Chief Finance Officers in relation to this subject. (Glasgow IJB) [12]

19. Whilst Stephen Fitzpatrick, assistant chief officer for Glasgow IJB recognised,"there can be clear advantages from developing an outcome based budgeting model," [13] he also highlighted the challenges encountered from implementation. He argued it is "resource intensive and extremely complicated to develop a modelling tool which will accurately reflect which budgets contribute to the delivery of which outcomes". [14]

20. Edinburgh IJB also confirmed that "whilst the idea of linking money to outcomes is valid, it is not straightforward. There is not a one to one relationship between investing money in a service and getting the outcome that you want, because outcomes are delivered through a variety of services." [15]

21. In written evidence, South Lanarkshire IJB acknowledges the "complexity and level of ongoing change involved with integration makes it ***impossible*** to directly link cause and effect". [16] They are therefore using a tool called 'contribution analysis'. It is a method for linking inputs (such as time, money, expertise, resources) to outcomes (such as good quality of life, reduced inequalities) and is very useful when the inputs and outputs are complicated. The aim of the methodology is to identify the contribution a development intervention – such as a project or programme – has made to a change or set of changes. Aberdeen IJB confirmed they will be visiting South Lanarkshire to review this new approach.

22. East Ayrshire IJB highlighted that the Scottish Government is providing "rich data" [17] which helps to ask questions about the changes required in the community and identify the priorities.

23. It would appear that through their own initiatives, IAs are taking an innovative approach and sharing good practice in order to meet their statutory duty in this area.

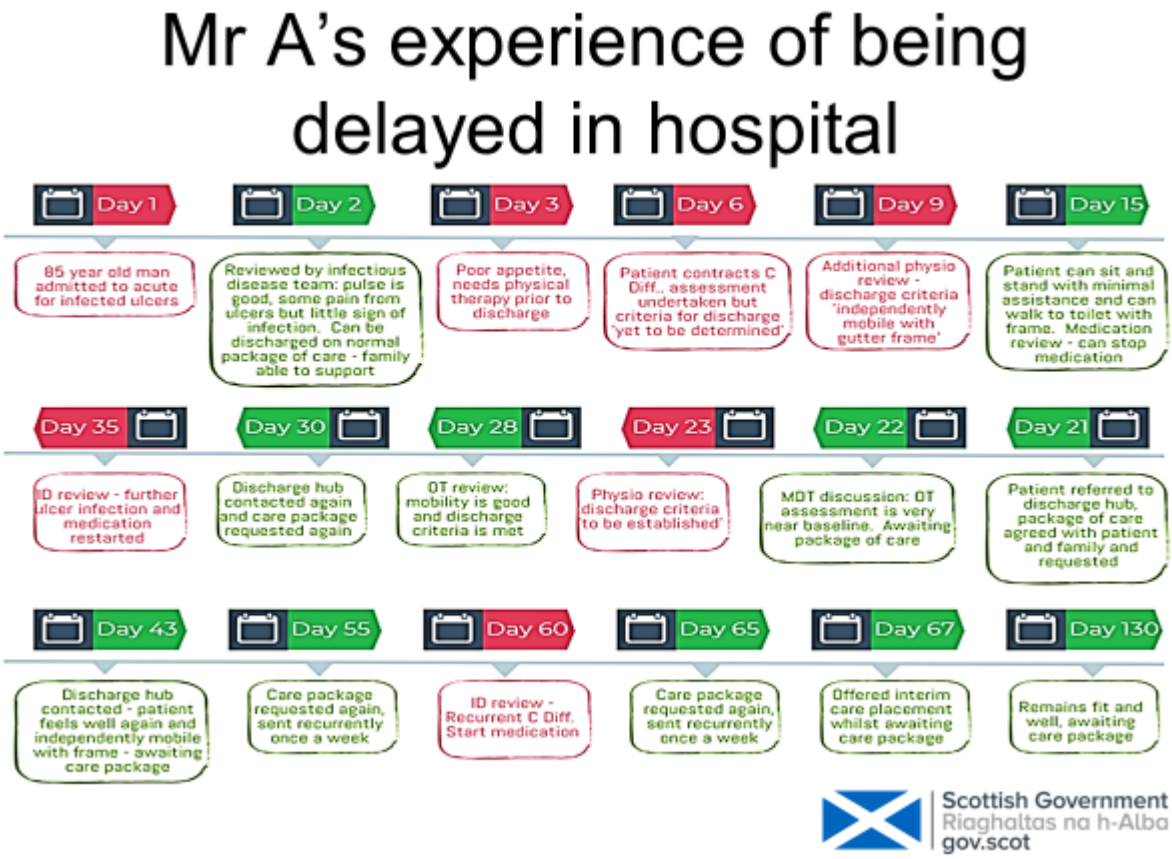
24. We expect this statutory duty to be met by all IAs and welcome an update from the Scottish Government as to when this will happen and how details of it will be reported. We would also welcome details of the support currently being provided by the Scottish Government in this area.

Delayed discharge

25. The Information Services Division (ISD) Scotland advise, “for most patients, following completion of health and social care assessments, the necessary care, support and accommodation arrangements are put in place in the community without any delay and the patient is appropriately discharged from hospital. A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place". [18]

26. Understanding the reasons for varying levels of delayed discharge in particular, was a key aspect of our Committee pre-budget scrutiny. If this aspect of the health service is not managed effectively, it has serious implications for the overall budget.

27. Prior to our oral evidence sessions for this inquiry, the Scottish Government provided the following information on delayed discharge. The diagram below represents a pathway for one delayed patient, Mr A. Mr A was an 85 year old man admitted to hospital with infected ulcers. He was still delayed after 130 days in hospital. This was his experience of care –



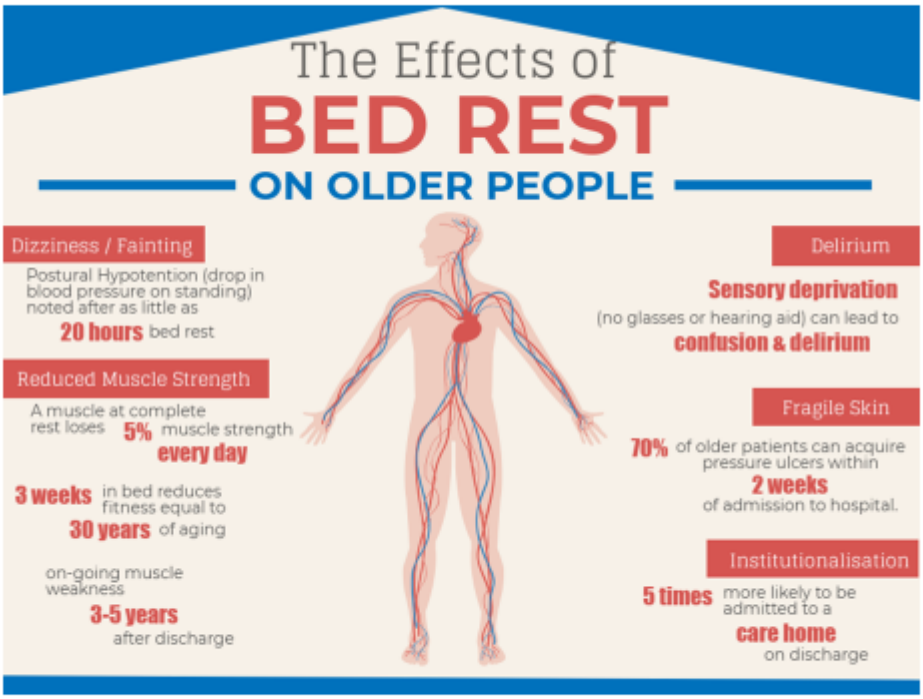
Source: The Scottish Government

28. Day 2 in Mr A’s journey through the care system was the window of opportunity to help him achieve a good outcome. Mr A had some pain but little sign of infection at this stage and his family were able to support him. An opportunity missed at Day 2

for Mr A led to a series of complications until Day 130 when he was finally ready to await a care package.

29. The Scottish Government also highlighted the detrimental effects of staying in hospital for too long and the physical impact this can have on the body, particularly for older people –

- Muscle wastage (3 weeks in bed = 30 years of ageing)
- Pressure sores, loss of independence, delirium – 5 times more likely to be admitted to a care home.
- Nearly 1 in 5 older people moving independently before admission will need assistance to walk after discharge.



Source: The Scottish Government

30. It could therefore be argued that that whilst sending patients home too early may pose a risk, keeping patients in hospital, when ready for discharge, is equally damaging to their health. Reviewing a patient's case and discharging them from hospital at the earliest opportunity is crucial (for example day 2 for Mr A). Once home, the patient's needs can be assessed and a care package finalised. Being assessed in their own home, with their family present is also likely to increase the patient's confidence.

31. We know that the Scottish Government is committed to significantly reducing the number of patients waiting to move to their next destination and the most recent Audit Scotland report found that there had been a reduction in delayed discharge between 2016-17 and 2017-18. However, this progress is not consistent across the

country as shown in the table below and in evidence from the chief officers on 4 June 2019. Also, in some cases positive progress in 2017-18 has been reversed in 2018-19.

4. Delayed discharge bed days; all reasons

Partnership of residence	2017-18	2018-19	Change (number)	Change (%)
Aberdeen City	**19,202**	**13,172**	**-6,030**	**-31%**
Aberdeenshire	16,334	17,221	887	5%
Angus	7,042	5,318	-1,724	-24%
Argyll & Bute	8,414	9,530	1,116	13%
City of Edinburgh	**76,933**	**81,071**	**4,138**	**5%**
Clackmannanshire	2,227	4,025	1,798	81%
Dumfries & Galloway	12,228	15,593	3,365	28%
Dundee City	10,893	9,376	-1,517	-14%
East Ayrshire	**4,730**	**5,038**	**308**	**7%**
East Dunbartonshire	3,557	5,031	1,474	41%
East Lothian	10,668	7,839	-2,829	-27%
East Renfrewshire	1,860	2,284	424	23%
Falkirk	16,726	19,644	2,918	17%
Fife	29,173	33,811	4,638	16%
Glasgow City	**29,897**	**38,656**	**8,759**	**29%**
Highland	36,302	37,824	1,522	4%
Inverclyde	1,609	835	-774	-48%
Midlothian	12,295	12,934	639	5%
Moray	11,487	12,727	1,240	11%
Na h-Eileanan Siar	5,854	7,876	2,022	35%
North Ayrshire	16,854	19,373	2,519	15%
North Lanarkshire	36,834	34,760	-2,074	-6%
Orkney Islands	1,411	452	-959	-68%
Perth & Kinross	16,785	14,203	-2,582	-15%
Renfrewshire	4,680	6,085	1,405	30%
Scottish Borders	14,246	12,750	-1,496	-11%
Shetland Islands	1,499	1,395	-104	-7%
South Ayrshire	14,152	21,536	7,384	52%
South Lanarkshire	**41,187**	**38,473**	**-2,714**	**-7%**
Stirling	5,827	6,991	1,164	20%
West Dunbartonshire	3,439	3,512	73	2%
West Lothian	**19,269**	**21,880**	**2,611**	**14%**
Stirling and Clackmannanshire	8,054	11,016	2,962	37%
Scotland	493,614	521,215	27,601	6%

Source: Information Services Division (ISD)

32. The table above illustrates the number of days where beds are occupied by patients ready to be discharged, for each IA over the past two years. The overall figure for Scotland has increased from **493,614** (2017/18) to **521,215** (2018/19), an increase of **6%** overall.

33. Theresa Fyffe, Director of Royal College of Nursing Scotland, commented on the ISD report and 6% increase -

> It is unacceptable for people to be kept in hospital unnecessarily and is completely at odds with the Scottish Government's vision of safe, high quality care at home or in a homely setting. More must be done to improve the resources in our communities.
>
> Scotland's care homes are struggling to recruit the nursing staff required to ensure they can meet the needs of those who are well enough to be discharged from hospital but continue to require clinical care.
>
> The Scottish Government must do more to address these workforce challenges and ensure Integration Authorities and NHS boards have the resources they need. [19]

34. Of the six IJBs who gave evidence to our Committee, Aberdeen City has seen the most substantial reduction at -31%. In written evidence, they also stated, "comparing the total number of bed days lost to delayed discharges in year 2015/16 to the bed days lost in the most recent full year, 2018/19, there has been a 70% decrease recorded. Through a programme of dedicated work focussing on delays (alongside wider prevention workstreams), year on year decreases have been achieved". [20]

35. New figures obtained through Freedom of Information legislation on 12 September 2019, revealed that "86 people died in Lothian hospitals in 2018/19 while waiting to be discharged, the highest number in Scotland". [21]

36. Age Scotland, also published research earlier this year which highlighted the average waiting time for people to access social care after being assessed as having "critical" or "substantial needs" was five weeks in Edinburgh and more than six weeks in West Lothian. The longest wait was more than 35 weeks. [22]

37. Brian Sloan, chief executive of Age Scotland, described the situation as "tragic". He said -

38. > These are people who were well enough to be discharged, but most were delayed because the social care they needed was not available.
>
> Despite the Scottish Government's repeated promises to tackle delayed discharges, these figures show that the problem is spiralling out of control. It's unacceptable that people in Edinburgh and the Lothians face waits of up to 35 weeks to get the care they need. We urgently need more investment in our social care system, so that every older person can access the care they are entitled to. [23]

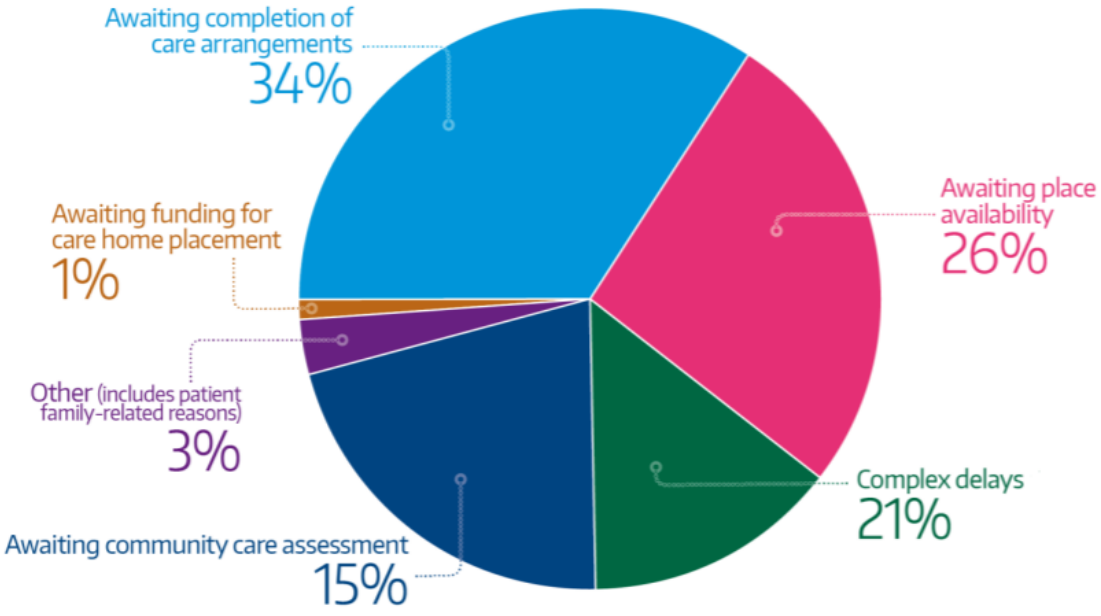
39. West Lothian IJB has experienced an increase of 2,611 (14%) over the past two years. Chief officer, Jim Forrest, addressed the concerns on delayed discharge at our Committee meeting. He admitted their "performance on delayed discharges deteriorated quite significantly about 18 months to two years ago". [24] He argued that the cause of this delay is due to care home beds being at full capacity, the standard of care homes decreasing which affects new admissions, a change in demographics and significant operational issues. [25]

40. Glasgow City IJB has also experienced an increase of 8,759 (29%). However, Stephen Fitzpatrick, assistant chief officer for Glasgow IJB, highlighted progress made on delayed discharge over the past few years, stating, "our performance in managing delays has improved progressively since 2011 to December 2017, when our performance experienced its first sustained reversal in almost 7 years. Performance has since consolidated at a higher level compared to November 2017". [26] He did also readily admit that the IJB has “already realised most of the opportunity that exists to improve the overall impact of delays on the system”. [27] Stephen Fitzpatrick made a key point that hospitals can only make limited progress on delayed discharge moving forward. The strategic focus needs to “move away from the back door, to the front door". [28]

Reasons for delayed discharge

41. The ISD report published on 11 September 2018, highlighted the key reasons for delayed discharge in Scotland. In 2017/18, awaiting completion of care arrangements was the most frequent reason with an average number of 459 delays (34%). In addition, an average of 347 (26%) delays were due to people waiting for care home availability and 285 (21%) delays were due to complex delay reasons, which includes delays under adults with incapacity legislation. Awaiting community care assessment accounted for 15% of delay reasons, other reasons (including patient and family related delays) accounted for 3% and delays awaiting funding for care home placements accounted for 1% of delay reasons. [29] The information is illustrated in the figure below.

42. **Figure 8: Proportion of delayed discharges by reason; Scotland; Apr 2017 - Mar 2018**



Source: Information Services Division (ISD)

Cost of delayed discharge

43. The ISD report also estimated the cost of delayed discharges in 2016/17 in Scotland was £125 million, with an estimated average daily cost of £234 per patient, per day. In comparison, the estimated cost of delayed discharges in 2015/16 was £132 million and an estimated average daily cost of £233 per patient, per day. [30]

44. It is recognised a focus on the most effective pathway for patients commencing at pre-admission and admission will reduce delays in discharge and help to alleviate costs and pressures on acute care.

Intermediate care

45. To reduce delayed discharge in hospitals, intermediate care is used in some areas of Scotland to varying degrees. In follow up evidence to the Committee, Stephen Fitzpatrick, assistant chief officer at Glasgow City IJB, advised that "the aim is to ensure that patients discharged from hospital, where possible, return to their own home. However, for some individuals, a return home is not possible due to the level of support required at that time of discharge, the housing circumstances which may not support discharge, or a requirement to undertake further assessment in order to ensure effective decision making about the longer term needs of the individual". [31] He also advised, there are "90 beds commissioned within 6 x 15 bed units across Glasgow City which act as a step down facility for residents of Glasgow City from hospital". [32]

46. We also heard from Kenny O'Brien, service manager at Aberdeen City IJB. He stated, there are "20 beds in a care home that deliver intermediate care with wraparound physiotherapy and OT [Occupational Therapy] but we also have 19 flats that are designed to mimic a person's own front door and their home." [33] Patients can regain their independence whilst they are being assessed. Often, the amount of care, support and social care a patient requires initially, is reduced as a result of the intermediate care model.

47. Although progress has been made by way of intermediate care, it was suggested that a reduction in delayed discharge figures does not "directly mean that people are getting their social care packages quicker". [34] Intermediate care is not a final destination for the patient, it merely moves them out of the acute setting and alleviates pressure on the ward whilst the patient is assessed at another location. Returning patients to the most appropriate destination is still being delayed regardless of the terminology used. In Glasgow, we heard that patients can often wait four weeks until a package at home or appropriate social care setting is provided. [35]

48. We also received written evidence to confirm that "West Lothian does not operate a bed based model of intermediate care as an alternative to a care at home approach". [36] Therefore, as the intermediate care provision does not operate in all areas of the country, it is difficult to gauge its sustainability and success.

49. Some reductions in delayed discharge have been made by utilising intermediate care. However, we heard evidence that not all IJBs use this model of care and it has varying degrees of success across Scotland.

50. We ask the Scottish Government to advise if intermediate care is an appropriate approach to caring for vulnerable people and if so should it be implemented across the country. We also request the Scottish Government to advise what data on intermediate care is available and their intention to collect and publish this data.

Unplanned acute bed days

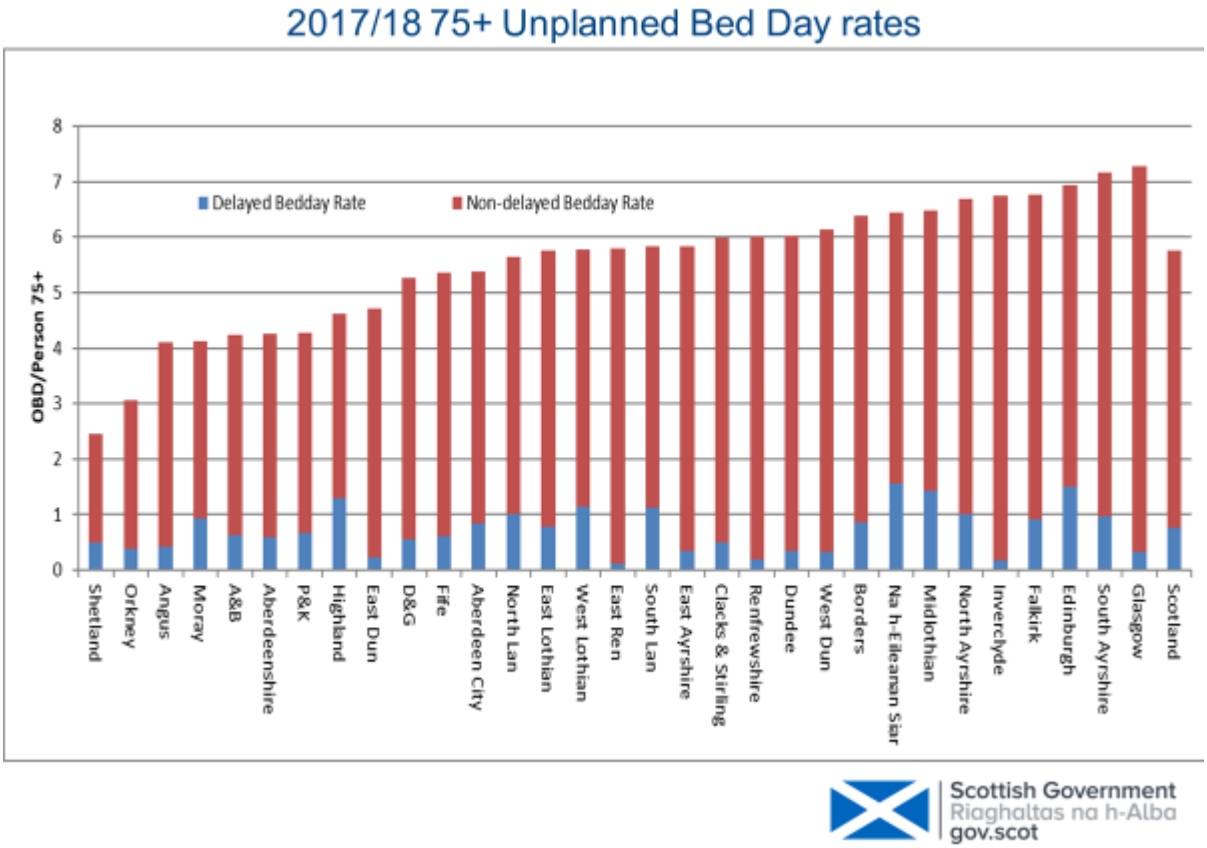
51. In addition to delayed discharge and intermediate care, chief officers discussed acute unplanned bed days with us, which is also an indicator monitored by the MSG. It is intended that more effective integration of services will help reduce the number of unplanned acute bed days. As outlined earlier in our report, attention also needs to focus on preventing hospital admissions.

52. Glasgow's IJB board paper in May describes how the IJB is tackling unscheduled hospital admissions. It highlights a decrease in unscheduled acute bed days in each year since 2016-17. However, the trajectory suggests an increase in 2019-20. Glasgow's written evidence to the Committee states that,"progress has been made in relation to unscheduled hospital admissions, and bed days lost due to delays" but it has been challenging.

53. Eddie Fraser, chief officer for East Ayrshire IJB, commented on the lack of any reduced pressure in acute services in response to reductions in unscheduled bed nights –

> MSG indicators on unscheduled care bed nights show that many partnerships across Scotland—probably the majority—have reduced the number of unscheduled care bed nights that they commission from the acute sector, but sometimes the acute hospitals are just as busy. In board areas such as NHS Ayrshire and Arran, where more than one IJB uses a hospital, all the partners need to reduce the pressure on the hospital before there is any release" of unscheduled care beds. [37]

54. The Scottish Government provided us with data which illustrates the number of unplanned bed days per person aged 75+ by partnership. On average, delays make up 13% of overall bed days, but this varies from 2.5% in Inverclyde to 28% in Highland.



Source: The Scottish Government

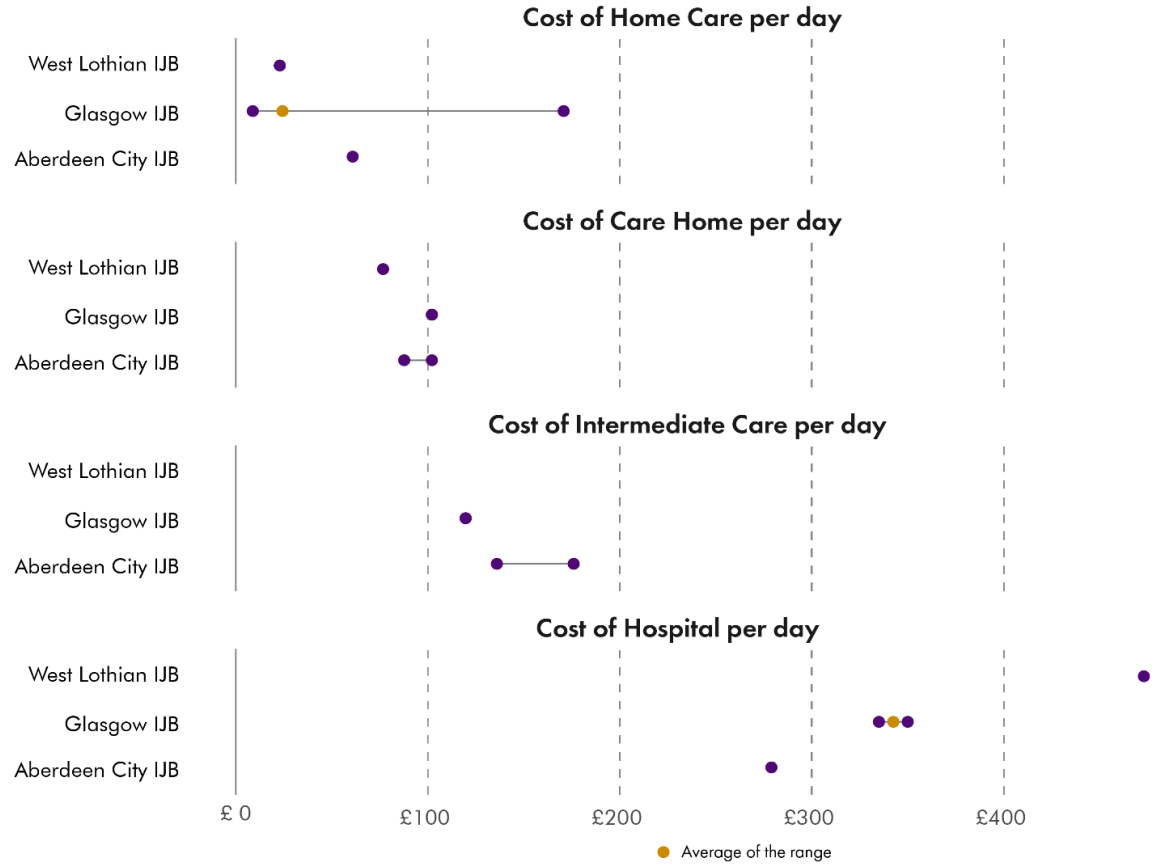
55. Sandra Ross, chief officer for Aberdeen IJB, also highlighted the way in which the city has addressed hospital admissions. They have “tested and implemented acute care at home, which started off being geriatrician led, and through which people have either been coming out of hospital or have been turned around at the front door”. [38] Often, patients with dementia are re-admitted to hospital and Aberdeen are considering a dementia village to alleviate this concern. Sandra Ross also confirmed the IJB "work closely with GPs and care homes in order to maintain clinical oversight of patients" [39] and reduce hospital admissions if they can be prevented.

56. On a similar theme, Jim Forrest, chief officer for West Lothian IJB, outlined the ways in which they are tackling dementia in the area without hospital admissions. He stated, “we seconded a GP to work with a nurse practitioner to go round all our care homes to look at how we set anticipatory care planning for patients”. [40] In addition, West Lothian have also created a mental health team led by psychology colleagues. The team work with care home staff to provide support for patients. [41]

57. The Committee requested further information on the range of daily costs for each care environment. The information below was provided by Glasgow, Aberdeen City and West Lothian IJBs. It is clear that the average cost of hospital per day in each of the three IJBs is greater than all other care settings provided.

58.

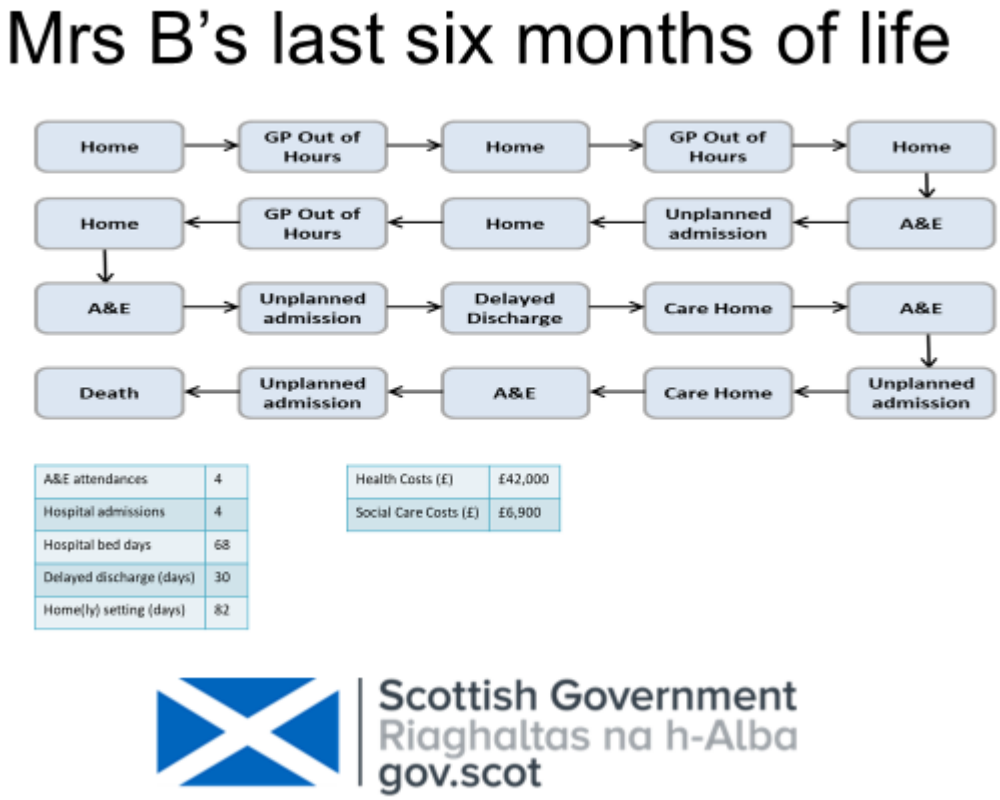
Costs of care in different settings



Source: The Scottish Parliament

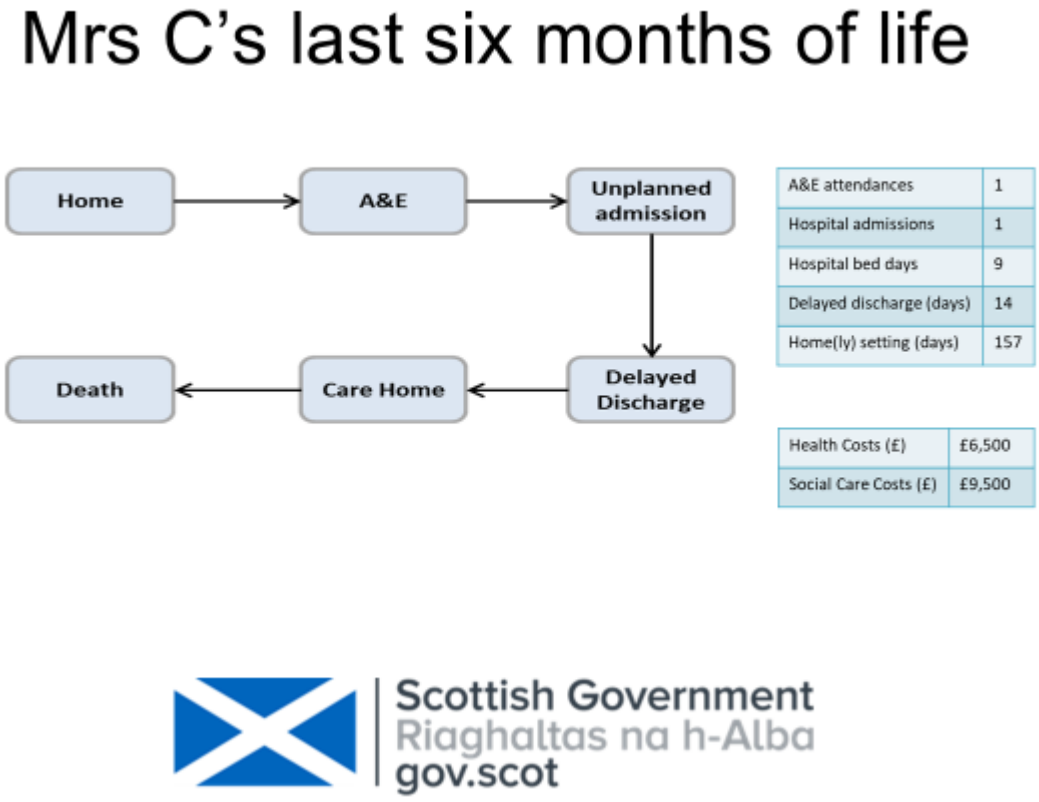
59. The Scottish Government also provided us with a case study to illustrate the costs involved for the last six months of a patient's life and their journey through the health care system.

60. The diagram below illustrates Mrs B's experience of care at age 80. Mrs B had five long term conditions (Arthritis, Cancer, Chronic Obstructive Pulmonary Disease (COPD), Dementia and Diabetes) and lived in a relatively deprived area. Mrs B was living at home at the start this period. Mrs B spent 55% of her last six months in hospital; 30% in a care home; and 15% at home. The cost of her care was **£49,000.**



Source: The Scottish Government

61. By contrast to the care of Mrs B, the diagram below illustrates a different example from the same partnership. Mrs C was another 80 year old woman, she had four long term conditions (cardiovascular disease, chronic heart disease, chronic obstructive pulmonary disease (COPD) and dementia) and lived in a relatively affluent area. In total, Mrs C spent 46% of her last six months at home and 41% in a care home, the rest (14%) being in hospital. The cost of her care was **£16,000.**



Source: The Scottish Government

62. Reviewing the above information from the Scottish Government and written submissions, it is clear that the daily cost of intermediate care, home care or a care home are all significantly less than residing in hospital. It is clear that whilst delayed discharge is a key issue across Scotland, it is not the sole reason for delays and there are opportunities which exist and could be utilised, for example, preventative medicine.

63. Reducing the number of patients entering hospital by meeting their needs in the community, will have a positive impact on occupancy, staffing levels and waiting times overall. This will also improve outcomes for patients and reduce costs.

64. The Integration Authorities are vital to making progress in this area. Yvonne Lawton, head of strategic planning at West Lothian IJB, advised, "we should be looking at it from the other angle. If we presume that home is the first place that we want to be, how can we design our systems around maintaining someone at home for as long as possible?". [42]

65. In agreement, Sandra Ross, chief officer at Aberdeen City IJB advised, "we need to start looking at the whole system and thinking about how to shape the prevention agenda. How do we make sure we that we will have fitter adults? We need to focus on our children, then we will have less ill population in the future. That prevention agenda will help shift that balance. Given the demographics, it will be extremely difficult to maintain things if we continue with what we have at the moment." [43]

Housing adaptations

66. Another area fundamentally linked to delays in discharge and the transformation of delivery of services from acute care into the community are housing adaptations. When patients are in hospital and due to return to the community, often discharge is delayed as their house requires an adaptation or they are waiting on suitable accommodation to meet their needs. We heard that “adaptations are a good, robust example of work that we do to sustain people in their homes". [44]

67. The issue of housing adaptations was also addressed by the Local Government and Communities Committee in their 2019-2020 pre-budget scrutiny . In a letter to that Committee, the Cabinet Secretary for Communities said –

> We are grateful to the Committee for its continued interest in our work on housing adaptations. This work has a practical focus, identifying barriers and potential areas for development within existing regulations, guidance and practice relating to adaptations. Officials will work actively with stakeholders to support Integration Joint Boards and their partners to improve arrangements at local level in the planning and delivery of the adaptations and ensure the person centred, tenure neutral approach to housing adaptations that both Ministers and the Committee want to see right across the country. We expect this work to continue to progress over the course of the calendar year and complete by the end of 2019. [45]

68. We asked chief officers if they felt there remained barriers to the timely provision of housing adaptations and any particular aspects that needed addressed. Kenny O’Brien, service manager for Aberdeen City IJB admitted there has “certainly been pressure on budgets and increasing demand” [46] but they have done relatively well in Aberdeen on this issue. He observed, there will always be a “lag of time from the identification of the need to completion”. [47] However, the IJB is working hard with social work employees and discharge hubs. "If someone has surgery for an amputation and we know that they live in a tenement three floors up, rather than wait until they are referred, we will get housing issues sorted earlier". [48]

69. The IJB has also obtained tenancies of two disabled-access and wheelchair accessible flats in the city. They have been adapted significantly to “work with a wide spectrum of individuals with different occupational therapy and adaptational needs”. [49] This initiative, allows patients to leave hospital sooner and retain their skills and independence, whist they are waiting to be rehoused or for their own home to be adapted.

70. Stephen Fitzpatrick, assistant chief officer for Glasgow IJB, confirmed that housing adaptations is a live issue in Glasgow too. They had saught to “prioritise and protect the budget when income for social care has been reducing”. [50] Whilst noting the importance of adaptions, he also highlighted that the issue is a “marginal factor in delayed discharge in Glasgow and a marginal cause of unscheduled admissions to acute care”. [51] The balance of care within the community is key.

71. South Lanarkshire stated, "supporting people and households to live independently in their own home or a homely setting within the community is a core cross-cutting theme." [52] They also advised that "over the three year period since 2016, a total of £15.587m has been spent by Housing Services on equipment, adaptations and the care of gardens to support people to remain at home." [53]

72. The Local Government and Communities Committee have completed work on housing adaptations during their pre-budget scrutiny for the past two years. We endorse their conclusion that "people should have access to a safe and secure home which meets their needs. A properly funded, streamlined and effective adaptations programme is an important part of enabling people to remain in their homes for longer as well as enabling people to more quickly return home from hospital thus reducing delayed discharge". [54] We also note a key recommendation of the Report of the Adaptations Working Group stating there should be a strategy for housing adaptations, which is 'tenure neutral' with a single funding source.

73. Further information can be found in their Report on the Scottish Government's Draft Budget 2018-19 and Report on the Scottish Government's Draft Budget 2017-18

74. It is clear that sustained focus on the timely provision of housing adaptations is a necessity to enable older people to live at home for longer. All IJBs we contacted, acknowledged the significance of housing adaptions and the need for funding requirements but accepted it is only one aspect of transferring care from acute services to the community.

Changing perceptions

75. We have highlighted the daily cost of residing in hospital compared to home care, intermediate care or a care home and shown that shifting the balance of care from acute services to the community using preventative care and housing adaptations is a positive, necessary and cost effective move. Public engagement on changing models of care was another theme we explored in our inquiry.

76. Eddie Fraser, chief officer for East Ayrshire IJB, illustrated his concern on this topic when he said, “our clinicians are only willing to transfer care if they see safe alternative models of care: if a practitioner is not going to refer someone to hospital, there must be an alternative that they feel is safe”. [55]

77. Val de Souza, chief officer for South Lanarkshire IJB, agreed, highlighting the challenges for integration authorities in the future. She said, “we work in an environment in which demand and complexity are increasing as people live longer and with more conditions”. [56] Transformation of services is required and we “need bigger national messages to bring the public with us in relation to what is required to take the next steps”. [57] Val de Souza also acknowledges that many people in society do not like change, but it is the responsibility of chief officers to lead on this transition, demonstrate that change is good and promote confidence in the system.

78. Val de Souza, also saw a need to change perceptions around hospital and community care –

> We need a scattergun approach to communicate the need for change and the fact that being in hospital is a bad thing. The general public still believe that a hospital is a good and safe place in which to be, but—with no disrespect to my acute colleagues—it is not a place in which to languish or stay. [58]

Transformation of services

79. It was suggested the term 'transformation of services' requires further clarity and to be clearly communicated to members of the public. It is estimated that a saving of £300 million must be made across the 31 integrated authorities this year and every year for the next three years. [59] To achieve this £900 million, difficult decisions will have to be taken, resulting in a change to the way services are delivered throughout each community. Eddie Fraser, chief officer for East Ayrshire IJB, is of the view that it is still possible to make savings and invest in the community. He argued that individuals need to feel valued and included, stating, "our public health colleagues tell us that the impact of someone being excluded and of social isolation is the same as if they smoked 15 cigarettes a day". [60]

80. **Scottish Government view**

In a response to our report in 2018, "Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?", the Cabinet Secretary for Health and Sport committed that, "by the end of this Parliament, more than half of frontline NHS spending will be in community health services". [61] In order to accelerate the pace of change required in behaviour and practice, we asked the Scottish Government to consider re-evaluating this aim and whether a more ambitious target could be provided.

Latest figures show a shift towards community health services in 2017-18. The level currently stands at 49.6% and this is set out in the diagram below.

81.

Shifting Balance of Care to Community Health Services

		2017-18			2016-17		
NHS Board		Hospital £000	Community £000	Total £000	Hospital £000	Community £000	Total £000
Total Spend		5,996,859	5,895,041	11,891,900	5,882,803	5,669,166	11,551,969
Balance of Care Split		50.4%	49.6%		50.9%	49.1%	

Source: The Scottish Government

82. The Scottish Government's Ministerial Strategic Group (MSG) for Health and Community Care focuses on six indicators that are regularly monitored. These are -

- Acute unplanned bed days;
- Emergency admissions;
- A&E performance (including four-hour A&E waiting time and A&E attendances);
- Delayed discharge bed days;

- End of life spent at home or in the community; and
- Proportion of over-75s who are living in a community setting. [62]

83. Audit Scotland reviewed performance data for each of the above indicators and found that performance had improved against four of the indicators. Performance had weakened in respect of emergency admissions and A&E performance.

84. Audit Scotland also found significant local variation in performance between IAs. The MSG report also made reference to the variation in performance and highlighted that future savings within the health and social care budget depend on reducing this variation –

> The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. [63]

85. Nationally, there is a mixed picture of success of integration for the six Ministerial Strategic Group indicators (Table 1).

86. **Table 1. Indicators of Scottish integration over time**

n/a indicates unavailable or, in the case of delayed discharge, changes in definitions that make earlier data incomparable to recent data

Scotland totals	2014/15	2015/16	2016/17	2017/18	2018/19	Positive or negative change?
Number of emergency admissions	n/a	581,195	583,277	588,250	n/a	Negative
Number of unscheduled hospital bed days	n/a	4,061,338	4,055,254	4,009,233	n/a	Positive
Number of A&E attendances	n/a	1,447,636	1,468,893	1,496,553	1,540,654	Negative
Number of delayed discharge bed days	n/a	n/a	n/a	493,614	521,215	Negative
Percentage of last six months of life spent in the community	86.2	86.7	87.0	87.9	n/a	Positive
Percentage of population residing in non-hospital settings for all people aged 65+	98.8	98.8	98.9	98.9	n/a	Positive

Data from Scottish Government, personal communication

Source: The Scottish Government

87. A report highlighting progress of the MSG indicators will be considered in November 2019. We request that the Committee is kept informed.

88. We acknowledge the steps taken to streamline the patient journey from hospital to the community with regards to intermediate care and the financial commitment from the Scottish Government for at least 50% of frontline NHS spending to take place in the Community Health Service by 2021. However, delayed discharge continues to be a key issue and progress remains inconsistent across Scotland. It is clear that the daily cost of intermediate care, home care or care homes are all significantly less than residing in hospital and further improvements would both

be of benefit to patients and also deliver budget savings. We are also concerned for the physical and mental well-being of the patient if the risk of residing in hospital is greater than the risk of being discharged.

89. We recommend an increased focus is given on the 'front door' of hospitals reducing unscheduled care and admissions and ensuring the needs of patients are met and addressed in other areas of the NHS. A proactive approach with emphasis on preventative medicine, GPs working with care homes and district nurses in the community will reduce heavy reliance on acute services.

90. We recommend a review of communication strategies around alternatives to GP referrals. GPs must have the confidence to offer alternative aspects of the health care system to the patient. Hospital is not always the best and most suitable option.

91. We also recommend an increase in the provision of health education and awareness, particularly in relation to ensuring patients are fully informed of all options to obtain appropriate advice and care. This will reduce unnecessary calls to the GP, out of hours service and A&E. In turn, this will assist in alleviating costs and pressures on the acute service.

92. Where there is more than one IJB using the same acute care service, it is essential they work together to reduce the number of unscheduled care admissions.

93. Priority also needs to be given to housing adaptations - reviewing and speeding up ways in which the move from hospital to person-centred accommodation is provided. IJBs must improve arrangements at a local level in the planning and delivery of adaptations across the country. This needs work to be monitored and reported on and its delivery from the next calendar year onwards. We look forward to receiving an update on progress towards implementing the recommendations in the Adaptations Working Group report.

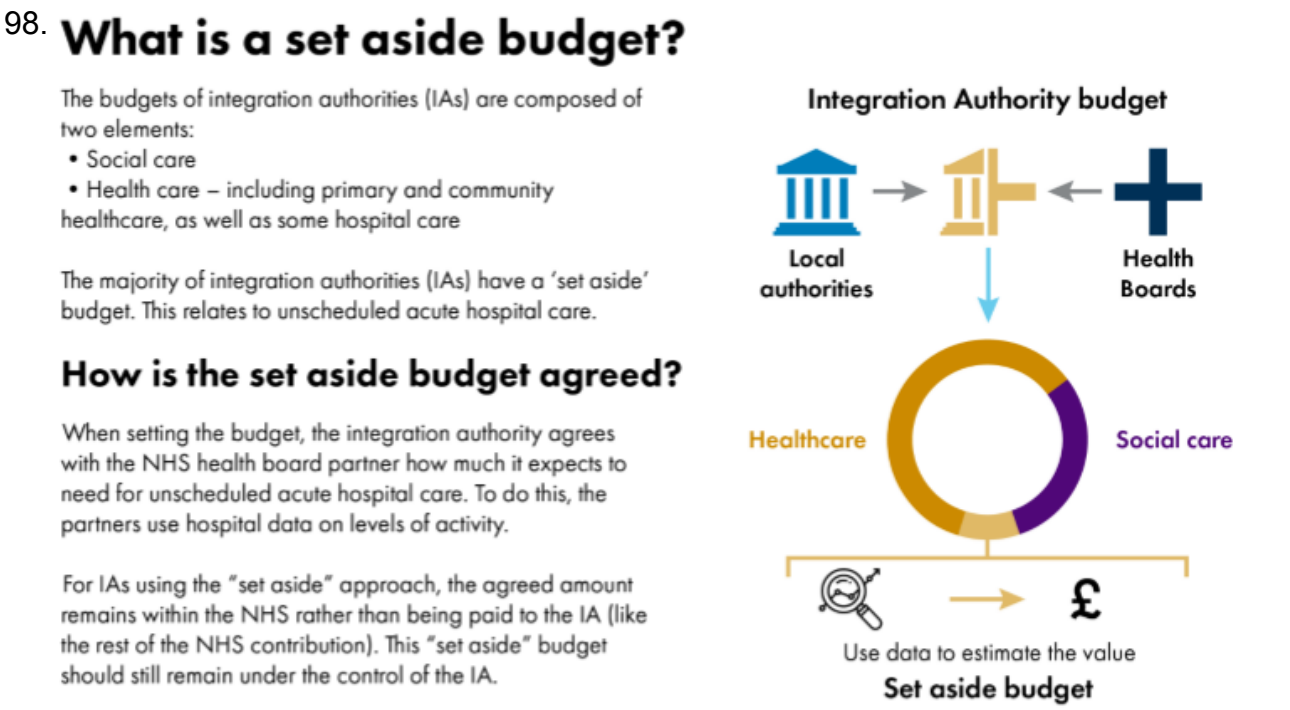
94. It is clear there is a responsibility on the chief officers to lead and fully engage with the local authority, health board, Scottish Government and wider community in order to move forward with the transition in the way services are delivered. A shift in public perception and expectation is required. All public bodies must work towards this outcome and it is imperative there is transparency, confidence and openness in the health care system.

Set aside budget

95. Closely linked to unplanned acute bed days/unscheduled care is the set aside budget. The set aside budget represents the Integrated Authorities share of the budget for delegated acute services provided by large hospitals on behalf of the IA.

96. An IA identifies how much it expects will be required for unscheduled care in its area. A decision is then made as to whether this amount is included or excluded in the sum allocated to the IA by the NHS Board. When not directly included, it is "set aside" and retained by the NHS Board to be drawn down by the IA as needed.

97. Some NHS boards manage set aside differently and do not use this terminology but the principle we are referring to is described in this section of the report and illustrated in the diagram below -

98. 

Source: The Scottish Parliament

99. If expenditure on delegated acute services is more than the amount anticipated in the budget, the IA will be required to fund this additional expenditure from elsewhere in the budget. Alternatively, if expenditure is lower than anticipated (for example a reduction in A&E or unplanned admissions) then the IA should – in theory – have access to the funds released and be able to direct that additional funding to other parts of its operation.

100. Set aside was a topic we followed closely in our 2018 report, "Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?". We concluded that "there remains a disconnect between how the set aside budget should operate in principle compared to how it is operating in practice". [64] It was apparent that IJBs were not

effectively controlling set aside and funds were remaining under the control of the health board.

101. We also concluded that "The Scottish Government described the set aside budget as a mechanism for shifting the balance of care, however this mechanism is not being utilised effectively across all IAs. Some IAs describe the budget as a "notional" budget rather than an actual budget that they can use to affect change." [65]

102. **Scottish Government view**

In response to our conclusions in the 2018 report, the Cabinet Secretary confirmed-

> We need to step up the pace of integrating health and social care. Truly integrated services, focused on the needs of citizens – individuals, carers and families, and on the health and wellbeing of local communities – require leadership and personal commitment. We need to act together to accelerate progress. We expect each health board, in partnership with the Local Authority and Integration Authority, to fully implement the set aside requirements of the legislation in line with the statutory guidance published in June 2015. [66]

103. Following our report, the Ministerial Strategic Group report agreed the set aside budget is not operating as intended -

> Each Health Board, in partnership with the Local Authority and IJB, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. These arrangements must be in place in time for Integration Authorities to plan their use of their budgets in 2019/20. The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. The set aside arrangements are key to delivering this commitment. [67]

104. Reflecting on the outcome of our 2018 report, we were intrigued to hear further evidence on this aspect of the budget. Stephen Fitzpatrick, assistant chief officer of Glasgow City IJB, outlined the difficulty when an acute service is operating at 90% capacity. He stated there is reluctance to release some of the resource to invest in community alternatives. He accepted that the "system can not be sustained" [68] unless funding can be reviewed and there is a more efficient way to fund services. A whole system approach is required.

105. We also heard the set aside budget is clearly not working as originally intended in South Lanarkshire. Chief finance officer, Marie Moy suggested, "Over the next eight years up to 2027, the older population in Lanarkshire will increase by almost 30%. To accommodate that increase, [we] would need to make available more beds and social care home services by shifting the balance of care. The underlying assumption that we could release resources from the acute services to fund [a shift to community care] is unrealistic and flawed". [69]

106. On a more positive stance, Edinburgh IJB were able to provide the Committee with examples of where they have "planned and delivered services differently with

funding from acute services being used or earmarked to deliver more community based or community facing, services –

- Services for people transferred from the Acute Mental Health Royal Edinburgh Hospital to deliver support to people in their own tenancy in the community;
- Closure of the Corstorphine Hospital and support to men and women with learning disabilities in the community in their own homes; and
- Plans for the closure of the Liberton Hospital and for resources there to deliver community models of support, re-enablement and early intervention under a Home First model." [70]

107. South Lanarkshire IJB were able to provide a concrete example of when the set aside budget has been used effectively although recognising there was "no pathway or guidance when [they] started to work on it." [71] Their example of Udston Hospital was also used as a case study in the 2018 Audit Scotland Report "Health and social care integration: Update on progress".

108. The case study reported on the closure of a care of the elderly ward at Udston hospital, after it was identified that patients could be better served in a community setting. "Prior to the ward closure, it was estimated over £1 million would be available to be used for other aspects of the health care system. Of this, it was eventually agreed that £0.70 million should be redirected to improve or provide community-based services. The remaining £0.37 million was retained by the hospital sector, to meet cost pressures on the set aside budget (such as inflation) and for reinvestment in acute hospital services, as demand was expected to change as a result of the ward closure. The plans for the £0.70 million for community reinvestment (alongside £0.06 million from elsewhere in their budget) are illustrated in the diagram below". [72]

109. **South Lanarkshire reinvestment to community services**

Service	Spend (£000s)
Homecare	376
Community nursing	243
Support Workers	60
Physiotherapy	40
Pharmacy	42

South Lanarkshire IJB, 2019[36]

Source: The Scottish Parliament

110. The aim of this transition was to address the need for services that respond to crisis care, prevent hospital re-admission and reduce the need to reside in hospital.

111. Particular issues identified during the process were -

1. Consultation and engagement - the integration joint board undertook public engagement to develop their Strategic Commissioning Plan allowing for the ward closure and change to community care (and existing governance arrangements as they related to engagement with NHS staff).

2. Ownership of the money and savings, as well as how these were spent – it was complicated to determine and agree where identified savings belonged in relation to the integration authority, health board, or local council. [73]

112. Set Aside budgets continue to be problematic in many ways including initial identification and release of “savings”. This is an unacceptable position four years after integration and we expect all issues to be resolved by the end of this financial year and clear identification of released sums reported quarterly.

Leadership and cultural change

113. Leadership and the importance of relationships has been a theme throughout our work this session, during our pre-budget scrutiny and an issue we investigated in our 2018 report, "Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?". In the 2018 budget report, we concluded that "a number of integration authorities do not appear to be exerting [a] challenge function and ultimately their authority and control over the budget is being dictated by individual partners". [74]

114. That report further states, "We do not believe at this stage we are seeing evidence that IA leadership across all 31 IAs is equipped to deliver [the required] change in relationships and ultimately deliver the transformational change in health and social care that is required". [75]

115. Audit Scotland found that "a lack of collaborative leadership and cultural differences are affecting the pace of change" and highlighted the high level of turnover at senior level, the dual roles often held by chief officers/chief financial officers and the lack of support services.

116. The Ministerial Strategic Group report also committed the Scottish Government and COSLA to identify and address leadership development needs and stated that "relationships and collaborative working between partners must improve".

117. **Scottish Government View**

The Cabinet Secretary for Health and Sport provided the following response to this aspect of the Committee report on 21 December 2018 –

> The Scottish Government agrees that strong, effective leadership centred on partnership working across health and social care is central to the success of integration. It is important to be clear that responsibility for making good progress in reasonable timescales is shared across the system and does not sit solely with individual organisations or individuals, no matter how senior. Trust between partners varies around the country. We are committed to ensuring both the correct expectations and conditions for integration are in place locally and nationally, and our work to review progress with integration is focussing especially on leadership challenges. [76]

118. We have been interested throughout the year to examine leadership and ascertain what if any, improvements can be identified since we reported.

Scrutiny of NHS boards

119. This session, our Committee has undertaken one-off evidence sessions with all territorial health boards. As organisations that receive public funds, they fall to be held accountable by the Health and Sport Committee in relation to their performance, value for money and meeting of objectives.

120. Common themes identified throughout this process was the issue of brokerage and lack of leadership at the most senior level. We heard from a number of health

boards which sought brokerage over consecutive years. Last year, the Scottish Government provided one health board with £18 million to balance the financial overspend on areas such as "medical staffing—particularly locum medical staffing—drugs and social care". [77] At least two Boards have also been have been escalated to 'Stage 4', the second highest level of concern and risk identified by the Scottish Government, which is defined as there being '*significant risks to delivery, equality and financial performance or safety; senior level external support required*'. [78]

121. We would welcome confirmation from the Scottish Government as to whether brokerage provided in this financial year will require to be repaid.

122. In our 2018 report, The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland, we considered Corporate Governance. We highlighted that "the main purpose of boards is to provide effective leadership, direction, support and guidance to organisations and ensure that the policies and priorities of Scottish ministers (and the Scottish Government) are implemented". [79]

123. We looked at how NHS leadership was providing the vision and the strategic direction to deliver the transformational change required in health and social care. As well as considering the functions boards should perform, we also considered whether the approach and behaviours adopted at the senior levels of the NHS were fostering a culture of openness and improvement.

124. The Scottish Government 'On Board' guidance details that two of the main functions of a board are to ensure strategic leadership and financial stewardship. The guidance details this should include developing and agreeing the organisation's strategy and ensuring financial information is accurate and financial controls and systems of risk management are robust and defensible.

125. The Cabinet Secretary for Health and Sport told us, "Our NHS boards are responsible for providing the vision and the strategic direction through which they deliver high-quality, safe and effective care to our communities." [80]

126. However, our evidence suggested that boards faced challenges in delivering this strategic leadership. There was a perception from some board members that NHS boards were powerless to set strategy and affect the change they want. They attributed this largely to the delegation of board functions to IJBs, the greater regional planning of services, and their assertion that much of the strategic direction is set centrally by the Scottish Government. [81]

127. Our Corporate Governance report in 2018, our 2018 budget report, our ongoing scrutiny of NHS health boards as well as this report, all provide evidence to highlight the challenges at senior leadership level. We remain clear that only through strong leadership can the transformational change required across health and social care be delivered.

128. The Public Audit and Post-legislative Scrutiny Committee's recent report also highlighted leadership and workforce challenges as a key theme for audits in the public sector.

129. Their report concluded there is an urgent need to address the leadership challenges the public sector is facing and "effective leadership is critical to the delivery of high quality public services which meet the needs of users of such services and also provide good value-for-money". [82] They also consider the "style and quality of leadership within organisations affects service users, staff, and the partners with whom public bodies need to work". [83]

130. The Committee further recognised that "making decisions requires leaders to take risks to pursue certain services and to stop providing others and, as such, leaders will need to possess the necessary skills and experience in order to do so". [84] It recommended that the Scottish Government take action across its directorates, and in collaboration with other public bodies, to address this issue.

131. In written evidence to our Committee this year, Glasgow City IJB made a number of comments that suggested relationships were not supporting integration and there is still considerable work to be done–

> The chief officer and chief finance officer experienced very limited engagement with NHS Greater Glasgow and Clyde during 2018/19 in the lead up to the budget offer issued. [85]

132. They also said–

> Integration requires all three parties [Local Authority, Health Board and IJB] to work together to assess what is required to deliver integration in the local area, which includes the budget. The IA is required to operate in this way, however to date Partner bodies and budget process continue to operate in isolation which results in budget decisions being taken by one partner which can have implications for the wider health and social care system and therefore the other Partner body and IA. [86]

133. This topic was investigated further with Stephen Fitzpatrick, assistant chief officer for Glasgow IJB. We also requested further written evidence with regards to whether money has lost its ‘social care’ or ‘health’ identity in the IJB in order for integration to exist. Stephen Fitzpatrick advised there has been a “conscious effort made by the IJB to lose the identity of funding within the elements of the system that the partnership controls”. [87] However, there is a structural issue still to be resolved of how the money flows in and out. This continues to place constraints on the IJB.

> Both sets of Partners remain vested in the budget allocation which they delegate to the IJB and expect this to be used to fund services within their respective services. As an example, Glasgow City Council’s budget report stated, ‘It is anticipated that the contribution from the IJB to the Council will be in line with the Council’s approved budget.’ This is contrary to the spirit of integration and the IA’s statutory responsibility to determine how funding is directed. [88]

134. When reviewing the cultural change required for the Local Authority and Health Board, he stated it is “not realistic to expect cultural change to take place on the

same timescales" [89] Glasgow IJB have "concerns that the conditions do not yet exist to give full effect to the policy intentions of the legislation". [90]

135. Jim Forrest, chief officer for West Lothian IJB, agreed more can be done and a shift in culture and attitude is at the heart of the issue. He highlighted that "good governance structures and oversight" [91] are needed to allow a change to happen. Adding, this is still an ongoing development.

136. In written evidence to the Committee, Jim Forrest also advised that "good progress is being made in developing integrated approaches to planning but more work needs to be done in this area." [92] He also provided a few examples of where pooled funding is being used to deliver the best outcomes for people -

- The Learning Disability Transformation Programme has facilitated the redesign of local services for people with learning disabilities. The programme has involved a whole system approach and is delivering a shift in the balance of care enabling people to live as far as possible in a homely setting;
- Pooled funding has been used to establish an integrated discharge hub within St John's Hospital which has seen health and social work staff co-located alongside the local carers' support organisation. The purpose of the hub is to deliver more seamless and timely discharges from hospital where ongoing care and support are required; and
- Pooled funding has been used to develop a discharge to assess model to support early discharge from hospital through a reablement approach. This has seen resources from health and social care being invested to enhance social care provision. [93]

137. Progress has also been made in Aberdeen City. Chief officer, Sandra Ross confirmed the "IJB has full control over their budget and there is no or little reference to where the budget ultimately came from in the budget monitoring or budget setting processes. It's difficult to provide a specific example, as there is no ownership over funding and the budget is managed and operated as one". [94]

138. Kenny O'Brien, service manager for Aberdeen City IJB, also confirmed "he has a shared budget now, it is not a council budget. It does not matter what is on the ledger. Consequently, I was very able to talk with our primary care colleagues and agree the appropriate contracts and service level agreements to support the medical cover and nursing cover to allow the seamless flow and turnover of people into those kind of settings". [95]

Sharing good practice

139. In a response to our 2018 budget report, the Scottish Government also provided information on how integration authorities are working together to share good practice. The Cabinet Secretary said -

> "chief officers of Integration Authorities across Scotland launched a collaborative leadership network called "Health and Social Care Scotland" at their inaugural annual conference on 7 December 2018. The First Minister opened the event, which provided an opportunity for partnerships to share learning and practice with one another". [96]

140. However, evidence received in our Committee meeting on 4 June, highlighted limited success in this area. When asked if enough is being done to share good practice across all integration authorities, Kenny O'Brien, confirmed, "it is not 100 NHS boards consistent across all the elements that we are working on". [97] Stephen Fitzpatrick, concurred, stating there is always room for improvement. He said, "there is a lot of innovation out there and sometimes you happen upon it by accident. Glasgow tries to "look externally and to avoid the temptation to be too insular". [98] Stephen Fitzpatrick added–

> ...it is important for all agencies to have a proactive approach to sharing information, reviewing what is working well across other partnerships and investigating how that can be achieved in your own area.

141. Strong leadership is fundamental to the integration of health and social care in order to deliver transformational change in services. Whilst we have heard concrete examples of where integration is working, there are still too many areas where this is not happening. Four years into the integration process there is evidence that funding for integration authorities is still failing to 'lose its identity' and all become partnership funding as legislation intended. It is clear that improvements require to be made.

142. We are unclear why this is taking so long and given the preponderance of reports highlighting this issue, sceptical about the attention and urgency being diverted in this area.

143. Leadership is critical and we observe the six indicators which are the focus of regular monitoring of the MSG [99] do not directly measure this. We recommend the Scottish Government identify a set of leadership indicators requiring boards to demonstrate their achievements and progress.

Conclusions

144. We heard Hospital is not a "place in which to languish or stay". Prolonged stay can have a detrimental effect on the health and well being of the patient, particularly the elderly. There is clear evidence hospital is for many not a cost effective or healthy setting.

145. In order to transfer care from the acute to community setting, an increased focus on the ‘front door’ of hospitals is required. There is a need to reduce unscheduled care and admissions and ensure the needs of patients are met and addressed in other, more appropriate areas of the NHS.

146. Leadership and financial management of the IJB budget remain paramount and require closer attention and monitoring.

147. The level of engagement required with members of the public must become a key focus in order to truly transform services.

Annexe A

Extracts from the Minutes of the Health and Sport Committee Meetings

12th Meeting, 2019 (Session 5) Tuesday 30 April 2019

1. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered its approach to Pre-Budget Scrutiny 2020-21.

14th Meeting, 2019 (Session 5) Tuesday 21 May 2019

2. Pre-Budget Scrutiny 2020-21: The Committee took evidence as part of its Pre-Budget Scrutiny from—

- Judith Proctor, chief officer, and Moira Pringle, Chief Finance Officer, Edinburgh Integration Joint Board;
- Val de Souza, chief officer, and Marie Moy, Chief Financial Officer, South Lanarkshire Integration Joint Board;
- Eddie Fraser, chief officer, and Craig McArthur, Chief Financial Officer, East Ayrshire Integration Joint Board.

3. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered the evidence heard earlier in the meeting.

16th Meeting, 2019 (Session 5) Tuesday 4 June 2019

1. Pre-Budget Scrutiny 2020-21: The Committee took evidence as part of its Pre-Budget Scrutiny from—

- Stephen Fitzpatrick, assistant chief officer, Older People's Services and South Operations, and Alan Gilmour, planning manager, Older People and South Locality, Glasgow City Integration Joint Board;
- Sandra Ross, chief officer, and Kenny O'Brien, service manager, Aberdeen City Integration Joint Board;
- Jim Forrest, chief officer, and Yvonne Lawton, Head of Strategic Planning, West Lothian Integration Joint Board.

3. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered the evidence heard earlier in the meeting.

22nd Meeting, 2019 (Session 5) Tuesday 1 October 2019

1. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered a revised draft report on its Pre-Budget Scrutiny 2020-21. Various changes were agreed to, and the report was agreed for publication.

Annexe B

Written evidence

- Edinburgh Integrated Joint Board written evidence
- South Lanarkshire Integrated Joint Board written evidence
- East Ayrshire Integrated Joint Board written evidence
- Glasgow City Integrated Joint Board written evidence
- Aberdeen City Integrated Joint Board written evidence
- West Lothian Integrated Joint Board written evidence

Supplementary written evidence

- Letter from Lewis Macdonald MSP, Convener of the Health and Sport Committee to Jeane Freeman MSP, Cabinet Secretary for Health and Sport – 14 May 2019
- Letter to Lewis Macdonald MSP, Convener of the Health and Sport Committee from Jeane Freeman MSP, Cabinet Secretary for Health and Sport – 20 May 2019
- Letter to Lewis Macdonald MSP, Convener of the Health and Sport Committee from Jeane Freeman MSP, Cabinet Secretary for Health and Sport – 5 June 2019
- Letter to Judith Proctor, chief officer, Edinburgh Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 6 June 2019
- Letter to Val de Souza, chief officer, South Lanarkshire Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 6 June 2019
- Letter to Eddie Fraser, chief officer, East Ayrshire Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 6 June 2019
- Letter from Eddie Fraser, chief officer, East Ayrshire Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 25 June 2019
- Letter from Judith Proctor, chief officer, Edinburgh Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 27 June 2019
- Letter from Val de Souza, chief officer, South Lanarkshire Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 8 July 2019
- Letter to Stephen Fitzpatrick, assistant chief officer, Older People's Services and South Operations, Glasgow City Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 24 June 2019

- Letter to Sandra Ross, chief officer, Aberdeen City Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 24 June 2019
- Letter to Jim Forrest, chief officer, West Lothian Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 24 June 2019
- Letter from Stephen Fitzpatrick, assistant chief officer, Older People's Services and South Operations, Glasgow City Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 8 July 2019
- Letter from Sandra Ross, chief officer, Aberdeen City Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 19 July 2019
- Letter from Jim Forrest, chief officer, West Lothian Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 22 July 2019

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Tuesday 21 May 2019 - evidence from Integrated Joint Boards

Tuesday 4 June 2019 - evidence from Integrated Joint Boards

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11 Letter from Jim Forrest, chief officer, West Lothian Integrated Joint Board, 22July 2019

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