OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 1 May 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 1 May 2018

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HEALTH AND SPORT COMMITTEE
14th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Sir Harry Burns (University of Strathclyde)
Roger Halliday (Scottish Government)
Sandra McDougall (Scottish Health Council)
Gerry McLaughlin (NHS Health Scotland)
Robbie Pearson (Healthcare Improvement Scotland)
Shona Robison (Cabinet Secretary for Health and Sport)
Alison Taylor (Scottish Government)
Pam Whittle (Scottish Health Council)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 1 May 2018

[The Convener opened the meeting at 10:00]

Scottish Health Council Review

The Convener (Lewis Macdonald): Good morning and welcome to the 14th meeting of the Health and Sport Committee in 2018. I ask everyone in the room to ensure that their mobile phones are on silent. You are welcome to use mobile devices for social media purposes, but please do not take photographs or record proceedings.

The first item on our agenda is an evidence session on the Scottish health council review. This session is a follow-up to a previous evidence session that was held with the Scottish health council in January 2017, which was before my time on the committee.

I welcome—personally, for the first time—Pam Whittle, the chair of the Scottish health council; Sandra McDougall, the acting director of the Scottish health council; and Robbie Pearson, the chief executive of Healthcare Improvement Scotland.

Given the range of witnesses on the panel, it would be useful if we could start by establishing the relationship between the Scottish health council and Healthcare Improvement Scotland.

Robbie Pearson (Healthcare Improvement Scotland): The Scottish health council is constituted in legislation as a committee of the board of Healthcare Improvement Scotland. As an entity, it is embedded in and is accountable to Healthcare Improvement Scotland. There is an accountability line that runs from the director of the Scottish health council to the chair of the Scottish health council, and a line of accountability that runs from the director of the Scottish health council to me, as the chief executive of Healthcare Improvement Scotland.

The Convener: That is helpful.

Pam Whittle (Scottish Health Council): The Scottish health council acts as a governance committee of Healthcare Improvement Scotland. As a result of that, we have a mixed membership. Half of the membership comes from Healthcare Improvement Scotland board members and the other half is separately appointed. At the moment, pending the final outcome of the review, we are considering how we might broaden that wider public membership.

The Convener: A primary function of the Scottish health council involves enabling public participation and influence in relation to change within health services. Is that role to scrutinise the efforts of others, or is it a support role? Is it perhaps a combination of both?

Robbie Pearson: It is a blend of things. There is a scrutiny role, a quality assurance role, an improvement support role and an enabling role. We can perhaps say a bit more about how we would like to strengthen the enabling of capacity and capability in Scotland and how we want to engage with communities as part of the review.

In some ways, the Scottish health council is a microcosm of Healthcare Improvement Scotland, which has a role in quality assurance, improvement support and the dissemination of good practice and evidence. You can see all that within the Scottish health council itself. We can say more about individual parts of that as the evidence session proceeds.

Sandra McDougall (Scottish Health Council): We have a relatively small team in the Scottish health council that specialises in working with boards and, more recently, health and social care partnerships, in relation to service change. The vast majority of that work is about offering advice on good practice, sharing examples of experience from other areas and conducting a bit of training and capacity building with staff in those bodies.

In a small number of changes that are identified as involving major change, the Scottish health council has a quality assurance role, which means that we work closely with the national health service boards throughout that process. The boards are required to carry out a minimum of three months' consultation. We have a role in making sure that they follow the requirements in the chief executive letter 4 (2010) guidelines and, at the end of that process, in producing reports that go to the boards to help to inform their decision making before any proposals are made to the cabinet secretary.

In such reports, we try to do three things. First, we set out the process that a board has followed and how that has complied with the guidance. Then we seek to provide an independent summary of any views and concerns that might have been expressed by communities throughout those processes. Thirdly, we think about recommendations for the board in moving forward, including next steps that we think it should take on particular changes, and also areas from which we think it could perhaps learn for the future.

The Convener: How far do any of our witnesses feel that the function and role of the

Scottish health council that you have just described are clear to the general public?

Robbie Pearson: I would like to mention a bit of feedback from the consultation that we undertook. There is not as much clarity as there could be about the council's role. In some ways, it would be fair to say that its name gets in the way. The evidence that we have given to this committee in the past, about the improvement hub, is a good demonstration of the broader opportunity that we have in Healthcare Improvement Scotland and what we are doing to explain its work. However, we still have work to do to make sure that people understand the role of the Scottish health council within the broader responsibilities of Healthcare Improvement Scotland.

Equally, there is a role for us in ensuring that the Scottish health council is fit for purpose in a different landscape. If we go back to when the Scottish health council was constituted in 2005, there were 15 territorial health boards with which there was a principal relationship. We are now in an environment that is more diverse: we must engage with around 70 different bodies, from local authorities to territorial boards and integration authorities—and that is putting aside where we are with the voluntary sector.

There is still work to be done in defining, very clearly, the role and contribution of the Scottish health council within the broader strategy of Healthcare Improvement Scotland.

Ivan McKee (Glasgow Provan) (SNP): I want to explore that a wee bit further. Sandra McDougall, you laid out the two things that the Scottish health council is trying to do and the three outputs from that, which are quite clear in my mind. In your submission, you talk about refocusing and possibly going in a different direction and changing what you are doing. Given your description of what you do, I would like to understand what you think that you should or should not be doing, and what extra you should or should not be doing.

Sandra McDougall: Do you mean specifically in relation to the service change work that we do, or more generally?

Ivan McKee: In your submission, you say that you believe that a refocused Scottish health council can look at making changes in what it is doing. What do you think you need to change?

Sandra McDougall: I suppose that health and social care integration has been very important for people who use the services and for communities across Scotland. Over the past couple of years, it has changed the way in which we have worked. We do not have a formal role to work with the integration authorities: our statutory role is about working with NHS boards. However, in light of integration and what it means for communities, we have already started to adjust the ways in which we work, following approaches such as the our voice framework, which was about strengthening people's voices across health and social care services.

Over the past few years, we have been doing that gradually, and have been doing more work directly with communities. We have offered informal advice on service change to health and social care partnerships, which was an opportunity for us to step back and reflect on how the landscape has changed and how we might have to change to adjust and accommodate that. We recognise that that means working with a number of different bodies and working in different ways. Other bodies have a real interest in that, and we want to make sure that our work is focused on the areas in which it will make the biggest impact. That was the purpose of having the consultation.

Ivan McKee: I understand about your landscape changing and the need to look at social care as well as health. That is clear. You are doing what you were doing, but expanding to work with different bodies. The bit that I want to ask about is a quotation from the review of the Scottish health council. Pam Whittle stated:

> "There are undoubtedly tensions between different aspects of the current role of the Scottish Health Council in acting as a ... quality assurance body ... and an emerging call ... to move to being an independent ... feedback body."

I am not quite sure where that is going.

Pam Whittle: Independence is quite a difficult issue for an organisation that sits within an organisation, but we do speak as an independent voice. We have become more assertive in trying to ensure that our view is clearer as we move forward, but nevertheless it is a complex picture.

Ivan McKee: Do you think that you are not independent? At the end of the day, it is the health boards that you are advising and it is the health boards that you are monitoring. Do you think that you are not independent of the health boards?

Pam Whittle: We are independent of them.

Ivan McKee: Exactly, so I do not understand why you think that there is tension.

Pam Whittle: It is a perceived lack of independence, from the point of view of certain people who have thought that in the past. It is a question of us being clearer.

Ivan McKee: It is a communication issue rather than fundamentally changing anything.

Pam Whittle: That is correct. It is about communicating what we are about. That is something that became quite clear in the progress of the initial review and the subsequent review. It

was not clear to everybody exactly what our role was.

Ivan McKee: Right, so you are talking not about changing the remit or the direction, what you do or the way you are doing it, but about how you communicate that to make it clearer what is going on.

Pam Whittle: Yes.

Robbie Pearson: I would like to pick up on a point that was mentioned about what would be different about the Scottish health council, as we evolve over the next couple of years. For instance, the primary relationship between the Scottish health council and the territorial boards is through our local offices around the country. That is an important working relationship at the front line of services out there in Scotland.

One of the other things that I would like to see the Scottish health council do, beyond the local contribution, is to give more of a voice to the bigger national issues facing Scotland. The committee has spent a lot of time looking at the quality of care offered to children and adolescents in Scotland. The Scottish health council could have a role in giving an overall thematic review of how easy it is for individuals, families, children and young people to access child and adolescent mental health services, from the perspective of the user. I would like to see more of that evolving for the Scottish health council in future.

Ivan McKee: I have a practical question to finish up with. In my area, in the east end of Glasgow, we had a situation with the Lightburn hospital site. Thankfully, that is behind us now. I have met the health board to discuss how to go forward, what was on that site, what was on other sites, and what it will do with services around the area. As part of that, I and other elected members intend to go out and talk to community groups on our own behalf and get some comments and feedback to take to the health board so that we can say, “This is what we have seen in the community.” Is that kind of engagement process, outside of what the health board is doing directly, something that you would be willing to engage with and support us in doing?

Robbie Pearson: Absolutely. One of the discussions that we had at a previous meeting of this committee was about the concern over being in an arbitrary position between major and all service change. Whether we are dealing with NHS boards or integration authorities, we want to enable them to do their very best in engaging with their communities, and to provide them with tools and expertise. That is very much akin to the resource that we provide nationally for improvement support through our improvement hub. I would like more of that to be taken forward through the Scottish health council as it engages in supporting those bodies that are responsible for engagement with communities, so that they can do so in a consistent, high-quality way.

Sandra White (Glasgow Kelvin) (SNP): I want to touch on the integration joint boards. Sandra McDougall mentioned giving advice informally, but it is still not clear to the general public or to me exactly what you do and who you are accountable to under the legislation. Should your role be extended to include intergenerational social care and health? Would there need to be legislative change for the Scottish health council to be able to work with the integration joint boards? You mentioned that you give advice, but you do not have any legislative clout. Does legislation need to change so that you can do the job, with the health integration that is coming?

10:15

Robbie Pearson: The position is that Healthcare Improvement Scotland, of which the Scottish health council is a constituent part, is already engaging with integration authorities. Improvement support around strategic planning and the strategic commissioning of services is a good example. We already work with the Care Inspectorate in the joint inspection of adult services. For example, we just published a report on North Lanarkshire.

I do not believe that there need to be legislative changes. It is about how we work with a broad range of stakeholders, including the Care Inspectorate, Health and Social Care Alliance Scotland, the Convention of Scottish Local Authorities and a diverse range of voluntary groups. We cannot possibly do everything with the Scottish health council’s resources, so it is about how we deploy our expertise and skills with other agencies to support and enable greater participation and the engagement of citizens in the design of health and social care services. I do not believe that there need to be legislative changes, but it is important that we work across organisational boundaries in a way that ultimately delivers better outcomes. That must be the objective.

Sandra White: You do not believe that there needs to be any legislative change, because you are already working with the integration joint boards.

Pam Whittle: We are already working with them.

Sandra White: You mentioned the groups that you engage with, and at the very end you mentioned the public, who are most important when we are talking about changes. How do you expect to expand your role in working with the

public to ensure that people are consulted and know about integration?

Robbie Pearson: There are two parts to that. It is really important to engage with people at local level. I can say a bit more on that, but Sandra McDougall might want to say a bit about engaging with people through the national citizens panel.

Sandra McDougall: We have tried to engage in a number of ways; our citizens panel is one mechanism through which we engage with people on national issues. We also use our local offices and their networks to gather views from people about various issues. There might be examples in our written submission.

The national citizens panel was set up partly because there was a perceived gap. How do we get the voice of the general public in Scotland—rather than that of people who have a particular interest and who might already be involved and engaged—into health and social care issues? Panel members were recruited from across Scotland. Our report sets out the rationale for and the thinking behind recruiting people in the way that we did: we went through the electoral register, we did some on-street recruitment and we did targeted recruitment. The idea was to get a profile that was broadly representative of the Scottish population. We have been quite successful in that, but there were one or two categories in which it was a bit trickier to get people, in trying to strike that balance.

Over the past year, we have tested working with the panel primarily through surveys. We have asked a number of questions, some of which have come from the Scottish Government on policies that it is working on, and some from third sector organisations. We produce and publish the reports, and we are keen for those reports to have an impact. We go back to panel members with the write-up of the findings, so that they can see what is emerging. We also follow up with people who have an interest in the questions and in taking findings forward so that we can feed back to panel members how their views have been used. That is one way in which we engage with the broader public.

Sandra White: A colleague will ask about the consultation process and how many replies you had, so I will not.

There is the national citizens panel, and local people who will be affected by change are also consulted, I hope, by the health board—at least, they should be. I do not mean this in a bad way, but do you think that there is still a role for the Scottish health council? You have said—not just to me but to others—that the council gives advice informally regarding integration, which is a huge issue. You speak to the health boards, and you see whether consultations have gone out, but those consultations are statutory and must be done.

Unfortunately, I had a situation in Glasgow that was similar to the one that was described by Ivan McKee, concerning the minor injuries unit, in which we had to push for things to be consulted on. Is there still a use for the Scottish health council? Have you spoken to the Scottish Government about it?

Sandra McDougall: Sandra White is, I think, focusing on service change. There is clearly still an agenda around service change, the 2020 vision and how we make changes to primary care services, for example. It is important that people in communities are engaged and are co-producing the changes, from the outset. In the vast majority of cases, we seek to add value to the process through offering advice and good practice to boards, by giving examples of what has worked elsewhere and by using our local knowledge and intelligence to suggest groups that might not have had an opportunity to contribute or which might not be on the radar of the health board or integration authority, in order to ensure that as many people as possible have a say. That sometimes also involves capacity building with the boards.

Sandra White: I am sorry to interrupt you. When you mention groups that have not had a say, do you mean local communities?

Sandra McDougall: Yes.

Sandra White: Does that include patient groups?

Pam Whittle: Yes.

Sandra McDougall: Yes.

Sandra White: Those are the most vulnerable people, who tend not to get a say. I will not go into how many people have replied in that group, because I know that it will be asked about. Is it your purpose to get hard-to-reach people to come to you?

Sandra McDougall: Yes—absolutely. In the case of major change or changes that are regarded as contentious, our report's value is in that we provide independent commentary and independent assurance—we hope—about how the process has been followed. We also provide an independent summary of the views and concerns that have been expressed by communities, and where we think the board can learn. We hope that that is of value in informing the decision-making process.

Ash Denham (Edinburgh Eastern) (SNP): In the light of the major questions that have arisen from the review regarding the Scottish health council's existence and role, can you tell me what

material actions and decisions have resulted from that lengthy review?

Robbie Pearson: We have received the review and are considering it. Over the past two months, we have been taking the outputs from it.

There are four or five big things that we want to do on the back of the review. First, we must respect that we no longer have 15 territorial boards, as was the case in 2005; there is a completely different landscape in health and social care. I will not dwell on that any longer, but we need to adjust to it.

Secondly, people are looking for us to influence and inform policy at national level. I have touched on how children and adolescents in Scotland access services. We know that half of adults in Scotland with a mental health condition acquired the condition before the age of 14. There is an important role for us in the Scottish health council and Healthcare Improvement Scotland in informing the design of services and in informing best participation and practice in terms of people accessing child and adolescent mental health services. That is one area where I would like us to adopt a national thematic approach.

The third point that has been identified from the consultation is that there is lots of good practice in, evidence about and toolkits for participation and engagement. However, implementation is pretty patchy. We have a greater role not only in quality assuring but in providing tools and in enabling more consistent capability.

The fourth area that has come out of the consultation concerns service change. There is an absolute need for clarity regarding the role of the Scottish health council in the more integrated landscape. We can say a bit more on our thinking about how we convey that.

Those are four big themes that are emerging from the review.

Another message is a positive one about the contribution of Scottish health council staff at local level through the supportive relationships that they have built up with NHS boards over the past 12 years or so. We also recognise that there is a need to enhance capability and expertise in order to allow greater involvement in the design of effective participation. That requires enhancement of skills and resources in the Scottish health council to build on our local presence. Those are resourcing issues, so we need to think how best to do all that.

I hope that that gives you a flavour of the key messages that are emerging and how we anticipate responding.

Ash Denham: You say that that is how you "anticipate responding", but I took a note of what you said. You identified areas where the Scottish health council might need to change, but you did not explain how. For example, you said that you would like to influence policy, but you did not say how you would follow that through. You said that you need to adjust to the different landscape of health boards, but you did not say exactly how you will do that. Can you enlighten me a little on that?

Robbie Pearson: This will be a transition and a journey. The Scottish health council has existed since 2005, so we cannot just flick a switch and achieve all those things. There are issues with resourcing, the workforce, skills and how we work with a range of partners to deliver what we deliver.

We have had good working relationships with the Care Inspectorate, the Health and Social Care Alliance Scotland, and the Convention of Scottish Local Authorities, and it is important that we build on those. It will be a two-year to three-year journey.

On the specific point about thematics, I meant that Healthcare Improvement Scotland will in the future publish a report about access to child and adolescent mental health services, for example. That would cover individual young people, their families and their mums and dads. It would cover how they were able to access the services—how easy it was and what the difficulties and challenges were—and how we can better inform more effective participation.

Sandra McDougall: I will describe a bit about how things have worked and how that might change for our staff on a day-to-day basis. A lot of requests come into the organisation locally and nationally for support. They are requests for us to get involved in a range of things; providing advice, perhaps, to somebody who is reviewing a service, providing training and so on. We have multiple activities going on across all our work.

We need to focus on areas where we can make a bigger collective impact, so that we join up some of the work that might be happening locally with our evidence function at national level, and with our volunteering programme, where there is a role for volunteers in a particular activity. We want to move in the future to a system that means that, rather than responding to all the different demands on us, we engage with our stakeholders and consider priorities for services, and where our collective effort might make the biggest difference.

That is what we mean when we talk about shifting to a more thematic way of working. We want to do that more collaboratively with our stakeholders to ensure that we avoid duplication, that we add value and that we can demonstrate a distinct impact. We want to ensure that we look for opportunities to collaborate with others when our collective effort might add the biggest benefit.

I hope that that articulates what the shift might look like for our staff and what we deliver each year.

Pam Whittle: One of the interesting developments in the past year was my establishment of a programme board for taking forward aspects of the "Our voice" programme for which the Scottish health council is responsible. That brought other people into play in a much closer partnership approach that has demonstrated how we are moving forward jointly with the Health and Social Care Alliance Scotland and COSLA. It has been very positive. We want to build on that type of partnership approach, and to do it on a bigger scale.

The Convener: If you go to a more national model of working, what will be the implications for the local engagement that colleagues have asked about?

Robbie Pearson: It is crucial that we do not throw the baby out with the bath water. The relationships with local offices are absolutely important. However, there are 31 integration authorities, 32 local authorities and three emergent regions, so we need to start to think about how we evolve our relationships beyond where they have traditionally been on the spine of 14 territorial boards. That will require different thinking about resources and how we use our people to best effect.

10:30

We have a budget of about £2.7 million and more than 60 people. We have some people who are extremely experienced in the work that they have done and the relationships that they have built. We need to be careful that we do not move towards a centralised system; that is not what this is about. It is about a balance between local identity and local presence and adding value at national level, where appropriate, by doing bigger national things. There are choices and priorities to be made within that balance.

Miles Briggs (Lothian) (Con): Good morning, panel. Following up on questions from Sandra White and Ash Denham, I want to look at how that will happen in practice. At our last meeting with the Scottish health council, our former convener read out a quote from one of my constituents, who believed that the SHC was a "toothless beast" with absolutely no power to enforce recommendations. How will your review change that for patients who are trying to put their faith in your organisation to speak on their behalf when major service changes take place? Is it time that we looked at whether there should be more of an independent role for the SHC?

Robbie Pearson: It would be fair to say that we in Healthcare Improvement Scotland do not pull our punches when we do our scrutiny work. We are very direct in how we convey some tough messages. There are some points of learning and reflection that we want to take from the service change process that we think will enhance our contribution from a participation and engagement perspective. Sandra McDougall might want to refer to that.

Sandra McDougall: It is a good question. We realise that people feel passionate about major changes, and that such changes can involve quite lengthy and protracted processes. People invest a lot of time and effort because they really care about the services that are being considered. What we have in common with those people is that we want to ensure that their voices are listened to and that that is evident in the decision-making process in NHS boards.

I have alluded to the fact that, as well as looking at the process for engagement, our reports seek to provide an independent commentary on the views and concerns that have been expressed by communities and on recommendations. We speak to communities directly through those processes. If campaign groups are established, we are keen to ensure that we understand and reflect their views in our reports. However, our report is produced prior to the board making its decision. We send our report to the board for it to take account of.

An interesting suggestion in the consultation responses that we received was whether boards could respond more formally to our reports and recommendations. We would welcome that and it would probably be welcomed by the communities that take part in such processes, because it would enable there to be a clear articulation of how the boards take people's views into account. That might not necessarily mean that the board agrees with the views and concerns of the people who have been involved, but boards need to be able to respond to people and explain the rationale if they are proposing something that is at odds with what communities want. That part of the process, and getting it right, is really important.

Miles Briggs: To get to the nub of the matter, we should look at what Nicola Sturgeon said in 2002 when she was a member of the Health and Community Care Committee. She said:

> "People feel that consultation processes are a sham; the health board goes through the motions then does what it wants regardless."—[*Official Report*, *Health and Community Care Committee*, 22 May 2002; c 2746.]

That sums up our concerns. Your recommendations are just that—they are recommendations. Health boards can, and do, ignore them. When people are running a

campaign, using your organisation to help them stand up is really important. I have not heard how you think that has to change to ensure that your recommendation not to go forward with service change, for example, is heeded and not just considered by health boards.

Robbie Pearson: The Scottish health council's role is to quality assure the level and quality of engagement in making sure that voices are heard when there is major service change. Our role is not to provide a commentary on, for example, the overall shape of the clinical model that has been advanced. Sandra McDougall has described a process that would be more transparent about how the board has responded to our recommendations about participation in the context of quality assurance. That would be similar to the role that Healthcare Improvement Scotland already has from the scrutiny standpoint about the recommendations and requirements for NHS boards. There would be a level of transparency in the responsiveness of NHS boards.

Alex Cole-Hamilton (Edinburgh Western) (LD): My question stems from that of Miles Briggs and touches on the granular detail of service redesign, which has been covered lightly so far. The Scottish health council's function to consult about major service redesign was discussed by the committee last year, and I ask panellists to remind us how a service redesign is designated as major or minor. If a service redesign is minor, what is your mandate with regard to consultation with the public?

Pam Whittle: I think that that question is for Sandra McDougall.

Sandra McDougall: The process is set out in the chief executive letter 4 (2010) guidance for NHS boards. Boards are required to consider whether a service change should be designated as major and to seek advice from the Scottish Government if they think that it may be. The approach to the Government has to take account of the guidance on identifying major change, which sets out nine factors to ensure that the consideration is full and comprehensive. The factors include the impact on patients and how many are likely to be affected; whether a relocation or centralisation of services is involved; whether it involves unscheduled or emergency care; any public concern so far about the proposals, based on engagement that has taken place; the likely impact on other services; and any particular history of the service.

The board should consider the guidance to reach its view on whether the change is major and, if so, approach the Scottish Government. If it does that, it has become custom and practice for the board to ask for our view to include in its approach. We take into account the board's consideration, our knowledge and understanding of the process and the concerns that have been expressed so far. We look at precedents, such as whether any similar changes that have been considered in the past were considered to be major change. All those views go to the Scottish Government, which ultimately makes the decision on whether a change is major.

It is unfortunate that the approach has become perceived as two tier—major versus non-major—because, from our perspective, it is important that the guidance and process are clear and that people are involved from the outset to help to shape the change, wherever the decision is to be made. We appreciate that whether the status of a change is major has become very important for some communities.

Alex Cole-Hamilton: If the Government designates a service change as minor, does the Scottish health council have any role in consulting affected communities?

Sandra McDougall: We do not have a role in consulting communities, as that sits with NHS boards. Our role for major changes is to provide a quality assurance report about how the board has consulted, and we speak directly to communities to inform our view. When the change is not major, our role is to advise on what engagement might be proportionate and we share practice from other areas for boards to take into account when planning changes. We still encourage boards to make sure that their communities have every chance to give views on processes from the outset and that boards take those views into account. However, we do not have a formal role on quality assurance of non-major change.

Alex Cole-Hamilton: Given that any service change can be very emotive for the patients it affects, the subjective application of the guidance can be quite troublesome. It worries me that the Scottish Government is the final arbiter of that decision, particularly when it is facing negative public scrutiny about the proposed service redesign. Do you agree that that decision should perhaps be taken away from the Scottish Government and that designation of whether change is major or minor should rest with yourselves or another third-party body?

Robbie Pearson: I do not think that it is appropriate for me to comment on whether a decision at that level should be taken away from ministers. Ultimately, the accountability of ministers for major service change in the national health service rests with the Parliament. It should remain with ministers; I am not here to comment on that. What is important for the Scottish health council is that, whatever the nature of the change, we ensure that there is best practice and effective participation. I very much take the point that has

been made that any change, whether it is major or less than major, matters to communities.

Pam Whittle: Absolutely.

Brian Whittle (South Scotland) (Con): Good morning, panel. I want to follow on from Miles Briggs's question. He said that HIS reviews and SHC reviews are recommendations and there is no compulsion to take them forward. Who has overview of the implementation of the recommendations? Robbie Pearson and I both know that an HIS review in 2017 was almost identical to the one that came out in 2012, which contained recommendations that have not been implemented. Should the implementation of recommendations be policed by yourselves? Should the effectiveness of the implementation of recommendations be published? At the moment, boards are self-reporting on the recommendations. Should HIS and the SHC have a bigger independent role in policing that change?

Robbie Pearson: That is an important point. To pick up the point that Sandra McDougall made, I would like there to be transparency around the recommendations that arise from major service change to ensure that NHS boards do not just add recommendations to the business case and then off they go. We need to ensure closure of the loop. When there are concerns—whether they are about a community's access to transport or the distribution of a service that is perhaps moving in a different way—those voices should be heard and there should be an active feedback loop from the issues that have been raised in our work and the recommendations that come from it. That is an important part of the role of Healthcare Improvement Scotland. The patients who are at the centre of our work are important. The voice of citizens in accessing health and social care services needs to be absolutely to the fore. There is a point about transparency in ensuring that NHS boards respond to recommendations in a very clear and meaningful way. It should not be about tokenism.

Brian Whittle: In that case, who is reviewing and publishing the implementation of recommendations? How will you make that more transparent?

Robbie Pearson: Sandra McDougall has described the process whereby we make recommendations on the basis of a process of engagement and participation, which might have been good, suboptimal or poor. We make recommendations, but we need to ensure that NHS boards respond visibly and publicly to such recommendations in the future. That would be a good step forward for transparency and for building a more effective system of responsiveness among NHS boards.

Brian Whittle: Does HIS need more legislative power to implement that?

Robbie Pearson: I do not believe that we need more legislative power.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I am interested in what has been done differently in the past year from the previous report to engage locally. Looking at the Scottish health council's website, we can see that there are documents and documents and documents—it would take me days to go through them—which are all excellent, but I have been a nurse for 30 years and I did not know that the health council existed until I joined this committee. I have also spoken to former colleagues who would be happy to engage. My question is about what the Scottish health council has done differently. Sometimes, local people are informed by social media action groups instead of by boards that are communicating more effectively. Is the Scottish health council able to support boards to engage with local people?

10:45

Pam Whittle: A key part of our role is to support boards and to encourage them to do more. Some boards are moving forward differently, and methods of communication change all the time. I accept your point that workers in the health service do not always know about the council. We have had positive social media action and are quite prolific on Twitter, but our visibility might not have been as clear in the past.

Sandra McDougall: A relatively new development for us has been the "Voices Scotland" approach, which builds capacity with community groups that might be interested in more involvement and broadens the reach and diversity of people who are involved at a local level. Chest Heart & Stroke Scotland developed this flexible, modular approach to support and enable groups to understand the structure of local services and how they work. The approach encourages people to think about their experiences of services, what matters to them, whether they might like to see change and how to go about having their voices heard locally. Our local staff have been trained to deliver the approach, which they are using flexibly with groups to encourage bottom-up engagement, so that bodies respond to the issues that matter to people, rather than just consulting on the issues that they want to consult about. It is about trying to encourage confidence in communities, and it has been received pretty positively by the groups that we have worked with.

Emma Harper: It takes a long time to push forward change in the national health service, as it

is slow and people have to join together. How do you decide how to do consultations? The consultation on organ and tissue donation and transplantation has no input from anybody in the NHS Dumfries and Galloway or NHS Borders area, but there is input from NHS Ayrshire and Arran. South Scotland is a huge region; how do you decide who to engage with locally?

Sandra McDougall: Our gathering views work usually responds to requests from the Scottish Government or other bodies. We have the advantage of a national presence and local reach, so we can use our contacts and community experience to engage with people in a targeted way, based on our conversations with the people who ask us to consult on their behalf.

For the consultation on organ and tissue donation and transplantation, work had been done and other engagement was already planned, but a need was identified to engage with particular groups, such as people with learning difficulties and looked-after children and young people. Tissue donation and transplantation has particular legal issues about consent for those groups, which is why the activity was intended to be targeted. We worked with Barnardo's Scotland, People First (Scotland), the Arran Youth Foundations and others to design a session to get the views of people with learning difficulties and looked-after children and young people, so that their voices would be heard on those important national policy issues. The targeting depends on the ask, the target audience that people seek to reach and which local organisations we might collaborate with to enable that to happen. Does that help to clarify the local engagement?

Emma Harper: Sure.

The Convener: That was helpful; thank you very much.

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): I have two very brief questions. First, in a word, are boards engaging better or worse with the public?

Robbie Pearson: I am not sure whether it is a binary answer. There are demonstrations of good practice in engagement around the country, but there are examples of pretty poor practice, too. Healthcare Improvement Scotland—and the Scottish health council, in particular—need to bring to the surface the really good practice. Equally, there needs to be transparency about where there is poor practice. That is how we will get engagement of a much higher quality across the country.

Kate Forbes: Secondly, I note that in 2016-17 boards were largely focused on feedback, comments, concerns and complaints when it came to engagement, which is very much retrospective. Can you give us an example of a board that has done a good job in engaging with the public in a way that is bigger and broader than just feedback on complaints?

Sandra McDougall: We did some work specifically around feedback on complaints that used our participation standard, which was about going out and looking at how boards are responding. There was a bit of a mixed picture. To clarify, are you looking for an example about broader engagement?

Kate Forbes: I will try to keep it quick. In your reports, how do you identify how boards are engaging with the public generally and whether they are meeting the three participation standards? I note that in 2016-17, the boards were focused largely on complaints and so on. Did you look at the other participation standards? Was there a particular board that stood out in terms of how it was doing that?

Sandra McDougall: During the recent assessment we looked only at how boards were handling complaints and feedback. That was on the basis of expectations in the Patient Rights (Scotland) Act 2011, which were about looking at complaints and feedback in a much more holistic way—not treating them as separate things, but looking at all the intelligence and ensuring that there are lots of different opportunities for people to give feedback, through things such as Care Opinion for example, and that people have access to the patient advice and support service. The participation standard assessment that we did was focused very specifically on that area of boards' responsibilities. The process this year showed that some boards have made real improvements since a couple of years ago, which was when we looked at the issue previously; other boards had shown less improvement. There is a national overview report that sets out our findings on that and pulls out examples of good practice from a number of different boards. It is a really important area for patients and carers.

The Convener: Thank you very much. We have had a very full session in a short and compressed period of time. We are very grateful, and I thank our witnesses.

10:53

Meeting suspended.

10:59

On resuming—

Revised National Outcomes

The Convener: Agenda item 2 is an evidence session on the Scottish Government's revised national outcomes. I am delighted to welcome to the committee Shona Robison, the Cabinet Secretary for Health and Sport; Alison Taylor, head of integration at the Scottish Government; Roger Halliday, the chief statistician; Gerry McLaughlin, chief executive of NHS Health Scotland; and Professor Sir Harry Burns, professor of global public health at the University of Strathclyde—and, I understand, a grandfather, as of a few moments ago, so congratulations as well as welcome to him.

Professor Sir Harry Burns (University of Strathclyde): It's a girl!

The Convener: I am sure that Professor Burns has many cheerful things to say to us in any case, but I can tell that he is going to have a particularly elated session this morning.

Nonetheless, there are some serious questions to ask. We will start with Alison Johnstone.

Alison Johnstone (Lothian) (Green): Good morning. I would like to ask the witnesses how the national performance framework will address health inequalities, which are obviously an area of some concern in Scotland.

The Cabinet Secretary for Health and Sport (Shona Robison): I will kick off with some comments in broad terms. The national performance framework is designed to enable us to see how Scotland is performing against a range of indicators that are relevant to health inequalities and to make sure that it informs policy making to tackle health inequalities. Wherever possible, indicators will be broken down by both protected qualities or characteristics and area-based inequalities. As part of the transformation of the Scotland performs website, we are going to report on progress for both those equalities aspects.

As I am sure you are aware, reducing inequalities is already a key feature of much of the Government's policy programme. For example, we have set targets for health boards to reduce smoking in our least well-off communities as a priority. That has led to greater levels of success in targeting services, and the proportion of people from more deprived communities who are quitting is now far higher than the proportion anywhere else. There is also a stark social gradient to alcohol-related harm, and minimum unit pricing, which starts today, will deliver greater benefits to lower-income communities, where health harms are disproportionately experienced.

We are also investing heavily in mitigating the impacts of welfare reform and austerity, with a £100 million per annum spend in that area.

I will let Roger Halliday comment, but it is worth noting the work that is being done across Government. It is not just my portfolio that is important in reducing health inequalities, and it cannot be done just by the national health service or integrated partnerships. It has to be done across Government, which provides an opportunity for the whole Cabinet and the whole Government to focus.

Alison Johnstone: I very much appreciate that point, because a Government letter in response to the Health and Sport Committee's 2014 inquiry into health inequalities stated that tackling health inequalities is not a matter for the NHS alone. I would be grateful if the witnesses could touch on health inequalities being addressed by all portfolios. Will you give a couple of examples of how that might be demonstrated?

Shona Robison: The £100 million per annum investment in mitigating the impacts of welfare reform is clearly about household incomes and supporting people, and it is clearly a tool to tackle inequality. Likewise, in education, we have the attainment fund resource for headteachers to be able to support children in schools, particularly in more deprived communities.

There will be examples across all portfolios. I guess that the importance of the national performance framework lies in its ability to take an overview and ensure that, as we measure Scotland's performance against those indicators, we take a cross-Government approach to that.

Roger Halliday (Scottish Government): I do not have too much to add. The framework looks at how we improve the economic, social and environmental wellbeing of people in Scotland, which is why we have the purpose and values and the set of outcomes that sets that out. Fundamental to this is the approach that mainstreams equalities throughout. This time, we have moved from having a specific outcome on reducing inequalities to that being done throughout the framework. As the cabinet secretary said, we will report on progress in relation to different equalities groups and area-based inequalities, and we will use that information to determine whether we are making progress for the whole of Scotland and for different communities within Scotland.

Gerry McLaughlin (NHS Health Scotland): I will pick up on an example that demonstrates the point that you raise. Work was done a couple of years ago on the development of a place standard for local communities, which looked at a range of outcomes and indicators for which responsibility is spread across public services. As regeneration

takes place in communities or as new communities are established, we look to create the conditions that will improve health and wellbeing. At the heart of that is the use of a tool that engages local communities in what is important to them, and they do not define that in the context of Government portfolios or the responsibilities of individual agencies. From a public health point of view, the extent to which we can influence local community planning in discharging its new responsibilities under the Community Empowerment (Scotland) Act 2015 gives an example of how we can draw right across different national outcomes.

Professor Burns: As I look down the list of indicators, I see that every single section has things that will contribute to narrowing inequality, from the economic one about productivity and jobs to the indicators on poverty and so on. I have spoken to the committee before about complex system change. For me, the critical part of this is about how action is to be taken, who will be doing things, and what we want to change, by how much and by when. Our experience with such things as the early years collaborative and the patient safety programme tells us that the best people to design that action are front-line staff. It is not easily done in offices a long way away from the communities that we are trying to help. You could imagine a local authority taking some of those indicators and saying, "Yes, we will try to change the following five things. What do we want to change, by how much, by when, and by what method?" Once that gets going, we will see change happening.

Alison Johnstone: Do you feel that there is a bit of work to do there?

Professor Burns: Under "Next Steps", the national outcomes document states:

> "We are testing new approaches around delivery of the Outcomes and will be focussing initially on four Outcome areas to identify methods to turn broad Outcome intentions into concrete policy options and proposed actions."

I think that I know what that means, but there is clearly a plan and it has got to get rolling and be scaled up as quickly as possible if it is to have a significant impact across Scotland.

David Stewart (Highlands and Islands) (Lab): I will build on Alison Johnstone's points about health inequalities. I was reading quite an interesting article by Pickett and Wilkinson from 2009 entitled "Why more equal societies do better". The basic argument was that we need more emphasis on social and economic factors, such as why the poor die younger than the rich. It argued for a fundamental change in society at the macro level to change the power distribution. That is obviously a wider point than this committee is addressing, but I wonder whether any of the panel, in particular Professor Sir Harry Burns, wish to comment.

Professor Burns: Pickett and Wilkinson's whole theory is based around what Sir Michael Marmot describes as status syndrome—the idea that inequality per se makes people at the lower end of the scale feel bad about themselves. It is actually more complicated than that, and I have had a number of discussions with Richard Wilkinson about that kind of thing. It is entirely possible to narrow inequalities using a whole range of approaches, but the fundamental one is to give people a sense of being in control of their lives. If you are living in bad housing and do not have a job or a sense of purpose in life, or if you are worried about drug pushers getting at your children, you are buffeted by circumstances, and if you have had a difficult childhood, your ability to feel in control is impaired.

There is a lot of evidence that the way in which the public sector interacts with people can either enhance or damage their ability to be in control. I have been arguing for a while about changing the way in which the public sector interacts with people living at the lower end of the social scale in order to enhance their sense of self-efficacy and control. There is lots of evidence that that improves the educational performance of children in those families and their chances of educational success, that it reduces the risk of offending and, ultimately, that it increases their chances of participating in economic growth.

We do ourselves a disservice by reducing complex problems to a single cause and effect relationship, as they are much more complex than that. We need to adopt complex system approaches to be successful. At the end of the day, if you get change, you might never know what it was you did that produced that change. It might be 10 of the 20 things that you tried that produced that change, but my argument is: who cares, as long as we make things better?

David Stewart: My final question is for the cabinet secretary. We had a unanimous decision on MUP, which is to be welcomed, but what are the next steps? We all know about the damaging effects of alcohol. There have been suggestions in the press—I am not recommending this—that we should have health warnings on products with alcohol, as we have with cigarettes. Another issue is the social responsibility levy, which has been put on hold. What are the next steps, given that alcohol is a major issue that affects health in Scotland?

Shona Robison: I am happy to talk about that, given today's importance in taking forward what I think is a hugely important public health policy, which I am pleased has cross-party support. You will be aware that the framework for action on

alcohol is being refreshed. We have always said that minimum unit pricing does not stand alone; it stands with a range of other measures that are being taken.

The issues of advertising and health warnings have been part of Aileen Campbell's considerations for the refreshed framework. Some products already have on them the chief medical officer's guidelines and messaging about drinking responsibly. I guess that some people are calling for us to go further than that in the warnings on products. Progress has been made, which is to be welcomed, and we will certainly give consideration to the further calls. Given that United Kingdom and international producers are involved, issues arise as to where the responsibility and the power to change advertising lie. Obviously, those are complex matters and they depend on where production takes place. However, we are looking at what more can be done in that space.

On next steps more generally, the evaluation will be important in looking at the success of minimum unit pricing and considering whether we need to make further adjustments. The evaluation will start straight away and run for five years, which will give us a wealth of information by the end of the period. As I have said before, I am happy to keep the committee informed about that, because it will not just be about where we have started and where we have ended; information will be flowing through the course of the evaluation.

David Stewart: Do you have anything to add on the social responsibility levy?

Shona Robison: As we have discussed previously, the social responsibility levy was designed to be a local mechanism to recognise demands on local resources. It was never really thought of as a national tool or response like the minimum unit pricing policy. However, as ever, whether it is the social responsibility levy or the public health supplement, we will keep those matters under review. Given the economic circumstances that the country has faced in recent times, we felt that it was not the right time to apply the public health supplement again although, obviously, we have applied it in the past. We will keep those matters under review.

The Convener: I encourage colleagues to keep their questions and answers in the context of the national outcomes.

11:15

Alex Cole-Hamilton: Good morning, cabinet secretary and officials. I congratulate Professor Sir Harry Burns on the new arrival in his family.

I want to draw the questioning towards the content of the indicators in terms of what is included and, more important, what is not. One of my constituents is 95-year-old William Valentine, whose son and daughter came to see me yesterday. William Valentine was admitted to the Western general hospital at Christmas and was declared fit to go home at the start of February. A social care package for him was drawn up, which was not complex and involved him receiving three visits a day. However, nearly 100 days later, he is still in the Western general because there is no provider willing to take up that commission.

We know that deficiencies in social care in our communities, particularly for older people, create an interruption in flow throughout the whole health service that means that, for example, elective surgical operations are cancelled because there are no beds for people to be admitted to; and the interruption in flow is partly responsible for delays in accident and emergency, because there are no beds in the wider hospital for people to be put through to. Given that context, why is there no indicator underlying the health outcome in the performance framework for the provision of social care to older people?

Shona Robison: You raise an important point about delayed discharge, but there has been a good, downward trend in that figure, with a 7 per cent reduction over the year. However, there are local challenges. You will be aware that there are particular challenges in Lothian and that a new chief officer is starting in the integration authority in Edinburgh who brings a wealth of experience from Aberdeen about the mechanisms and policies that have been taken forward there.

Generally, the national performance framework looks at the key indicators that can establish Scotland's performance, but a wealth of work goes on underneath that, particularly in integration authorities, which have been doing huge amounts of work on data collection and developing their own indicators. Tackling delay is one of the key indicators and, as Mr Cole-Hamilton said, it connects to ensuring that we can reduce the level of unscheduled care and the length of stay in hospital, and avoid admission to hospital in the first place for some. All those things are key for the indicators that the integration authorities use. Alison Taylor has more detail about the work that has been done in that regard.

Alison Taylor (Scottish Government): Absolutely. The national performance framework sits across the top of Government responsibilities. We are doing a lot of work with the integration authorities, as the cabinet secretary said, to support them to have a core of improvement measures that they share with us and which are common across the country; and to build around those a network of measures that are appropriate to local circumstance. I would expect to see quite

a lot of variation in which measures individual partnerships use, particularly where they have recognisable problems of the sort that Mr Cole-Hamilton described. For example, in South Lanarkshire, a local framework for improvement has been built up around the partnership that looks across about 100 measures but specifically focuses on areas where they know that they need to see improvement and progress.

We therefore have a lot of work under way to reinforce the data that is available to partnerships to ensure that they use a common set and that comparable lessons and evidence can be drawn from that. However, on top of that, as Mr Cole-Hamilton rightly reflected, there is also the need to consider what local pressures need to be addressed. As the cabinet secretary has indicated, we are supporting colleagues in the Lothian partnerships, but particularly Edinburgh, to address the problems that Mr Cole-Hamilton described.

The Convener: Cabinet secretary, you will recall that a commitment was given during the budget scrutiny that we would receive data on integration joint boards by the end of March, but it has still not arrived. Do you want to comment on that?

Shona Robison: If memory serves me right, a letter that has been drafted on that is coming to you soon. We will ensure that you get it as soon as possible.

Roger Halliday: It might be helpful to say something in general about the indicators and why we have chosen the set that we have. We could have had hundreds or thousands of indicators. I am in charge of statisticians around the country who are beavering away producing some great data. However, we have chosen 79. Among other countries around the world that I have seen, some use a maximum of 50 indicators when they are trying to describe economic, social and environmental progress.

We did some consultation events with a couple of hundred experts that generated literally hundreds of ideas, and I knew that I needed to whittle the number down. I did that according to some principles: it was important that the indicators measured progress towards each of our 11 outcomes, that they could tell us about progress across different parts of Scottish society and equality groups, and that the data was technically feasible—that is, that the underlying data would allow us to tell whether measure were improving or worsening. Where possible, we aligned the proposed indicators with the indicators from the United Nations sustainable development goals. All that has helped us to decide which of the indicators to go with.

Alex Cole-Hamilton: I will be brief. I am not suggesting that the indicators are not worthy; they are, and some are quite exciting. However, even though the process is as you have described it, I am not persuaded that an indicator that measures the number of visits to the outdoors is more important than the fact that we have nothing in the suite of indicators that measures the health of our social care landscape. As we know from much research that the committee has done, that is one of the main blockages to adequate flow through the NHS. Why should we not think that the Government has its head in the sand on social care, since it does not have an indicator to measure social care provision in our communities?

Shona Robison: As Alex Cole-Hamilton is well aware, tackling delayed discharge is a Government priority, which is reflected in the fact that all the integration authorities have it as a key target. Local delivery is going to deliver—and is delivering—a reduction in delayed discharge. Without that local delivery and the indicators and targets that are being applied across the integration authorities, we would not have the reduction in delayed discharge. An indicator sitting in the national performance framework will not, because each area is different, deliver the change locally that partnerships need in order to ensure that their targets are relevant to their area. Sustained work around tackling delay has led to reductions.

What the city of Glasgow has managed to achieve, given the size of its integrated authority, is absolutely astonishing, and we need all partnerships to be doing that. We recognise that there are in the Lothians and Edinburgh market issues to do with the ability to recruit social care staff. We are well aware of that and have to help the partnerships there to overcome those issues. The issues are particular to Edinburgh and the Lothians, therefore the response has to be shaped in that local context if it is to be in any way successful. That is why the targets sit better with the integration authorities.

The process is working. That is why we have seen a reduction in delays, which I believe we would not have seen had there not been that focus within the integration authorities on driving delayed discharges down.

Sandra White: I have a small follow-up to Alex Cole-Hamilton's questions. The framework has been mentioned. There is not just negativity—there are improvements in health. On older people, I think that it is quite a good thing that it is projected that people will live longer. I am looking forward to joining them; I am sure that lots of us are. It should be celebrated that people are living longer—and we hope, in a better atmosphere and in a better way.

I was a wee bit concerned that there is no outcome for older people, but I understand that there are many underlying issues in that respect. When we are getting feedback from the various agencies, what would be an outcome for older people? Will one be included in the framework or will that be included in all the other outcomes?

I want to pick up on a couple of other points. People are living longer, but probably the worst thing for people's health—this applies mostly to older people, but not just to them—is loneliness. Will a strategy for loneliness be included in framework?

I also want to pick up on David Stewart's point about minimum unit pricing of alcohol. We always mention younger people, but Alcohol Focus Scotland did a massive survey in which it found that unfortunately—I hope that minimum unit pricing will help in this respect—the group that is affected most by alcohol is lonely older people who sit at home and drink. There are facts and figures to prove that. Will that be included in the strategy that will feed into the national performance framework?

Shona Robison: Yes. The system is like a pyramid: the broad indicators are at the top of the national performance framework, and underneath lies all the work that Sandra White highlighted. Local delivery is how the change will happen. Again, I cannot emphasise enough the role of the integration authorities, which are the delivery mechanisms for change. They will take all that work and craft it so that it is relevant to local circumstances. The integration authorities will ensure that they focus on the priorities in their local areas.

Sandra White mentioned loneliness. Many integration authorities focus on reducing social isolation and on bringing people out of their homes. We have talked in the committee previously about our not wanting a person to see nobody from when their care worker leaves on Friday through to Monday. The involvement of the third sector is crucial in tackling loneliness, and we are encouraging integration authorities to focus on reducing social isolation.

There is a pyramid, and the work throughout that pyramid will, in one way or another, impact on the very broad outcomes at the top.

Brian Whittle: Good morning, panel. You are probably aware that I have a particular predilection for looking at the prevention agenda. When looking at national outcomes, I think about the health of the nation; the outcomes are measurements of the health of the nation. I think that we would all accept that we are not doing particularly well in mental health, drink, drugs, obesity and the health of our healthcare professionals, which is fundamental to delivery of any national outcome. With that in mind, do the national outcomes need a stronger focus on prevention in order to create an environment that encourages better and healthier choices?

Shona Robison: Yes. There is a focus on prevention, and a lot of the work to reduce inequalities that we talked about earlier is around prevention. On alcohol, minimum unit pricing and the rest of the framework are about culture change—change in the nature of our relationship with alcohol. Clearly, that involves preventing alcohol misuse in the next generation and trying to get people to view alcohol in a different way.

We have made quite big strides forward through public health policies—on smoking, for example. Brian Whittle is right to highlight obesity, which is the next challenge. He will be aware of the work that Aileen Campbell has been doing to ensure that we take an evidence-based approach to our public health policies, so that we can make inroads into the problems.

The new public health body will be able to give a sharper focus to prevention work—not just in healthcare, but in support for local government, for example. The new body will be able to help local government and other local decision makers in the decisions that they will make on public health. Work is going on apace on the new public health body. That will help us to focus, quite rightly, on prevention.

11:30

Harry Burns's point is important, too. Our giving people a chance in life and giving them hope has to underlie what we do. It is not just about particular health challenges. Getting it right for children and young people is key to improving opportunities for the next generation through making a direct impact on their health and wellbeing. That is why we focus particularly on children and young people.

Professor Burns: Rather than talk about the health of the nation, I prefer to talk about the wellbeing of the nation in a broad sense. A healthy population will tend to have low crime, high participation, good social cohesion and good productivity. It will be firing on all cylinders, across the board. A positive and nurturing childhood gives young people an environment in which they learn, participate and behave well. On the train today, I saw an article in the free newspaper about how young people who get into trouble have brains that are wired wrongly. We have known that for 20 years; studies in Glasgow have shown that psychological activity is different in people who have lived in complex situations as children. They learn to be defensive, are emotionally labile and

their executive functioning is such that they do not make good decisions. We can see that; teachers nod when I talk to them, because they see those things in their classes. Making families secure and safe, and feeling that they can move forward in life, will make the big change in the future. Something in every single part of the suite of indicators contributes to that.

I come back to the point that the number of indicators is huge, so how do we make them work together? How do we get local authorities, health boards, Police Scotland, education authorities and so on to work together to deliver across all the indicators and make the necessary change? I am very excited by the possibility, but I am in no doubt about how difficult it will be to make it happen. We will need an open-minded approach to working together and testing things so that, if they work, we do more of them, and if they do not work, we stop doing them and move on.

Shona Robison: A good example of the cross-Government approach was the recent event about adverse childhood experiences. Every cabinet secretary was there to listen to people's experiences and, importantly, to look at how the experiences could have been prevented in the first place and how to make early interventions when the experiences occur. The impact on the population, including cases such as Harry Burns referred to, is huge. One cabinet secretary cannot begin to tackle it; a cross-Government approach to the work is under way and will be very important.

Gerry McLaughlin: On the preventative approach, members will recall that a pillar of the Government's health and social care delivery plan was reform of public health. It is particularly relevant to NHS Health Scotland because we will become part of the new national public health organisation. One of the important developments as we pursue reform will be the publication next month of a new suite of public health priorities. They have been developed using a whole-system approach across public services. The discussions, especially at the oversight board that is looking at the reforms, have included a strong focus from local government on there being a much stronger public health voice in communities to inform community planning, and there has been a plea for public health to support community planning partnerships.

It is within communities that plans for transport and planning will encourage, rather than just exhort, people to be more active. That is a good example of the preventative approach. The priorities that are emerging are entirely aligned with the national outcomes, as they have been developed.

Brian Whittle: The cabinet secretary alluded to the fact that this is not just about her portfolio, but is cross-portfolio. Can you clarify whether the other portfolios are feeding into the national outcomes and implementing their policies according to national outcomes on health?

Shona Robison: They are very much doing so. I gave an example relating to adverse childhood events. The development of the framework is a cross-Government process in which there has been a change of focus, towards looking for opportunities to collaborate. Brian Whittle may be aware of work that I am doing with Michael Matheson in justice on the prison population and how we can improve outcomes for prisoners, in particular when they leave prison, in order to reduce the risk of reoffending. That is about making sure not only that they get access to health services to address addiction, for example, but that there is a range of ways to minimise the risk of reoffending. That is one example of collaboration feeding into the framework; there are many others. There is real willingness to seek out such opportunities.

Miles Briggs: Good morning, panel. How will the principles that are espoused in the Government's review of targets and indicators be manifested in the national performance framework? The rationale for the review of targets was that NHS staff and managers had expressed frustration at how targets are affecting their work and priorities, and leading them away from best practice. How do you see empowerment of our NHS and social care staff happening in the future? Nurses tell me of their frustration at the amount of form filling that they are asked to do. How will the framework change their lives and empower them to do the job that we want them to in our health service?

Shona Robison: We certainly want to reduce bureaucracy and paperwork generally. Increased use of technology offers an opportunity to do that and to ensure that we maximise the amount of time that health professionals and anybody else has for working with people, rather than on paperwork.

In developing the new framework, we were very mindful of the need for coherence with the work that Sir Harry's review has carried out. The new framework reflects that in a number of ways. It provides improved clarity on the aims of the system, focuses more on indicators and targets, has been shaped through engagement with a range of stakeholders and looks across the whole system at how the parts are interconnected. We have sought to incorporate the findings of the review into the work on the framework, but the framework will continue to evolve and the recommendations from Sir Harry's work can be further incorporated, as we take it forward.

A number of other pieces of work are under way, looking at how we can focus more on outcomes than on targets. Work is being done on cancer waiting times and accident and emergency departments, where the four-hour target is important. The experience of patients across the whole range of unscheduled care is important, so we are looking at that, as well.

A lot of work that is aligned to the framework is under way, and some of that work will be reported on quite soon. The committee will find that it is very much in line with what Sir Harry recommended.

Professor Burns: The comments that I made in the report about the previous national performance framework were that it was frustrating that the national performance indicators were measured only annually, which did not seem to be often enough to enable change. If something were to go wrong, waiting a year to measure what was being done would not give decent feedback on whether it was having an impact.

The second thing is that although some process targets and indicators in healthcare—four-hour waiting times, for example—are important, I was hearing stories about people attending their local A and E department 40 or 50 times a year and calling 999 40 or 50 times a year. A four-hour waiting time in A and E would not help such an individual, because there are other things going on in that person's life that need to be addressed, which is where the high-level indicators come in.

I was not worried about how quickly people were getting through the system; rather, I was interested in asking why people were going into the system in the first place and where they were going at the end of it. The NPF indicators will give the opportunity to start to manage the broader system and to get change happening that will reduce demand and improve outcomes. That fits with what I was concerned about in the review.

Miles Briggs: When you highlighted that, the whole committee agreed that people should be getting treatment and care from the right professional in the right setting.

However, my point is about empowering our professionals. I have met nurses who have never met their managers—they know their name but have never seen them. We need to look at how our health service will change in the future with different systems working. There is lots of talk in the report about change management but, from that, I do not know how we will make that happen in the health service. How should that happen in the future?

Professor Burns: I agree with you: where we have seen successful change in things such as the early years collaborative, it has been through front-line staff being empowered to make change happen. That requires leadership from the top and leaders who will come along and say, "You know about this better than me, so I am happy to let you test the change and tell me what happens." They must give staff permission to do things differently in the hope of finding a better way of doing them. There are any number of examples of that happening in industry, and we have examples in public services, too. Spreading this is the way to make change happen quickly.

Shona Robison: One of the best examples in the NHS is the patient safety programme, which has worked on the principle of empowering front-line staff rather than having memos from senior managers saying, "You need to do this."

The methodology is now being used in other areas of the health service—for example, in mental health and primary care and in other parts of the public service such as justice—because it is about empowering front-line staff. It drives cultural change, too. An example of making sure that our finances are spent as well as they possibly can be is the empowerment of front-line staff in testing ideas about the way in which things are ordered and money is spent. For instance, in Raigmore hospital, front-line staff on wards have been making changes that they have wanted to make for quite some time. They have now been empowered to do that, which has brought a huge financial benefit to that area of the hospital, because they knew that processes could be improved.

It is about listening to front-line staff and empowering them to make changes, whether in procurement, patient safety or other areas. It is a big cultural shift.

Professor Burns: When managers feel that they will be shouted at in the press or—dare I say it?—the Parliament for failing to meet a four-hour waiting time, it is understandable that their focus is on that rather than on the big picture. We all need to understand that the change that is under way is complex. The 95 per cent target may not have been met, but that might be because a lot of people have come in the front door and hospitals have to manage that situation rather than throw all the money and effort at the four-hour waiting time.

11:45

Ivan McKee: Good morning, panel—it is still morning.

I enjoy talking about this subject, because it is what I did for a living before I came into politics and it reflects the experience that I have had in implementing such systems across a range of organisations.

On the positive side, it is great that we talk about empowerment and systems thinking. That is correct. It is clearly important that we measure the right things, and we understand the need to dig in and understand unintended consequences and make sure that we are focused on the right stuff. I can see that the thought processes are starting to go in that direction.

However, what concerns me when I look at this, thinking about organisational review and things that I have done in the past, is the fact that, although it is great that you are measuring things and having a conversation about whether you are measuring the right stuff, there is a long way to go on whether the things that are being measured line up with each other and are measuring what is important to the organisation and on whether you are living and breathing this stuff and using it to drive process improvement.

I do not have the feeling that, when you wake up in the morning, the first thing that you think about is the national performance indicators or that they are the last thing that you think about before you go to bed. If you were following the process properly, that is exactly what you would do, because the indicators on the paper in front of us would be completely aligned with everything else that is important across the organisation and everything that is happening in the organisation. You would understand the linkage between those things and the indicators on the paper. I think that there is still a way to go on that journey, but that is fine because the further we go, the better things are going to get.

In a perfect or sensible world, the national performance indicators, the work that is done on indicators and the work that health boards and integration authorities are doing on local delivery plans should all be joined up so that we know that what is happening in one place links up with what is happening in another and we understand the linkage and relationship.

We must understand that what is happening in a health board at a local level has a direct impact on an indicator on a piece of paper in front of us. How are we getting on with joining all of that up so that it is all linked?

Shona Robison: We are joining it up. The work that is under way with integration authorities in the data working group is aligned with the local delivery plan standards. Those continue to be important and are being reviewed, as I touched on earlier.

The point about measuring the right things develops Harry Burns's point. He is right to ask why people end up at the front door of the hospital, and we understand that issue a lot more now. Integration authorities are explicitly saying that they are going to reduce those unscheduled episodes because they know that hospital is the wrong place for a lot of them. Integration authorities invest in primary care and services that keep people at home in order to deliver that outcome.

We see far more focus on understanding addiction issues. That is the reason for some of the work at Glasgow Royal infirmary, for example, which has identified the people who keep coming through the revolving door. Having alternatives for those people is the focus.

We have understood those issues more. The work is aligned and the success of all that work will drive the indicators in the national performance framework in the right way. It goes back to the pyramid. All the work at the bottom will drive the indicators at the top in the right direction by making sure that we focus on the right things.

Alison Taylor: The cabinet secretary has given the important example of the objective to reduce occupied bed days in hospital, which is set out in the delivery plan. For a very long time, we have focused on delayed discharge, as is right and proper. However, as everyone knows—everybody in local systems tells everyone this—it is far too late to start thinking about the problem at the point when someone is already delayed. We needed to take a more holistic look at the whole pathway of care and the sort of experience that Harry Burns is describing, including admission and what happens before admission.

An objective to reduce unscheduled bed occupancy is narrow enough in definition that we can actually count it—which is important—but is also a good signal about what is happening across the system and in our relationship with the partnerships. It is important that they are looking at the current performance and are establishing a positive objective for improvement to fit into the national aim. That is a good balance of responsibility and signals a good relationship between national and local partners. I hope that we are measuring better and in a better way than we were.

Gerry McLaughlin: We I am responsible for NHS Health Scotland, which is one of Scotland's public health bodies, and, just over five years ago, it was very clear that health inequalities had become a real focus in Scotland's public policy narrative. We looked to the then national outcomes to source the authority for a change of emphasis towards inequalities, which is why our organisational strategy was called a fairer, healthier Scotland. That gave us the opportunity to look outside the world of the NHS, in which we operate for most of our business, and to work with natural partners. That required us to develop a

whole different approach to what such a partnership should look like.

I mentioned the place standard tool. That piece of work was undertaken by NHS Health Scotland, Scottish Government planning officials and Architecture and Design Scotland, which are not natural bedfellows. However, on the basis of the evidence that we considered, bringing those specific people together was most likely to create conditions in which people's health and wellbeing could be preserved, maintained and supported.

The changes in public health give me a lot of cause for hope because of the extent to which the Scottish Government has now engaged in a very formal partnership with local government on how to create public health. One of the disadvantages in Scotland in the past 40 years or so is that public health has become quite disconnected from local government in many cases. This is an opportunity to put public health right back at the centre of the public sector space between the NHS and local government, and it is largely driven by the focus on the national outcomes.

Roger Halliday: Stepping back, although there are some challenges in implementing the national performance framework, it is considered to be world leading—as international commentators from around the world, such as Professor Stiglitz, have said. Over the past few years, many countries have seen what is happening in Scotland and have adopted our approach. We have some way to go, but we are still quite a long way ahead of other people.

Kate Forbes: You have discussed how to empower staff and how to include staff to ensure that the framework is at the top of the agenda in their daily work. What about improving the ways in which staff can feed back into the implementation? I am talking about trial and error. There will be times when things work and times when there are lessons to be learned as you monitor and review the performance indicators. How do you envisage professionals being able to feed into the process, not just at the beginning but on an on-going basis?

Shona Robison: We need to look at what the evidence tells us works. A lot of change is happening—there is a lot of reform in the public sector generally—and we have learned lessons. The worst thing to do is to send a memo from on high, saying, "As of next Tuesday, this is how we are going to do things." That does not create change.

The better way to create to change is through the improvement methodology that the patient safety programme has shown works. That approach is to test the theory of a change in a setting, so that you get a group of staff—wherever they are and whatever they are doing—to test the method. When they see the benefits, they become the proponents of the change and tell others why it is a better way of doing things. It is not rocket science, but it works.

We need to make sure that staff are involved in understanding and talking about why a change is necessary and why it is better to do something a certain way. The methodology of change is about making sure that a change is tested properly and that the staff who are involved become the promoters of acting in that different way.

If we look at the patient safety programme 10 years on, we will see that it started small, by doing something different in one area, and has now become a way of developing and delivering change across the public sector.

When I was at the Western general hospital, I was told by folk who were involved in the early days of the programme that there was a lot of cynicism about the programme—they had heard it all before and queried why it would be any different from other approaches—but those same people told me what a difference it had made, because they could see the benefit to patients straight away. That way of working can be applied in any setting and, as we reform our public services, we should use that methodology as much as possible.

Professor Burns: Data drives front-line staff to make changes. Recent events are making me think of bedtime bear. How do you raise the level of cognitive development in children? One way is to make sure that they all have bedtime stories. We could say that we will have a strategy for bedtime stories, but such a strategy would not work. However, we could ask front-line staff what they could do with parents who come to collect their children from nurseries that would enhance bedtime reading. The next day, we could ask the children whether they had had a bedtime story, and we could then log the results. If you do something and the figures increase, you do more and they go up again, and staff become seized with it.

Bedtime bear is a classic example of that. A nursery gave a teddy bear to all the children and said to them, "Bedtime bear needs a story before he will go to sleep at night. When he is going to sleep, you take bedtime bear to mummy or daddy and get them to read you a story." In that way, the child gets a story. That was one of the first tests of change in the early years collaborative, and it is small things like that that make a difference. Suddenly, the numbers went up. East Ayrshire Council tweeted a picture of an A4 sheet with the numbers going up, and everyone started thinking about the approach.

Showing people that what they are doing works encourages them to do more of it. You then share that across Scotland and, before you know where you are, you have a result.

Kate Forbes: I understand that all the indicators are given equal weighting. Ultimately, meeting those indicators will filter down into staff's daily priorities. However, there may well be rural and urban inequalities in how they meet those indicators, targets or priorities.

Professor Burns: There should not be. Patients are patients, whether they are in a rural or urban setting—people are people, wherever they are. If you want to enhance hand washing on a ward, the same principles apply no matter where you are.

The critical aspect is that staff working in rural settings need to be involved in and part of the change. They certainly were involved—800 people would get together every six months for the early years collaborative, which was very powerful.

12:00

Ash Denham: Geoff Huggins mentioned the same topic at a previous meeting, which he framed as

"working to develop a next-stage process."—[*Official Report, Health and Sport Committee*, 9 January 2018; c 52.]

What is the next step? When can we expect a bit more information on this outcomes-based approach?

Shona Robison: The work is on-going. To return to Ivan McKee's point, we need to make sure that everything aligns, that everyone can see how it all aligns, that there is a clear line of sight on how the work that the integration authorities are taking forward on the ground fits with the national performance framework and that the work that Harry Burns has set us on a track to achieve shifts us more to outcomes.

The work on how we focus more on the outcomes for people, whether that relates to their coming through the front door of a hospital or remaining at home or to tackling social isolation, is going on in a number of settings. All those things are hugely important, but their detail will be captured through the work of the integration authorities.

Alison Taylor: That is right. There is also process related to that work. For a number of years, the cabinet secretary has chaired a ministerial strategic group for health and community care, which is co-chaired with the Convention of Scottish Local Authorities. That builds on Gerry McLaughlin's point about true cross-public sector working. The group receives regular updates on the progress that integration authorities are making on key indicators that sit at the heart of what their local planning for improvement looks like.

How we are providing those updates may not sound novel, but it is. There is a national aspect to it, but we also ask chief officers from individual areas to come and talk about some of the issues that they are grappling with. It is all new off the blocks, but it is a good model to work with. The progress that is made will be reflected in the integration authorities' annual reports, so there will also be a formal published mechanism.

We are building on all that work. A lot of effort and investment has gone into supporting it, including to improve the data and the skills in local systems. We have analysts on the ground in every partnership area, and we are learning from specific improvement activities. For example, Dumfries and Galloway NHS Board has been doing interesting work on dementia indicators. Therefore, we are learning from individual good practice, too.

That is, basically, the outline of the next stage in the development of the work.

The Convener: I thank the witnesses for their evidence today. We now move into private session.

12:02

Meeting continued in private until 13:03.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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