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Health and Sport Committee

To consider and report on health policy, the NHS in Scotland, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Sport, and measures against child poverty.

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## Committee Membership

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Foreword

1. As Winston Churchill once said, “Healthy citizens are the greatest asset any country can have” and Session 4 has seen the Health and Sport Committee focus on scrutinising those areas that most affect the health of the people in Scotland. Our Committee work has taken us across Scotland and seen us investigating a range of areas, from teenage pregnancy to palliative and end of life care.

2. Our focus on health inequalities demonstrated that only continued focus and momentum in tackling the wide range of health and wider societal factors that influence health inequality will reduce the disparity between those who enjoy good health and those who don’t. This will be an enduring challenge for our successor Committee.

3. The Committee examined a range of new laws which will significantly change the way health and social care is delivered in Scotland. This includes laws to integrate health and social care services, to better support those who care for others, and to address one of Scotland’s greatest challenges – its poor relationship with alcohol.

4. The Committee has also inquired into a wide range of issues which affect the quality of people’s day-to-day lives, such as seeking to improve mental health services, delivering more effective access to new medicines or exploring ways to increase participation in sport.

5. Session 4 has been our busiest session yet and the outcomes of much of the work we have undertaken will only become visible in Session 5. It will be a key role for our successor Committee to scrutinise whether those health outcomes are delivered successfully such that more of Scotland’s greatest asset, its citizens, are able to contribute fully.
Introduction

6. This report is intended to highlight key pieces of work undertaken by the Health and Sport Committee during Session 4, and to outline to its successor committee areas where it considers further work would be worthwhile. The report also outlines a number of new and innovative working practices that the Committee wishes to draw to the attention of its successor committee and the Parliament as a whole.

7. Our successor committee will, of course, wish to consider its priorities in the light of its own work programme.
Session 4 in numbers

- **171** Committee meetings
- **180** SSIs considered
- **13** Bills scrutinised
- **15** Inquiries held
- **1014** Number of people who gave evidence representing 629 organisations
- **62** Reports published
Legislation

Scottish Government Bills

8. The Committee has considered the following Scottish Government Bills during Session 4—

- Alcohol (Minimum Pricing) (Scotland) Bill
- Burial and Cremation (Scotland) Bill
- Carers (Scotland) Bill
- Food (Scotland) Bill
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill
- Mental Health (Scotland) Bill
- Public Bodies (Joint Working) (Scotland) Bill
- Social Care (Self-directed Support) (Scotland) Bill
- Victims and Witnesses (Scotland) Bill

Members’ Bills

9. The Committee has also considered the following Members’ Bills during Session 4—

- Alcohol (Licensing, Public Health and Criminal Justice) (Scotland) Bill
- Assisted Suicide (Scotland) Bill
- Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill
- Transplantation (Authorisation of Removal of Organs etc.) (Scotland) Bill

Legislative Consent Motions (LCMs)

10. The Committee considered four LCMs this session on:

- Care Bill
- Children and Families Bill
- London Olympic Games and Paralympic Games (Amendment) Bill
- Welfare Reform Bill
Subordinate Legislation

11. Over the course of the session, the Committee scrutinised 180 Scottish Statutory Instruments and published 28 reports on subordinate legislation. The Committee took oral evidence from stakeholders, Scottish Government ministers and officials where appropriate.

12. The Committee highlights to its successor committee the following matters which arose during our scrutiny of subordinate legislation, and which may benefit from being revisited in Session 5.

Scrutiny of UK-wide regulators of health and care

13. At its meeting on 23 June 2015, the Committee took evidence on the Health and Care Professions Council (Registration and Fees) (Amendment) (No. 2) Rules Order of Council 2015 (SI 2015/1337). This instrument sought to increase the registration fees charged by the Health and Care Professions Council (HCPC) in respect of registration with it (initial, renewal, restoration and readmissions to the register) and scrutiny fees connected with registration. At that meeting, the HCPC gave evidence on the reasons for the subordinate legislation.

14. The Committee heard that there are nine UK-wide regulators that are under the auspices of the Professional Standards Authority (PSA). These regulators’ activities include regulation of professionals working in Scotland.

15. The Committee noted that it had undertaken very little scrutiny of the activities of these UK-wide regulators to date and agreed to recommend to its successor committee that it considers taking evidence from these regulators on the impact of their fees and regulatory activities on professionals in Scotland.

Inquiries

16. Owing to its other commitments, the Committee has had less opportunity to undertake inquiry work than it would have wished. Nonetheless, during the course of the session, the Committee has conducted a number of inquiries on issues/topics including—

- Access to new medicines
- Health inequalities
- Integration of health and social care
- Teenage pregnancy
- Palliative and end of life care
• Regulation of care for older people
• Support for community sport

Health Inequalities

17. In 2012, the Committee agreed that a major priority for its inquiry work for the mid-part of Session 4 would be into health inequalities. We held a scoping exercise which included a health inequalities event and visit. We also agreed to hold a short, parallel inquiry into teenage pregnancy which reported in 2013. Throughout the inquiry into health inequalities we held shorter, more focussed, evidence sessions on key contributory factors which widen health inequalities.

18. As part of that work, we recognised that the root causes of health inequalities often lie outside the field of health and are primarily linked to the wider social and economic inequalities that exist in society. Given this, we wrote to each relevant committee in Session 4 to recommend that they consider inviting their successor committee to include, as part of any inquiry remit or Bill scrutiny during Session 5, the impact of that policy on inequalities.

19. In addition, as part of its work into health inequalities, the Committee agreed that it would also provide a summary of the key evidence it received on health inequalities in early years.

20. This summary is provided in Annexe A to this report and identifies three areas where the Session 5 committee may wish to consider undertaking further work and which have been repeated below.

21. Our successor committee may wish to review the progress being made by the Scottish Government in relation to early years health inequalities with an emphasis on the need for the routine and systematic evaluation of projects. It may also wish to follow-up the on-going work of the Early Years Collaborative.

22. In this inquiry, the Committee heard about challenges in primary care, particularly pressures on GP and health visitor workloads and the need for an increased level of support to be available through school nursing services. Our successor committee may therefore wish to inquire into the Scottish Government’s workforce planning and how it is supporting early years services.

23. Finally, our successor committee may also wish to explore whether a more nuanced approach to tackling health inequalities in early years, such as ‘proportionate universalism’, is desirable or achievable.
The future of the NHS

24. A recurring theme during the course of the Committee’s work this session has been recognition that the NHS and the wider care landscape need to be restructured in order to meet future demand and to make the most efficient possible use of available resources.¹

25. The Committee therefore welcomed the Scottish Government-led ‘Creating a Healthier Scotland’ national conversation and the opportunity given to host, with the Scottish Government, an engagement event as part of this work.

26. This conversation involved a number of public events and consultations focused on the long-term future of health and social care service in Scotland. The Convener, on behalf of the Committee, contributed to this conversation by speaking at an ALLIANCE event held in Musselburgh on 7 December 2015.

27. The Committee notes that the Scottish Government is due to produce a final report of the national conversation before the Parliament dissolves.

28. In addition, during 2015/16 a wide range of work was undertaken by different Scottish Government review groups to determine the future direction of health and social care services. In addition to the recent publication of the Public Health Strategy and a National Clinical Strategy for Scotland², Professor Lewis Ritchie published his Report of the National Review of Primary Care Out of Hours Services³ on 30 November 2015.

29. That review considered the current delivery landscape and recommended a range of actions in relation to primary care out of hours services. The report identifies recommendations about a new model of care; individuals with specific needs and access requirements; health inequalities; the future workforce and the roles of its multidisciplinary members; the roles of Health and Social Care Partnerships and Integrated Joint Boards (IJBs); Special Health Board and Public Bodies; the third and independent sectors and other statutory agencies.

30. Recommendations are also provided about supporting the public to promote prevention and self-care, where appropriate, and to seek the right Out Of Hours and urgent care service, when needed. National workforce, Out Of Hours service specification and implementation plans are recommended, with guidance for local translation. Proposals are also made about research, evaluation, affordability and best use of resources.

31. It is understood that the Scottish Government will publish a response in early 2016 which will outline the implementation of the report’s recommendations.

32. Given the significance of this report to the future delivery of health services, our successor committee may wish to take evidence from Professor Ritchie and the Scottish Government early in Session 5 on the proposals for the future delivery landscape of primary care out of hours services.
33. Our successor committee may also wish to consider the final report of the National conversation, alongside the Public Health Strategy and a National Clinical Strategy for Scotland, and the Scottish Government’s response to the Report of the National Review of Primary Care Out of Hours Services given they will, collectively, determine the future direction of health and social care service provision in Scotland.

Palliative and end of life care

34. The Committee carried out an inquiry examining access to palliative care and the initial conversation about palliative and end of life care - We need to talk about Palliative Care. The inquiry also included undertaking some focused research into international comparisons of measurement of data used in palliative and end of life care.

35. Our report raised various concerns, including the need to:

- provide palliative care on a ‘need not diagnosis’ basis
- ensure there was a “joined-up service” so that transitioning between services ran smoothly and had no detriment on the care provided to a person
- ensure a person-centred approach was undertaken when deciding what services were required for each person
- collect input and output data so that the quality of services could be better understood
- ensure that conversations around death and dying were brought to the fore and made more approachable
- identify how information relating to a person’s palliative care needs (such as within anticipatory care plans) can be easily accessed and shared between medical professionals
- ensure that more appropriate respite options were available for young adults transitioning from children’s hospices.
- provide mandatory training in palliative care across the health sector.

36. The inquiry was timed so that it could feed into the Scottish Government’s Strategic Framework for Action on Palliative and End of Life Care. This Framework was published on 18 December 2015. In its response to the Committee’s report the Scottish Government explained that “The Strategic Framework for Action on Palliative and End of Life Care provides both a high-level vision, and commitments that are intended to provide a solid foundation for future implementation action over the period 2016-2021”.

8
37. Our successor committee may wish to explore with the Scottish Government the progress made in delivering the Framework’s vision, and the effectiveness of the implementation work undertaken during Session 5.

Penrose Inquiry Report

38. The Penrose Inquiry Final Report was published on 25 March 2015 and represented the final outcome of the Scottish Public Inquiry into Hepatitis C/HIV acquired infection from NHS treatment in Scotland with blood and blood products. The Committee has had a longstanding interest in this issue starting with our predecessor Committees considering petitions on this issue in 1999 (Session 1), undertaking its own inquiry in 2000 (session 1) which recommended that an expert group examine the issue and then calling for a full public inquiry in 2006 (Session 2).

39. In February 2016, we took written and oral evidence from the key stakeholders in Scotland (Haemophilia Scotland, The Scottish Infected Blood Forum and the Hepatitis C Trust) on the progress made since the Penrose Inquiry report was published and then took evidence from the Cabinet Secretary for Health, Wellbeing and Sport.

40. Following that evidence, we wrote to the Cabinet Secretary welcoming the progress made but acknowledging the work underway in relation to the Scottish Government’s response to the Financial Review Support Group, the forthcoming report from the short term working group on the look back exercise, and the UK Government’s review of the Skipton Fund.

Budget Scrutiny

41. The Committee has scrutinised and reported on each of the Scottish Government’s draft budgets which have been introduced this session.

42. The Committee has also developed further, this session, its scrutiny of NHS board budgets and has undertaken an annual survey of NHS Board budget plans. These surveys have been an effective tool to provide an in-depth examination of spending plans at a local level.

43. The Committee’s approach to budget scrutiny this session has reflected the structure adopted by the Finance Committee in considering issues of prioritisation, affordability, value for money and budget processes.

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\(^{i}\) A survey of NHS board budgets was conducted for the proposed spending in each of the following financial years 2010-11, 2012-13, 2014-15, 2015-16. A survey was not conducted for 2016-17 due to NHS board budgets being set post dissolution. Was the annual survey conducted in 2011-12 and 2013-14 too?
44. In relation to the budget process, the Committee has sought to encourage the Scottish Government to demonstrate more explicitly the links between budget lines and targets and objectives.  

45. An increasing area of interest for the Committee’s scrutiny of the health budget has been the integration of health and social care. The Committee noted in its report on the Draft Budget 2015-16 that there was a risk that the acute sector was not going to be sufficiently challenged to reconfigure the way it organises and provides its services, with the result that the hoped for degree of integration and reorganisation of services may not be fully realised.

46. Recent scrutiny of the sport budget has focused on the legacy of the Commonwealth Games and determining the impact investment has had on the provision of facilities and participation levels in sport.

47. The Committee suggests that budget scrutiny of the integration of health and social care is an area its successor committee may wish to explore further as Integrated Joint Boards become fully operational in the next financial year.

48. The Committee recommends that its successor committee continues to conduct an annual survey of all NHS boards’ budget plans to support its budget scrutiny.

European Issues

49. During Session 4, consideration of European issues has been part of the Committee’s inquiry and legislative work, such as with scrutiny of alcohol minimum pricing or e-health, or through our visit to Spain to learn about its organ donation system/programme.

Post-legislative scrutiny and post-inquiry scrutiny

50. Session 4 has seen considerable change within the health and social care sector, and many of the policy or legislative changes on which we have undertaken scrutiny will be implemented during Session 5. As such, we have set out below some areas where our successor committee may wish to undertake post-legislative or post-inquiry scrutiny.
Integration of health and social care

51. One of the most significant changes to the health and social care landscape has been the implementation of integrated joint authorities (IJAs) which will begin operating, with delegated services and budgets, from April 2016.

52. The Committee has undertaken a considerable volume of work in this area, considering not only the policy intention but also subsequently the funding, governance and accountability arrangements of IJAs. In our January 2016 letter to the Scottish Government on the draft budget 2016-17 we noted that the Scottish Government estimates that the budgets for which integration authorities are responsible will be in excess of £8bn, with the total to be determined by the scope of delegated services. This includes over 60% of current health board expenditure.

53. In that letter we highlight a range of future challenges for IJAs, including budget setting; the ability of health boards to ‘set aside’ funding for IJA\(^\text{ii}\); accountability for the performance of IJAs as well as how external accountability between the integrated authority, NHS board and the Parliament will work, and governance arrangements between the different IJA partners.

54. Given IJAs will begin operating from April 2016, in Session 5 our successor committee may wish to scrutinise how well IJAs are addressing these challenges.

Prescription for Excellence – progress update

55. In April 2014, the Committee took evidence from the Scottish Government on its action plan and vision for pharmaceutical care – “Prescription for Excellence”\(^6\). This plan, published in September 2013, complements the Scottish Government’s 2020 vision for health and social care in Scotland and sets out a vision and action plan for the delivery of high quality pharmaceutical care across communities in Scotland over the next 10 years.

56. The Committee agreed that it would be helpful to review the progress made with this action plan following its implementation. Our successor committee may wish to consider seeking such a progress report in Session 5.

Scrutiny of future Regulations

57. Some of the legislation that the Committee has considered will give rise to further regulations which will be laid in the Parliament during Session 5. The following are

\(^{ii}\) That proportion of the health board budget that is allocated to the IJA in relation to acute hospital services for unplanned care.
key regulations that this Committee would wish to bring to the attention of its successor committee as being of particular interest.

Mental Health (Scotland) Act 2015

58. The overarching objective of the Mental Health (Scotland) Act 2015 is to help people with a mental disorder access effective treatment quickly and easily.

59. The Act introduces a number of provisions regarding the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003. It also makes a series of minor and technical changes to the Criminal Procedure (Scotland) Act 1995, in relation to the way in which criminal courts deal with people with mental disorders who are involved with criminal proceedings. Furthermore, the Act makes amendments to the Criminal Justice (Scotland) Act 2003, for the introduction of a notification scheme for victims of some mentally disordered offenders subject to certain orders.

60. It is expected that the successor committee will have a number of negative and affirmative statutory instruments to scrutinise in relation to bringing the majority of the Mental Health (Scotland) Act 2015’s provisions into force by spring 2017.

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill

61. Part two of this Bill proposes to give health, social care and social work organisations a ‘duty of candour’. What this would mean is that, in the event that a person experiences (or could have experienced) an unintended or unexpected harm from their care, which is unrelated to their illness or condition, the organisation would have a duty to tell the individual.

62. The Bill does not set out this procedure: it will be the subject of future regulations to be brought forward by Scottish Ministers. The Bill at section 22 explains that such regulations may include provisions about (among other things) the notification procedure, the apology to be provided and the actions which must be taken, and will emphasise learning, change and improvement.

63. Whilst the Committee was content with the inclusion of a duty of candour, we recognise that the regulations will play a significant part in ensuring that the duty of candour is able to be implemented across a wide range of health and care settings. In our stage 1 report, we made a number of recommendations about the content of these regulations, including that the procedure:

   a. builds in existing candour procedures and processes
   b. includes a wide range of health and care staff in their formulation
   c. enables patients and their families to change the details about an incident, and
   d. involves patients and families in identifying the causes of incidents as well as in identifying any future service improvements.
64. We therefore invite our successor committee to consider these stage 1 findings when it considers the regulations which seek to implement the duty of candour proposed in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill.

Regulation of cosmetic procedures

65. In February 2016 the Committee considered four Scottish Statutory Instruments\(^7\) which, when taken together, will have the effect of providing for Healthcare Improvement Scotland to inspect independent clinics whose services are provided by medical professionals, dental professionals, registered nurses, registered midwives and dental care professionals. This represents the first phase of a three phase approach which the Scottish Government explained would provide for the regulation of cosmetic procedures.

66. The Committee took evidence from stakeholders on 11 February 2016 and from the Minister for Public Health on 23 February 2016.

67. Phase 2 will cover cosmetic procedures provided by non-healthcare regulated practitioners (beauty/cosmetic salons). This may involve a licensing system within which a register is available and inspections can be carried out. At the Committee meeting on 23 February 2016, the Minister for Public Health confirmed that this phase will begin in April 2016 and will be completed by the end of 2016.

68. Phase 3 will consider healthcare provided by other allied health professionals, such as healthcare scientists. At the Committee meeting on 23 February 2016, the Minister for Public Health confirmed that this phase will start in 2017 and will likely take a year to complete.

69. Our successor committee may wish to reflect upon the evidence taken by this Committee on the regulation of independent health care clinics (phase one) when considering the outcome of work at phases 2 and 3.

Petitions

70. In Session 4 the Committee considered the following petitions:

- PE1056 by Gordon, Jane and Steven McPherson on deep vein thrombosis
- PE1378 by Mairi Johnston on silicone breast implants - rupture awareness
- PE1384 by Kim Hartley on behalf of the Royal College of Speech and Language Therapists on Giving Voice - speech and language therapy transforms lives
• PE1398 by Alastair Kent on behalf of Rare Disease UK on access to therapy for orphan diseases

• PE1399 by Allan Muir on behalf of Association for Glycogen Storage Disease (UK) Ltd on equitable access to therapy for Pompe disease

• PE1401 by Lesley Loeliger and Professor Peter Hillmen on behalf of PNH Scotland and the PNH Alliance on access to therapy for paroxysmal nocturnal haemoglobinuria.

• PE1434 by Nairn McDonald on additional funding for sport facilities and a minimum level of sports facilities.

• PE1451 by Belinda Cunnison on behalf of Freedom to Choose (Scotland) on review of the smoking ban.

• PE1453 by Caroline Wilson on behalf of The Evening Times and Kidney Research UK (Scotland) on opt for life.

• PE1466 by William Tait on Local Authority charges for non-residential services.

• PE1492 by Mr Alan Kennedy on co-location of GP practices and community pharmacies.

• PE1499 by Robert Watson formerly on behalf of CHAS Young Adult Council on creating suitable respite services for younger disabled adults with life-limiting conditions.

71. For full details of the Committee’s and Parliament’s consideration of these petitions please see the Parliament’s website at: http://external.scottish.parliament.uk/gettinginvolved/petitions/index.aspx

Areas for further scrutiny

Co-location of GP practices and community pharmacies (PE1492)

72. Decisions on where community pharmacies are located were a recurring issue in Session 4 and were also raised in PE1492. The Health and Sport Committee scrutinised two sets of amending regulations aimed at changing the process by which NHS Boards approve entry on to the pharmaceutical list. More widely, we also heard concerns about the closure of dispensing GP practices and the subsequent impact on the sustainability of health services in remote and rural areas.

73. Changes to the regulations have sought to improve the process, for example, by requiring consultation with affected communities as well as allowing the participation of community representatives in the consideration of applications to open a pharmacy. However, we are aware of ongoing disputes about the location of pharmacies in Scotland.
74. The new committee may therefore wish to keep this issue under review, with a view to scrutinising it at a future date.

**Giving Voice - speech and language therapy transforms lives (PE1384)**

75. Whilst we agreed to close this petition at our meeting on 8 March 2016, we acknowledged that had time permitted during Session 4 we would have undertaken further scrutiny of those issues in this petition relating to the provision of services by Allied Health Professionals and Speech and Language Therapists in particular.

76. We recommend that our successor Committee give consideration to undertaking an inquiry into the support for services provided by Allied Health Professionals and Speech and Language Therapists. These services will become more important with the integration of health and social care services and with the focus on delivering more services in the community.

**Potential topics for inquiry**

77. The Committee has identified above a range of areas where its successor committee may wish to undertake further scrutiny, some of which will automatically be referred to the Session 5 committee as statutory instruments.

78. We recognise that the successor committee will have its own views as to which issues it wishes to inquire into but in addition to the areas identified above, there are a number of other topics which, had time permitted, the Committee would have undertaken inquires. These have been set out below:

**Obesity and related issues**

79. While the Committee was keen to explore issues around obesity and nutrition/vitamin D deficiency, it agreed that the topic would require a significant amount of Committee time to consider fully, and that time was not available in Session 4. The Committee also considered conducting some work on community food initiatives, including how such initiatives can improve the health of disadvantaged, vulnerable individuals and families through improved access to healthy food.

**Work, Health and Wellbeing**

80. The Committee expressed an interest in investigating the links between emerging patterns of work, employment and welfare on health and wellbeing and believed that a one-off roundtable session on this topic would be beneficial.
81. Around the same time, the Economy, Energy and Tourism Committee launched a major inquiry into work and wellbeing which included exploring the health and social impacts of low pay and low quality work. The Economy, Energy and Tourism Committee published its inquiry report ‘Taking the high road – Work, Wages and Wellbeing in the Scottish Labour Market’ on 14 January 2016.

82. The Committee suggests that these issues may be ones its successor committee would wish to consider exploring further.

Learning from serious failings in NHS care in Scotland

83. On 10 July 2015, the Academy of Medical Royal Colleges and Faculties in Scotland published a series of major recommendations aimed at addressing systemic failings in NHS care in Scotland, evidenced in recent reports on hospital deficiencies, which it believes have been predominantly caused by the failure of clinical staff and NHS management to work together to deliver improved healthcare. The Academy has offered to present its findings to the Committee.

84. Unfortunately our very full work programme meant that it was not possible for us to take evidence on this report from its authors and the Scottish Government in Session 4.

85. We therefore recommend that our successor committee considers taking evidence on this report early in Session 5 to understand how the findings from this report can be used to improve healthcare in Scotland.

Working practices

86. This session, the Committee has been at the forefront of pioneering new and innovative ways to reach a wide and diverse audience to engage with the work of the Committee.

87. The Committee was the first to launch its own Twitter account, following approval from the Public Engagement Board, on 16 February 2012. The account is followed by a combination of individuals and stakeholders. The Committee primarily follows stakeholders such as NHS boards, local authorities, third sector organisations and some individuals particularly active in the health and sport policy areas.
88. Twitter’s primary role for the Committee was to promote the meetings of the Committee, publicising calls for written evidence and announcing the publication of reports. The Committee’s account has been most effective when disclosing specific information (for example, the results of a survey).

89. The Committee was the first to host an “Ask the Cabinet Secretary” session, where members of the public were encouraged to suggest questions, via Twitter and email, that they would like to be put to the Cabinet Secretary for Health, Wellbeing and Sport. A large volume of questions were received from the public with a selection put to the Cabinet Secretary by Committee members at a formal Committee meeting for response.

90. The Committee has also sought to encourage people to submit evidence in alternative formats. This has included linking in with a Festival of Politics event on vlogging, the outcome of which was a series of vlogs from young people on their experiences and views on e-cigarettes. These vlogs fed into the Committee’s scrutiny of the Health (Tobacco, Nicotine etc. and Care) (Scotland).

91. Throughout Session 4, the Committee has dealt with a range of sensitive issues and it has sought to engage people affected by them who wish to share often very personal and difficult experiences in a way that they are most comfortable with. This has included a number of informal evidence sessions where Members have visited people in their local communities to discuss their views and experiences.

92. During the course of this session’s legislation and inquiry work the Committee has benefited enormously from the opportunity to meet with people from across Scotland and outwith Scotland including: adult and young carers; individuals who require self-directed support; those requiring or who have received a donated organ; adults and children requiring hospice care, and support staff and individuals affected by the issues raised in the Burial and Cremation (Scotland) Bill. The Committee has found these sessions invaluable in informing and enhancing the scrutiny of the work it has conducted.
93. As well as informal evidence sessions, members of the public have also submitted evidence by sharing their views over the telephone with an individual clerk or Committee Member, who has provided a written summary of the conversation to the rest of the Committee.
94. The Committee has also used online surveys promoted through Twitter and Facebook to gather views on specific provisions within Bills. These surveys seek responses via buttons or free text boxes, enabling views to be provided in minutes. This has proved to be an easily accessible way for the public to share their views. The surveys have proved very popular, with the online survey on the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill achieving 845 responses.

95. The Committee believes that reaching as wide and diverse an audience as possible enhances its scrutiny work. The Committee would like to thank all those who have engaged with it this session. The Committee would like to encourage its successor committee to adopt a similar approach to ensuring that as wide and diverse an audience as possible is engaged with its work.

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1 Health and Sport Committee Report on Draft Budget 2015-16, paragraph 124.
3 http://www.gov.scot/Publications/2015/11/9014/0
4 Health and Sport Committee Report on Draft Budget 2015-16, paragraph 103.
5 Health and Sport Committee Report on Draft Budget 2015-16, paragraph 132.
7 National Health Service (Scotland) Act 1978 (Independent Clinic) Amendment Order 2016 [draft]; Healthcare Improvement Scotland (Fees) Regulations 2016 (SSI 2016/26); Protection of Vulnerable Groups (Scotland) Act 2007 (Prescribed Purposes for Consideration of Suitability) Regulations 2016 (SSI 2016/27), and Public Services Reform (Scotland) Act 2010 (Commencement No. 7) Order 2016 (SSI 2016/22).
Annexe A

Health inequalities - Early years

1. To progress its work on health inequalities the Committee agreed to hold a short inquiry on early years. The overall aim of the inquiry was to investigate the extent and character of health inequalities in the early years in Scotland. This paper outlines the Committee’s work and highlights some of the key themes to emerge.

2. The Committee published a call for written evidence to which it received 67 submissions. The Committee also held a number of oral evidence sessions:

- 6 May 2014, on the Early Years Collaborative
- 13 May 2014, with Professor Sir Michael Marmot and Professor Sir Harry Burns, followed by a roundtable session with representatives from ScotCen Social Research, University of Glasgow, University of Dundee, Centre for Excellence for Looked After Children in Scotland, University of Edinburgh, University of Dundee, WAVE Trust, Centre for Confidence and Well-being and the University of Aberdeen
- 2 December 2014, a roundtable session with health professionals with representatives from British Medical Association, Community Practitioners and Health Visitors Association, Director of Public Health NHS Greater Glasgow and Clyde, Homeless Families Health Care Team, Lothian Deprivation Interest Group, Royal College of Midwives, Royal College of Nursing, The Royal College of Paediatrics and Child Health.

3. The Committee undertook two visits. Members visited Royston Wardieburn Community Centre in Edinburgh where they heard presentations on Stepping Stones work with young parents, Family Nurse Partnerships, Total Craigroyston, and had an opportunity to talk to parents involved in these programmes. Members also visited Barnardo’s Threads in Paisley and Templeton Business Centre where they heard from Mark Feinmann and Gary Dover, Glasgow City CHP and Phil Rakhra, Healthy Children Programme Manager. Members also visited Westerhouse Nursery School and Family Learning Centre and Bridgeton Family Learning Centre.

4. The Committee concluded its work with an evidence session with the Minister for Public Health and the Minister for Children and Young People on 9 December 2014.

Early years health inequalities within the wider context

5. In its previous report on health inequalities (SP paper 637) the Committee noted that many of the root causes of health inequalities lay outside the field of health and are primarily linked to the wider social and economic inequalities that exist in society. The report went on to note that the NHS has a key role to play in tackling health inequalities and measuring progress against the broad objectives of
reducing health inequalities, but that it cannot do so successfully entirely on its own. The efforts to address the issue need to be made on a much wider number of fronts. Dr Charles Saunders from the BMA told the Committee “Health picks up the consequences of inequalities, which arise from the effects of Government policies, both here and in the south, and also from other Government actions and actions within society. The social determinants of health have far more effect on people’s health than the NHS ever will. We are just trying to minimise the adverse consequences on people’s health that those inequalities cause”.

Summary of written evidence

6. In written evidence, the Committee heard that the early years (including preconception) are of crucial importance in laying the foundations for future health. The Royal College of Paediatrics and Child Health described these years as setting the ‘blueprint’ for life. A number of reasons were given for why these years are important, but the general view from the written submissions was that they set the foundations for optimum physical, mental and intellectual development. It was considered that, unless these basic foundations are optimised, an individual’s future potential might be compromised.

7. Most of the submissions highlighted the link between deprivation and health inequalities. In terms of early years, this was illustrated through reference to higher rates of stillbirths, low birth weight, lower breastfeeding rates, poorer childhood nutrition, dental decay and higher levels of obesity. Also highlighted were differences in wider childhood development, for example, poorer language skills and lack of readiness for school.

8. Many submissions highlighted the influence of the ‘inverse care law’, that is, that those most in need of services and support are least likely to benefit from them. As a result, they called for greater targeting of services as a way of reducing inequalities. However, other submissions were critical of the tendency for services to focus on those perceived to be in greater need of support based on assumptions such as their socio-economic circumstances. The Centre for Excellence for Looked After Children in Scotland highlighted the need for ‘proportionate universalism’, a term coined by Professor Sir Michael Marmot. Proportionate universalism does not focus solely on the disadvantaged to reduce the steepness of the health gradient. Instead, actions should be universal but delivered with a scale and intensity proportionate to the level of disadvantage.

9. A number of submissions made the point that early years support cannot be separated from support for parents/carers and the wider family or community. It was felt that tackling adversities faced by those caring for children also has benefits for the child. Such adversities were described as the wider socio-economic inequalities such as poverty, poor housing and unemployment, as well

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3 Scottish Parliament Health and Sport Committee, Official Report, 2 December 2014, Col31
as lifestyle factors such as smoking and drinking. As a result, many of the submissions called for a ‘whole family’ or holistic approach to the early years.

10. Some submissions stated that, while it is difficult to counter powerful economic and structural influences, a lot can be done to build ‘resilience’. Resilience was described as the avoidance of poorer health outcomes amongst those experiencing disadvantage.

11. The submissions generally welcomed the policies in place in Scotland, viewing them as an indicator that the early years are a priority for the Scottish Government. Written submissions praised Getting It Right For Every Child (GIRFEC), the Early Years Framework, Equally Well, Achieving our Potential and the Early Years Collaborative for focusing on the early years.

12. Many submissions highlighted valuable work that is taking place in their area and beyond. Amongst others, the following projects were mentioned:

- The Solihull Approach which promotes emotional health and wellbeing in children and families.
- Triple P - ‘Positive Parenting Programme’. The main goal of the programme is to increase the knowledge, skills and confidence of parents at the population level and, as a result, reduce the prevalence of mental health, emotional and behavioural problems in children and adolescents.
- Incredible Years – this project is described as a research-based programme for reducing children's aggression and behaviour problems and increasing social competence at home and at school.
- Roots of Empathy – this is described as an evidence-based classroom programme that has shown significant effect in reducing levels of aggression among school children while raising social/emotional competence and increasing empathy.

Summary of oral evidence

13. In oral evidence, the Committee heard from the health inequalities expert Professor Sir Michael Marmot and the former Scottish Government Chief Medical Officer Professor Sir Harry Burns. Professor Marmot explained that, when people think about health inequalities, they commonly think about the health of the poor. He said that while the poor did indeed have poor health, the real challenge was “the gradient”. People “near the top” had worse health than those at the top, people in the middle had worse health than those near the top and so on. The same applied to children, in relation to physical development and growth, cognitive, linguistic, social and emotional development, performance in school and the socio-economic characteristics of their parents or the area in which they lived. The lower the socio-economic level, he said, the worse the performance.

Professor Marmot therefore argued that, if we are to do better globally, we “must address not just the poor performance of those at the bottom, but the gradient”. He suggested that the gradient implied a need for “proportionate universalism”
because “a health service for the poor is a poor health service, and an education system for the poor is a poor education system”\textsuperscript{4}.

14. Professor Sir Harry Burns agreed and stated that “If we really want a future generation to deliver intellectually, to be innovative, to be creative and so on, we must give them the best start in life. We know, from our studies in Glasgow and from studies done internationally, that the physical damage that is done by poverty limits the capacity of young children to learn and behave appropriately in complex situations. There is very powerful evidence of that. The more adversity that young children experience in early life, the more likely they are to become alcoholics, drug addicts, violent and so on. That evidence comes from cast-iron longitudinal studies\textsuperscript{5}.

Good services can make a difference

15. During the roundtable session with academics, the Committee heard that, while there was wide agreement on the need for measures to reduce poverty and increase income (for example, through the living wage) there was also agreement that services could play a key role in making a difference. Professor Sir Harry Burns highlighted the work that was being carried out through the “early years collaborative, the family nurse partnerships and the positive parenting plan, which are all very much focused on young teenagers who are having children. At the heart of many of these interventions is the philosophical view that no one wants to be a bad parent—they just do not know how to be a good one”. He went on to say that “I certainly hope—that in the course of the next year we will begin to see significant impacts on markers of child development\textsuperscript{6}. However, in working with local authorities across Scotland, he could “see great differences in capacity and willingness to act”\textsuperscript{7}.

Visits

16. A number of themes emerged from the visits. All the areas the Committee visited (North Edinburgh, Paisley and Easterhouse) had relatively high levels of deprivation, with all the impacts that deprivation brings in terms of health inequalities. The Committee was impressed by the way in which the statutory agencies (the NHS boards and local authorities) were working together alongside third sector agencies, and that they were attempting to engage meaningfully with their service users in a cross-cutting way.

Themes from evidence sessions with health professions

17. A number of issues arose during oral evidence with health professionals.

Evidence, data and evaluation

\textsuperscript{5} Scottish Parliament Health and Sport Committee. \textit{Official Report, 13 May 2014}. Col 5376 
\textsuperscript{6} Scottish Parliament Health and Sport Committee. \textit{Official Report, 13 May 2014}. Col 5378 
\textsuperscript{7} Scottish Parliament Health and Sport Committee. \textit{Official Report, 13 May 2014}. Col 5395
18. The Committee heard that there is a need for more routine evaluation of the policies and programmes that have been put in place to tackle health inequalities in the early years. Dr Ron Gray of NHS Greater Glasgow and Clyde stated that “a culture of evaluation is still lacking” and, despite there being a large number of policy initiatives and programmes, there was a risk that “we will never have any idea whether we are making any difference”.

19. Tied to the need for more systematic evaluation of these programmes was the issue of the timescale over which they are funded. The Committee heard of the importance of providing long-term funding for projects. Dr Saunders from the BMA told the Committee, “The specific programmes concerning the most deprived need long-term funding in order to work well. Childsmile has long-term funding and I would say that its future is pretty well established, but there are a lot of other programmes that need that sort of certainty in order to achieve the same things.”

Universalism and targeted services

20. Witnesses were supportive of universalism of services, particularly in relation to health visiting and GP services. However, Dr Anne Mullin from General Practitioners at the Deep End highlighted the need for “realistic universalism”. Noting that resources are needed to meet the level of need she stated that “in our south community health partnership, we are having to lose £500,000 in the next financial year from our children and families budget. We cannot realistically run universalism with that scale of cut. That is one of the very real issues that we face.”

21. Dr Gray from NHS Greater Glasgow and Clyde told the Committee “I agree with everything that has been said about targeting resources at deprived areas and the need to improve universal services”. He noted that, “Maybe it would be possible to target some resources at that group to try to make a real difference, such as has been achieved in Scandinavian countries, where there is now little difference between the outcomes of looked-after children and the outcomes of children who are not looked after.” This chimed with much of the written evidence that called for greater targeting of services to reduce inequalities and to mitigate the influence of the ‘inverse care law’.

Workforce planning and resource allocation

22. Several of the health professionals welcomed the increased level of investment in health visiting, reiterating the important role that health visitors have in delivering early years health services and providing the continuity of care that can be vital to some of the most vulnerable families. However, concerns were also raised in

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relation to the size of health visitors’ caseloads and their ability to manage these, particularly in light of the shift in their role towards child protection.

23. Witnesses also expressed concerns in relation to other aspects of workforce planning in early years health services. In particular, the important role of school nurses was highlighted, with a broad agreement that there was a need for increased capacity in this area.

24. The role played by GPs was also highlighted by Dr Mullin. She noted the limitations of the GP contract in relation to child health saying it could be “more robust around child health”\textsuperscript{13}.

Possible areas of follow-up

25. As with all other areas of health inequalities, the Committee found that children and young people in the most deprived areas, and those whose parents and families also suffered wider inequalities in relation to income, employment, housing and education, were most at risk of negative health and wellbeing impacts, particularly later in their lives.

26. The Committee was made aware of a number of successful projects which were supporting children and their families. The Committee was encouraged by the work being developed by the Early Years Collaborative and supported the allocation of further resources to support early years provision amongst the most vulnerable children in the most deprived areas.

27. Our successor committee may wish to review the progress being made by the Scottish Government in relation to early years health inequalities with an emphasis on the need for the routine and systematic evaluation of projects. It may also wish to follow-up the on-going work of the Early Years Collaborative.

28. In this inquiry, the Committee heard about challenges in primary care, particularly pressures on GP and health visitor workloads and the need for an increased level of support to be available through school nursing services. Our successor committee may therefore wish to inquire into the Scottish Government’s workforce planning and how it is supporting early years services.

29. Finally, our successor committee may also wish to explore whether a more nuanced approach to tackling health inequalities in early years, such as ‘proportionate universalism’, is desirable or achievable.

\textsuperscript{13} Scottish Parliament Health and Sport Committee. \textit{Official Report, 2 December 2014}. Col 55