OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 16 May 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 16 May 2017

CONTENTS

HEALTH AND SPORT COMMITTEE
13th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Andrew Fraser (NHS Health Scotland)
Gerald McLaughlin (NHS Health Scotland)
Shona Robison (Cabinet Secretary for Health and Sport)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 16 May 2017

[The Convener opened the meeting at 10:00]

NHS Health Scotland

The Convener (Neil Findlay): Good morning, and welcome to the 13th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is, of course, acceptable to use mobile devices for social media but not to take photographs or to film proceedings.

Agenda item 1 is an evidence session with NHS Health Scotland. I welcome to the committee Gerry McLaughlin, chief executive, and Dr Andrew Fraser, director of public health science. I ask Mr McLaughlin to make an opening statement.

Gerald McLaughlin (NHS Health Scotland): NHS Health Scotland, which is the national improvement agency, is Scotland's smallest national health board. It was formed in 2003 by bringing together the Public Health Institute of Scotland, which dealt with a lot of the evidence about health and population health, and the Health Education Board for Scotland, which had been responsible for much of Scotland's health promotion. The advantage of the merger was to have within one body the function not only to look at and synthesise evidence but to translate that into usable knowledge to improve Scotland's health.

In 2012, about 18 months after I joined the organisation, we developed a five-year organisational strategy, which was called "A Fairer Healthier Scotland: Our strategy 2012-2017". That signalled a shift in our emphasis. Throughout 2010 and 2011, we had heard a lot of public narrative, notably from the chief medical officer and the new Minister for Public Health and Sport at that time, about health inequalities being Scotland's biggest health challenge. We took that as a cue and looked to develop the evidence that we had both analysed and produced ourselves. We focused much more on the nature of health inequalities and, even more important, on what it would take to reduce health inequalities.

We have just come to the end of the first five-year organisational strategy. We have set out a second five-year term, which very much sticks to that general health inequalities theme.

In the past year, an important development that has followed the Government's announcement of the health and social care delivery plan has been plans for a new public health landscape. We are both welcoming and enthusiastic about the plan, because it follows on from one of the main recommendations from the public health review, which commented on the challenges of having the national functions for public health sitting with different parties. Bringing those together will strengthen the public health contribution to public services transformation in Scotland.

The Convener: As far as I can work out, the strategic plan is about delivering improved public health in Scotland. Over the past five years, what tangible delivery has there been as a result of your organisation's work that anyone could point to and say, "That's what happened—that was good value"?

Gerald McLaughlin: First, I will talk about the generality. Concern about health inequalities has never been more central to—

The Convener: Can I stop you? The concern about health inequalities is well established—you could fill this room with reports that have been written on health inequality. I worked with your organisation in producing one of those reports, and the assistance that I got was fantastic. However, we know the problem and we know about the generalities; I want to know what tangible difference there has been as a result of your organisation's work.

Gerald McLaughlin: We have been working within the national health service and, increasingly, with public services more generally, to try to ensure that that evidence is able to be used nationally and, particularly, locally. We have worked significantly with a number of community planning partnerships on how they can use their local population health profiles to make different decisions.

More recently, we have worked with a range of community planning partnerships, along with a couple of other national boards. We are supporting integration joint boards by helping them to understand the population health challenges in their area in order to make different policy decisions and resource allocation decisions. We have done that in a number of ways. We have given the committee a series of inequalities briefings, which, as I said, point not only to an analysis of the problem but to ways of making different decisions. Mr Findlay may have been referring to the triple-I report—"Informing investment to reduce health inequalities in Scotland".

The Convener: I am looking at a number of reports that Health Scotland has published.

Gerald McLaughlin: The triple-I report very clearly sets out quite a different approach. For the

reasons that the committee has rehearsed well, the actions that we need to take to reduce inequalities clearly go way beyond what we do to improve the general average population health. We have tried to produce less published information that is simply distributed to people and instead we sit down much more with people to say, "What can you do differently based on that information?" We are now working with teams.

I will give a couple of examples of such work. You will be aware that there have been a number of fairness commissions across Scotland, and we have been invited to help with those. As recently as the past couple of weeks, one of our senior staff was involved as a commissioner with the Perth and Kinross commission and made a specific contribution on the importance of good work and fair work to improving health in a local community. Those are just some examples.

The Convener: I have to come back again, because I was asking for tangible examples. For example, let me pick a random place in Scotland. In Perth and Kinross, has a recommendation from Health Scotland been implemented that has made a difference in reducing health inequalities? Has something been done in Perth and Kinross in housing, transport or any field? Similarly, have things been done in Highland, Glasgow or Edinburgh? Where has something specific that Health Scotland has recommended been enacted?

Gerald McLaughlin: On the Perth and Kinross work, it is perhaps a little early to say, because it was published just before the election period.

The Convener: I picked that at random.

Gerald McLaughlin: I can give you an example from Dundee, where I sat as a commissioner on the Dundee fairness commission. One of the outputs from that was that Dundee declared itself to be a living wage city. It has not only worked within the public sector but encouraged private sector employers to adopt the living wage specifically because of the evidence that was introduced about the impact on health in a city whose health challenges are well known.

Dr Andrew Fraser (NHS Health Scotland): It is always a challenge to attribute specific actions to things that we have done. We work with others and influence others, so whether Health Scotland was the main influence is sometimes in doubt.

Examples might include the work on the place standard, which is about putting a health dimension into decisions on physical planning and the process of involvement in defining a good place. We have been a substantial supplier of evidence on a minimum unit price to Government lawyers or lawyers acting on behalf of the Government in the court process on that. We have altered the balance of advice about the use of e-cigarettes in smoking cessation efforts. On child poverty, we have directed attention towards adverse child experiences and have rolled out the healthier, wealthier children project. It started in Glasgow and we have potentiated its effect, shall we say, across the rest of Scotland.

Gerald McLaughlin: One final example is that there is a long-term strategy to make Scotland a no-smoking country. One of the challenges that the Government gave us was to help to lead the NHS as a model contributor to that. You might be aware of the policy position about removing smoking from NHS campuses, which was always going to be a big challenge. On behalf of other NHS boards, we led a fairly major marketing exercise—you may have seen the television advert. That was never going to immediately stop smoking in and around NHS grounds, but we have certainly seen a significant reduction as part of the longer-term programme.

The Convener: I will bring in my colleagues in a moment. Can I confirm that you have worked with four community planning partnerships?

Gerald McLaughlin: Yes.

Ivan McKee (Glasgow Provan) (SNP): I will follow up on what Dr Fraser said about place, which is important in my constituency and elsewhere around the country. Where has that got to? Has it had a specific impact on planning regulations or processes? We all agree that the focus on place and communities is great but, in reality, it often does not happen because of the way in which the planning process is constructed. The people who make decisions in that process follow a set of rules and tick boxes that do not necessarily take account of any of this stuff and its impact on health. Where have you got to in terms of influencing that and inputting to the planning review process that is going on? Are there any specific instances of planning decisions being changed to take account of the impact on health?

Dr Fraser: I do not think that the place standard was ever intended to influence legislation, although one would hope that any legislation would be complementary to what it is trying to achieve. In a way, "place standard" is a slight misnomer, because it is not about standards but about involvement in the process of defining what people want in a good place. It was conceived and developed jointly with Architecture and Design Scotland and planners in the Government. It is a shared ambition, and it has influence well outside the health sector.

The place standard was launched to great support. We believe that it does quite a lot of work at the local authority level and the planning level to apply its principles in the processes. It is a little

early to tell the outcomes, because its launch was only about a year or two ago. I think that it will feed through and influence the planning process by bringing local people's say into the definition of what the place could be—its attributes and positive features.

Gerald McLaughlin: We have tracked the local authorities that are actively using the place standard—70 per cent of local authorities are now doing that—and they are coming back to us for further advice. However, the importance of the place standard is in the fact that, in planning our new communities and thinking about our existing communities, we are recognising that the environment in which our children are growing up has a direct impact on their health. We have had an incredibly enthusiastic response from local government, which welcomes the fact that it has an evidence base on which to plan differently.

Ivan McKee: Right. You think that it can influence, but is early days for that. In my experience, what I see does not reflect that. I see planning applications going in and lots of houses being built in the wrong place without regard to facilities, amenities, green space or anything, just to get houses up. You are hopeful that the place standard will influence that at some point.

Gerald McLaughlin: My experience of talking to planners is that they are often as concerned as the rest of us are about some of those developments, but they need a strong evidence base to demonstrate why they might resist particular planning applications.

More positively, we can see the value of the investment in, for example, a new housing estate whose design has paid attention not simply to the needs of car users but to getting us to be physically active. There is an evidence base for the benefits on health of having planned green space in new community development, which helps planners to shape new developments.

Ivan McKee: Right.

Dr Fraser: I have been quite closely associated with the go well research programme, which has been led from the Glasgow centre for population health. Health Scotland has been a co-funder of that research. One of the big lessons from that programme has been that regeneration—on which billions of pounds has been spent in Glasgow—is not just about the bricks and mortar, putting up new accommodation or converting and improving it; it is about the process of how that is done.

I believe that a strong message has been sent out around a lot of Scotland about lessons learned on regeneration and its relationship to health. There will not be an immediate health benefit from regeneration but the lesson is that, in the long term, if there is no regeneration, health suffers. One of the studies that we have been involved with jointly with the Glasgow centre for population health has been on the Glasgow effect.

10:15

Ivan McKee: I think that you are saying that changes to legislation or guidelines are not needed to make a positive impact. I find that a bit counterintuitive, because I would have thought that they would have been needed. The Community Empowerment (Scotland) Act 2015, for example, has allowed stuff to be done that has the potential to make a difference to how space is utilised. However, you are saying that the process of influencing is enough to make a difference.

Dr Fraser: We jointly chaired a side meeting to a housing conference in March this year, at which I was particularly struck by how housing associations—the meeting was principally about housing associations—have changed their culture and are reflecting on the change of culture towards being community-empowering organisations and thinking about the quality of their service to tenants, rather than just being the major capital investment machine that they may have been perceived as being. They have changed a lot, and I would like to think that that research has helped to enlighten, describe and challenge them on their way through. Anecdotal accounts that I am getting certainly suggest that that is the case.

Donald Cameron (Highlands and Islands) (Con): The cross-party group on health inequalities has heard lots of evidence on the place standard, which I think is one of the most interesting things that are going on to address health inequalities.

I want to move the discussion on to the Scottish Government's health and social care delivery plan which, as you will know, foresees that by 2019 there will be a new public health body. Where do you fit into that vision?

Gerald McLaughlin: At the moment, there are a number of domains of public health, with health improvement being one of the very significant ones. We are currently the national body for health improvement in Scotland, so we will go, alongside the health protection and health intelligence functions, into the new body. We will cease to exist as Health Scotland when those plans are implemented.

Our hope and desire is that we will leave a strong legacy for the new public health body, on the basis of the work that we have been doing over the past 13 or 14 years.

Donald Cameron: We have seen a lot of the non-territorial health boards over the past year or

so, and one impression that I have had is that it is quite a cluttered landscape and there is a lot of overlap and duplication. What reasons can you give for your role to survive, as it were?

Gerald McLaughlin: In any orthodox approach to public health, health improvement would be seen as one of the important functions. In the review of public health, the Government stressed the importance of the health improvement function. However, the national operation and management of that function in a body that is separate from the other important contributors has been suboptimal. That was the review's conclusion, and the Government's response has been as a result of that.

I have been very confident and optimistic that the national health improvement role will only be strengthened by its inclusion in the new public health body. Not just the leadership of the organisation but our staff across the board have been very enthusiastic about the planned changes.

Dr Fraser: If you review the body of evidence on what is effective in tackling health inequalities, you see that, although there is a lot that you can do at the local level and the very local level, there is a great deal that you can do at the national level, on legislation, regulation and influencing policy. A national agency such as ours needs to exist, in order to press that case, assemble the evidence, and influence fellow national bodies, such as those that deal with the natural environment and planning. There is a role at the national level for an agency that is focused on tackling health inequalities and improving health nationally.

The Convener: You mentioned your legacy. In "Long Term Monitoring of Health Inequalities: Headline Indicators—October 2015", the Scottish Government noted that

"There have been no significant changes to inequalities in male or female healthy life expectancy ... since 2009-2010".

That ain't a good legacy, so who is failing?

Dr Fraser: I would like to say that it is not us. It looks as if we are associated with no change over our past five years. Are we getting our message across? We need to ask ourselves that question. Are we doing enough to improve or become more influential? Are we producing usable knowledge?

The Convener: Your message about how to change health inequality is crystal clear, but somebody ain't listening and nobody is taking action. As I said before, we could fill this room with reports on health inequality. That is the bloody frustrating thing—all of us have concerns about health inequalities, yet they grow wider and wider and we have seen no action. Who is failing?

Dr Fraser: We need to take radical and focused action—

The Convener: But we are not, so who is failing?

Dr Fraser: We are building consensus in order to try to succeed. That is our job. We are building the evidence on which other people can take decisions. We are not a political organisation.

The Convener: Are those people taking the decisions? Are they taking the radical decisions that are in your opinion required? You are surely here to give a commentary on that.

Dr Fraser: Not all the decisions that we would like to be taken in favour of reducing health inequalities are taken. We have a keen weather eye on all decisions, whether they are in the health sector or not—we look at many economic and social policies. Few policies are potentially damaging in relation to health inequalities, but I would argue that some—especially some that are outside the Parliament's remit—risk widening health inequalities.

Gerald McLaughlin: I will add a couple of things. It is fair to say that at times we share the convener's frustration about the issue, but there are positive signs. We have influenced some Government thinking on creating a different approach to fair work and good work, and we have made a number of contributions to the fair work convention. Those messages seem to have been taken on board, and they have been quite powerfully made by our organisation since we began hosting the healthy working lives programme a number of years ago. I am encouraged by that.

Likewise, there has been open-mindedness about the extent to which and ways in which the new welfare powers that are coming to Scotland could be used to mitigate the effect of at least some of the worst aspects of inequalities. We know, and the World Health Organization says, that there are fundamental causes for health inequalities, which you, convener, are familiar with. We need to think about what we can do with the powers that are available to us in Scotland that will allow us to make different decisions. I remain optimistic that—

The Convener: What would you do with the powers that we have?

Gerald McLaughlin: I would ensure that we do all that we can to reduce income inequality.

The Convener: Give me a specific policy. Would you increase taxes? Would you cut taxes?

Gerald McLaughlin: I am not sure that it is for me as the chief executive of a public body to say that. From the evidence of much of the work that

has been done in the healthier, wealthier children project, which Andrew Fraser cited, we know that taking every step in public services to maximise the income that is available to families makes a difference to their health. We supported Glasgow in rolling out that project, which is about the benefits that accrue from much closer integration. Under that project, front-line healthcare and other public services staff direct people to sources of support in a much more integrated way, to maximise people's income.

Tom Arthur (Renfrewshire South) (SNP): Your publication "The Right to Health: Tackling inequalities" states that

"We are committed to supporting the Scottish Parliament and Scottish Government's efforts to tackle social injustice, working with a wide variety of partners to address the issues in this leaflet".

What is your relationship with the United Kingdom Government and what engagement do you have with it?

Gerald McLaughlin: We have no direct relationship with the UK Government. Given that we are a national health board and that the matter is entirely devolved, our direct relationship is with the Scottish Government.

Tom Arthur: Your comment that this is an entirely devolved matter highlights an interesting tension. Under the heading "What causes health inequalities?", the same publication says:

"There is widespread agreement that the primary causes of health inequalities are rooted in the political and social decisions and priorities that result in an unequal distribution of money, income, resources and power across the population and between groups ... the fundamental causes result in an unfair distribution of power, money and resources. This often leads to discrimination against, and marginalisation of, individuals and groups."

We know the impact of UK Government welfare reforms and how cross-cutting and cross-sectional the challenges are in addressing health inequalities. Is it possible for you to achieve your aims of reducing health inequalities without engaging with the UK Government, particularly when many of the levers that it controls—and controls solely—have such a huge impact on health inequalities?

Gerald McLaughlin: I appreciate that we use the international evidence on the causes of health inequalities, which go beyond the UK. Indeed, the unequal distribution of resources is a global phenomenon. As for our constitutional arrangements, we are responsible to this Parliament rather than the UK Parliament.

Tom Arthur: I appreciate that, but my question is whether you can realise your goals of creating a fairer, healthier Scotland and reducing health inequalities without having any engagement with the UK Government. I will give you an example: the family cap will put thousands of children into poverty. The corollary of what you are saying is that you will have had no engagement with or input into the UK Government on that and it will not have sought your advice on it.

Dr Fraser: Perhaps I can answer in part the question that you are asking. As an agency of the Scottish Government, our primary relationship is with it, and we work through it to try to influence the UK Government. We also work with our colleague national public health agency, Public Health England, which is constrained in the agenda that is set by its Government.

A number of years ago, I represented directors of public health as a professional group at the Work and Pensions Select Committee in London, and that is one route that can be used to influence and comment on Government policy. Moreover, sole among the UK health improvement agencies, we have done work on the potential impacts on health of welfare changes. That work has been much supported by the other agencies, which do not feel in a position to do it, partly because of challenges in having a relationship with a Government that is set in a particular direction. We have distance, which brings limited freedoms that we are trying to exploit.

As I said, we have done work on potential effects of welfare changes. Those effects are becoming evident, but the reports that we have produced so far have not been definitive, although we are concerned about the trends in mental health. We are trying to get our message across; for example, we have produced work on taxation and the relative effects of council tax rises or income tax changes.

We feel that we can present such evidence, but we cannot necessarily say, "Do this" or "Do that"; it is for parliamentarians and politicians—and the public and commentators—to make judgments on what we say, the authority with which we say it and the quality of the evidence behind that. We are there to influence what people do, what they think and how they act.

Tom Arthur: In that case, do you accept that we are limited in what we can do within the confines of the devolution settlement? I will give you an example: a constituent—a woman who had been forced out of work because of chronic ill health—came to my surgery and told me that, although she wanted to get back into work, she needed time to recover. However, she had lost a particular benefit that she had been receiving, and the indignity of the assessments that she was having to go through was exacerbating her existing hypertension and affecting her mental health. She was in tears at my surgery; she told me that she felt suicidal and that she could not tell

her son any of this, because he, too, was unwell and she did not want him to get more stressed.

We cannot do anything fundamental about that in this Parliament, and the situation is having a massive detrimental impact on that person's health. Do you accept that we are limited in what we can do in the Scottish Parliament and that the Scottish Government is limited, too? Is it not the case that, ultimately, instead of being able to "undo the fundamental causes", as the leaflet that I quoted suggests, we are reduced to merely mitigating their effect?

10:30

Dr Fraser: I am not inventing excuses for what we do. We perceive limitations in what we can do and the influence that we can have. We have seen changes, which we describe. Our first report on welfare made the point that we did not have certainty on the health effects but that we were looking in certain directions. Our second report showed that it was still too early to see changes. You have to accept that we look back on data about events that have happened rather than make predictions, because there is no modelling to help us to predict the effects of welfare changes.

I entirely accept what you say about the personal experience of people such as your constituent, and I used some of that from the deep-end practices in my testimony to the Work and Pensions Select Committee. We are extremely worried and frustrated by the direction in which welfare is going, and that is a professional judgment. However, we need evidence and data. We will describe the data in future reports about what is actually happening at population level, which is our job, and we will square that with individual accounts such as those that we get from members, deep-end practices and research bodies and research knowledge, to create a picture of what is happening.

Tom Arthur: I, too, am extremely frustrated and worried about the direction in which welfare is going, and that is putting it mildly. I have no further questions, convener.

Maree Todd (Highlands and Islands) (SNP): Picking up where Tom Arthur left off, I note that the Resolution Foundation expects income inequality to grow over the next five years and that this UK Parliament—of course, we are now getting a new one—could be the worst for income growth for the poorest half of households since comparable records began, and the worst since Margaret Thatcher's Government for inequality. We have a Government at Westminster that is decreasing benefits, and welfare reform has targeted disabled people and the poorest and most vulnerable in society. Today in the Parliament, we will talk about the impact of welfare reform on disabled people and tomorrow we will talk about the impact of the reduction in housing benefit for 18 to 21-year-olds. Is it not the case that it is nigh on impossible for the Scottish Parliament to tackle health inequality when income inequality is so impacted by the UK Parliament?

Dr Fraser: I accept that there are limits to the powers that we have to protect the vulnerable. As you have said, we are damaging the income prospects of vulnerable groups and people. Our job is to study, describe and advocate on the basis of the health effects that we know to be happening. My earlier point was that we are searching for those effects but they have not come up in the data yet. That is partly because it has taken time for the welfare reforms to feed through. The real bite came two springs ago, so we will now see the effects of those reforms, because they will feed through to health events—the sort of events that we will describe in future reports.

Gerald McLaughlin: You will see from our publications that we are not likely to demur from the general principle that reducing individual or family income potentially has a negative impact on health. That is our real concern. Our approach is to recognise that, in addition to some of those fundamental drivers, there are other things that we can do through the decisions that we make. Some significant policy areas are available to us in Scotland. For example, the way in which we approach housing policy can have a real impact on individual and family health—and, indeed, community health—and we can see the impact of homelessness on public health. Those are areas where we can draw attention to the evidence. Mr Arthur referred to our description of the fundamental causes, but in that document there is also a middle column, which relates to prevention. There are a number of policy areas where it is within our gift in Scotland to make different decisions that we believe would have a positive impact on health.

Maree Todd: I know, but it is striking that addressing the fundamental causes is not within our gift. One of the questions asked in inequality briefing 1 is:

> "What works to reduce health inequalities?"

The first answer is:

> "Introduce a minimum income for healthy living",

but we have no control over that. The second is:

> "Ensure the welfare system provides sufficient income for healthy living and reduces stigma for recipients through universal provision in proportion to need",

but we have very little control over that. The third is:

"A more progressive individual and corporate taxation."

We have control over part of income tax, but it is given to us in such a way that it is almost impossible for us to exert a different policy in that respect. The fourth answer is:

"The creation of a vibrant democracy, a greater and more equitable participation in elections and local public service decision-making",

very little of which is within our gift in this Parliament. The situation is extremely frustrating.

Gerald McLaughlin: You will not be surprised to hear that we share your frustration. However, I point out—partly because I am an inveterate optimist and partly because I look to see where we can make a difference—that some of the other briefings in your pack show the areas where we have been working to assemble and synthesise that evidence and to ask what we need to do differently. We have given you some examples of that today, but we are happy to give you more, and we will continue to look at various areas where public services in Scotland, responding to the Christie commission's challenge, could make different decisions that would drive improvements in health in a much more equitable way.

One reason why we have moved away from a focus simply on average population health is that, when we compare the situation across European countries, we see that although our health has improved, it has done so at a slightly slower rate than many other countries. For me, the big challenge is that it is those whose health is poorest and needs to improve most who are doing least well. That is the fundamental challenge with regard to why we are not making as good progress as many other countries in western Europe.

Miles Briggs (Lothian) (Con): I was interested in what the "Place and communities" document says about community empowerment. The committee has done quite a lot of work on that area in looking at all the organisations involved in health in Scotland and decision making around health in general. How do you believe that people are being engaged in health reforms in Scotland?

Dr Fraser: We are primarily an intermediary organisation. We are a national agency working to help people at a local level, and as you have heard, we engage with specific community planning partnerships. We have marshalled evidence, as you will have heard from your colleague, that community engagement and empowerment form an important part of how we improve health among individuals in communities.

What part do we play in making that happen? I think that we supply the tools and means for people to take local action, and we work with, help and empower voluntary organisations at national and local levels, because they are in a good position and are close to the people who are experiencing the effects of inequalities. We are looking at the potential of the Community Empowerment (Scotland) Act 2015 and how one might evaluate its effects. We have found people on the ground not to be aware of this new and quite complex piece of legislation, so we have a job to do to enable it to have an effect, and in that respect we will be starting from the ground up.

Our job is to marshal the evidence, advocate, facilitate, get people on the ground to modify their plans for action and influence practice among health professionals, particularly health improvement professionals. That would be my interpretation of our role with regard to community empowerment.

Gerald McLaughlin: I would like to mention a specific area in which I am personally involved. The north Ayrshire community planning partnership recently produced its community plan and has formed an advisory group of people involved in a number of aspects of the business of community planning, including health. I was invited to join that group, and at its most recent meeting, a very specific discussion point was the extent to which local communities can be engaged in identifying areas for improvement in their communities and in finding resources to be released in support of that. I think that that is a very good example.

Another good example is community food and health (Scotland), one of the programmes that NHS Health Scotland hosts, which supports local community groups around Scotland in seeing the importance of food in local community life, the importance of being able to access affordable food and the importance of food in social cohesion. A number of those local groups are heavily involved in their local community councils or other local community planning arrangements.

Miles Briggs: My line of questioning is more about the reform of health services. For example, the Scottish Government's centralising agenda of health services means that Edinburgh's cleft palate and lip surgery services for children are being centralised in Glasgow. In fact, I find people complaining daily about the centralisation of our health service. Is your organisation making its voice heard on that issue?

Dr Fraser: What I am about to say might be at the limits of where we are in NHS Health Scotland and might also be contentious. Four jobs ago, I had a job in NHS National Services Scotland dealing with highly specialised services. We had to take courageous decisions on interventions with regard to those rare diseases requiring the kind of expertise that people gain and which gets driven up largely as a result of their seeing a lot of the

same sort of condition. Unless we take those decisions and have fewer centres doing better, outcomes will not improve and resources will not be freed up for other things that we would like to be done to tackle health inequalities.

In Scotland, we will always have limits on the amount of resource available, so we have to make those difficult choices. Patients will accept that they have to travel for highly specialist treatment—indeed, the committee heard last week that even non-specialist treatment, such as that for cataracts, necessitates a journey to the west of Scotland from the east of Scotland—if we put the case clearly for the consequences, which relate to outcomes and the freeing up of resources for other things.

Gerald McLaughlin: The local aspects of public health are an important part of the development of the health and social care delivery plan. The Government's announcements so far have been simply about reforming the national landscape, but it has recently embarked on the first stage of ensuring that public health is positioned in a very different space between local government and the NHS. I was invited to an event where senior local government leaders were involved in shaping the public health priorities for Scotland, and in answer to Mr Briggs, I wonder whether such an approach might bring more of a local dimension to the shaping of national priorities. I expect to see a shift to a certain extent and, in many cases, public health resources have been relocated to health and social care partnerships. The relationship between the national priorities for public health and the local delivery landscape is a crucial issue.

Miles Briggs: What do you think is key to people feeling empowered when it comes to those decisions? It is quite clear that people do not feel that their views are being taken into account.

Gerald McLaughlin: Frankly, I cannot bring much new thinking to that. Perhaps we just have to go back and read the Christie commission report on that.

Tom Arthur: It is commonly accepted that, if we are going to be able to deliver the care and health technology that is now available, that will require reconfiguration and moving towards specialist centres and centres of excellence. What role can politicians play in communicating that to their constituents? Does further action have to be taken collectively to communicate the benefits that will follow from such changes in service?

10:45

Dr Fraser: In attempting to answer that, I will try to fold it back into our area of focus. Quite a lot of our recommendations, which are based on the evidence on tackling inequalities, are plain and simple and sound straightforward to implement through, say, legislation or regulation. At local level, though, they are much more contentious, given the effect on the individual and the way in which they see the world. On the clinical side, we have grateful patients and very skilled doctors with their medical teams around them, and they do not like to see change unless it is explained and they are won over. There are those stakeholders and players to take into account.

I think that the role of MSPs is to understand all the dynamics and represent their constituents. However, there is a bigger picture about the future of Scotland and its public services, including its health service. One of the justifications for our remaining as a national public health agency is that we can do once and well what other people could do 14, 22 or 31 times with less skill or expertise.

Efficiency, effectiveness and better outcomes come from certain functions taking place at national or regional level, although it depends on the intervention and the type of thing that we are looking at. Highly specialised evidence on, for example, the health effects of welfare, the refining of interventions to tackle inequalities and cleft lip and palate interventions needs to be held at the national level so that we get the best from the public pound.

The Convener: You have mentioned local issues several times now. What impact are the budgetary decisions that are made here in the Parliament and then passed on to local government having on health inequalities? Historically, local government has been on the front line in addressing poverty and health inequalities. I can only take my local authority as an example but, in West Lothian, we have had £90 million removed from the budget. What impact is that having on local government's ability to address local health inequalities?

Dr Fraser: I do not have detailed information on that to hand. Empirically speaking, I think that if less resource is available, local government can do less to alleviate the effects of inequalities. Also, quite apart from local authorities' role in the integration bodies, the things that they do in transport, in planning and in schools and education—

The Convener: And in housing.

Dr Fraser: Yes. Those things are fundamental to alleviating or mitigating the worst effects of inequalities. How can they prevent them? There are roles—certainly in targeted social work, for instance, and on the population-wide housing and planning side—in which they can take evidence-based measures to prevent inequalities from getting worse.

We have a growing relationship with the Convention of Scottish Local Authorities, as the national representative agency for local authorities, and we can also try to get that message across through local public health colleagues and local authorities. I believe that closer links with the integration authorities and some joint appointments between local authorities and health boards will bring the groups closer.

The review took on board and paid particular attention to local authorities' concerns about the influence of public health expertise on what they do. We want to see improvement in that area once things settle down after the review and implementation is under way.

Colin Smyth (South Scotland) (Lab): Good morning. It is recognised that, if Government is going to play a role in tackling health inequalities, a cross-departmental approach is needed, but there is still a perception that Government policy on health focuses all too often on what the national health service can do rather than on what Government can do. A recent example is the mental health strategy, which has been widely criticised for not being as transformative as it could have been. Is there enough cross-departmental work when it comes to tackling health inequalities in Scotland?

Gerald McLaughlin: The short answer is no, but I see a number of policy areas in which there is room for encouragement. The current policy focus on educational attainment has broadened the discussion quite significantly from what happens specifically in the classroom. Indeed, we have been invited into a number of related areas of work on understanding the impact of family income and other important dimensions, such as earlier childcare, on future educational attainment. Those are encouraging signs. The problem is not that people do not get that intellectually—I think that they do—but that sometimes it is very hard to free up resources to focus on that joint effort, especially given how we allocate resources, which are often very much in particular channels, and particularly when resources have been reducing. From the start of our work on health inequalities, we have said that it is not a job that we can do alone; it is collaborative.

Another area that is encouraging is the extent to which local government and locally elected members often have an acute sense of the state of health in local communities. Local government has been hungry for the kind of evidence that allows it to promote different decision making across a range of functions.

Beyond that, there is a role for other public services, from environmental protection to transport planning. For example, we want a more active population and we know from the social attitudes study that people know that they need to be more active, but simply telling people to be more active will not achieve that. The people that we most need to get to are the least active. Therefore, we need to think about how we design a different approach not just to our public transport and travel policies but to the environments in which we build new communities, so that we do that in a way that makes people more active.

I am encouraged that we are at least hearing from organisations—and, indeed, from across Government—about their willingness to consider such an approach. However, it is often much more difficult to deliver in reality.

Colin Smyth: How do we break down the barriers to making it a reality? One of your resources is the health inequalities impact assessment. How widely is that used by people other than health policy advisers? Is it used right across Government? How do we break down barriers to every Government department having health inequalities at the top of its agenda?

Dr Fraser: By slowly, gradually and perpetually trying to gain influence in places where we have not been before. Two jobs and 18 years ago, I was a health policy adviser to the Government. We started to break out of the old mould in which health policy was about health services and little else. If we compare where we are now with where we were then, we are a lot further forward, but there is lots more to do.

Internationally, Scotland is seen as being way ahead on integrating children's policy: for example, health interests influence what happens in schools here more than they do in many other countries. We are talking to the energy minister and officials about efficiency in that area, we have mentioned housing, and we want to have more influence over climate and sustainability. We are being heard and—largely—welcomed, because people accept that if there is a health case for doing something, there is more power for the global case that they can make for changing things.

Those are areas that we are just getting into. Eighteen years ago, I would never have dreamed that we would have had such an influence over planning and policy makers as we have had over the place standard. There are cold areas, but we have warmed up a lot of others. "Health in all policies" might be a slogan, but we would like to be the embodiment of that—to be everywhere and doing everything. However, to come back to a point that Gerry McLaughlin made, we need to look at our priorities and where we can have the most influence. That process is partly strategic and partly tactical and opportunistic. Whether we are heard takes us back to the point about welfare and devolved and non-devolved powers. We have

things to say; the issue is whether we are listened to and whether the ground is fertile.

Our job is to create the conditions in which health can improve and we can tackle health inequalities effectively. That includes focusing on the political, as well as the public and media, tenor of the debate. We are trying to get into other areas, working with policy makers in local authorities, just as much as we are trying to influence other audiences.

Gerald McLaughlin: Employers are one of the other audiences. I mentioned the healthy working lives programme. Last year, we were in touch with 7,000 employers who were seeking advice on how to create and support a healthier workforce, not least because that will make their workforce more productive.

We also host the healthy living award, which supports retailers in promoting better choices in retail food outlets, especially in the fast food sector. We work across a range of public services and with third sector organisations. We have done significant work with Shelter Scotland, the Poverty Alliance and others in bringing evidence to support them in pushing for specific changes.

We are first and foremost a public services organisation, but we are supporting other aspects of civic life in Scotland.

Colin Smyth: If you are a public services organisation, is it not a bit strange that you have to lobby public services to tackle health inequalities? It sounds as if you are a lobbying organisation rather than a Government organisation, because you are having to lobby the Government to follow through on the reasons why your organisation was set up.

Gerald McLaughlin: I do not think that we are a lobbying organisation. I have worked for a lobbying organisation in the past, and I am very clear that we are a public services organisation. However, we have resources that can help in examining the evidence on what makes a difference. Where that is not happening, an organisation such as ours is an asset to Scotland's public sector. Using a very small fraction of the total budget that is spent, we identify unintended consequences of particular decisions and point out where we can make a difference—for example, in access to public services and in the quality of service that some of our communities experience.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Dr Fraser, you said a moment ago that health policies impact on what happens in schools perhaps more in Scotland than elsewhere. Point 2 in the five strategic priority areas that your delivery plan sets out is headed, "Children, Young People and Families". You and Mr McLaughlin will both be aware that the Government's current priority is to close the poverty-related attainment gap. Could you give us some concrete examples of where your work has impacted on healthcare in education?

Dr Fraser: There is a good deal of work going on—although it is not closely associated with what we have done—on school nursing and schools in general. A specific example is the HPV vaccine, which is a joint enterprise between public health, health services and education. That has been a great success, and the data is very encouraging.

We are co-operating increasingly closely—and we could go further—with Education Scotland on the integration of health topics with the curriculum. We are also doing work around the quality of childcare and influencing policy in that regard.

It is work in progress. You ask for specific instances, but—although this might sound negative—it is almost as if we are invisible. We would like to move and change things without people finding out, for example, that it is for health reasons that the curriculum, or the content of school activities, has changed. Such a change need not necessarily be made for health reasons if other good reasons exist and are more attractive to decision makers.

Closing the attainment gap is about what happens not just in schools but outside. Ensuring that children come to primary 1 ready to learn is not a function of the education system as it stands. In many ways, mitigation is needed when children arrive at the school gates aged four or five and they are already behind. We have to understand that; we must also see what more we can do in primary and secondary schools to help people to catch up, so that the attainment gap is not widened further. However, these are not just functions of the education sector.

Gerald McLaughlin: We also host the Scottish public health network, which produced an influential report in May last year that addressed the experience of childhood in Scotland and talked about the impact of adverse childhood experiences on learning, along with a number of other factors. That report made recommendations about ways of focusing and introducing actions that help to mitigate some of the impact of the adverse experiences that many of our children have during their early years.

Jenny Gilruth: Thank you.

The Convener: We are just about out of time. My experience of dealing with your organisation is that the professionals who work for you produce some terrific pieces of research, and I can only compliment them on that. However, I have a great sense of frustration that some of the stuff that you are doing is not developing into policy and having an impact on the deep-seated health inequalities

that we have in this country. You summed that up when you said, "We have an opinion, we just wonder whether anyone is listening." That sums it up.

Thank you for your evidence.

11:01

Meeting suspended.

11:04

On resuming—

Subordinate Legislation

Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Amendment Regulations 2017 [draft]

The Convener: Agenda item 2 concerns subordinate legislation. We will deal with one draft instrument that is subject to affirmative procedure. As is usually the case with affirmative instruments, we will have an evidence-taking session with the minister and officials, which will be followed by a formal debate on the motion. I welcome Shona Robison, the Cabinet Secretary for Health and Sport; Peter Stapleton, Carers (Scotland) Act 2016 implementation manager; and Kate Walker, principal legal officer in the Scottish Government.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thank you for the opportunity to speak briefly to the committee on these amending regulations. You will be aware that, when the Parliament passed the Carers (Scotland) Act 2016 last February, integration of health and social care was already under way across Scotland. The committee will also recall that the purpose of the existing Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Regulations 2014 is to prescribe the mandatory delegation of adult social care functions to integration authorities so that those functions must form part of authorities' strategic commissioning plans for delivering health and social care services locally.

The instrument that we are discussing today has been laid in order to amend the existing regulations so that they take account of the provisions in the 2016 act in the same way. If approved, the regulations will specify that the function of preparing local eligibility criteria under section 21 of the 2016 act is one that must be delegated by local authorities to integration authorities. The committee will be aware that the purpose of setting local eligibility criteria is to determine whether a local authority is required to provide support to individual carers to meet their identified needs.

As you know, the provisions of the 2016 act will commence in full on 1 April 2018. Most of the provisions in the act can already be delegated to integration authorities. Indeed, carers support services are already part of the integrated arrangements across Scotland under the existing regulations. Mandatory delegation of the function

to local integration authorities will help to ensure that there is synergy between the strategic planning and commissioning priorities that integration authorities are setting and the legislative requirements to improve outcomes for carers that we as a Parliament supported during the passage of the 2016 act.

I am happy to take questions on the regulations.

The Convener: As there are no questions from members, we will move to agenda item 3, which is the formal debate on the instrument on which we have just taken evidence. I remind the committee and others that questions should not be put to the cabinet secretary during the formal debate and that officials may not speak in the debate. I invite the minister to move motion S5M-05457.

Motion moved,

That the Health and Sport Committee recommends that the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017 [draft] be approved.—[*Shona Robison*]

Motion agreed to.

The Convener: As was previously agreed, we now move into private session.

11:08

Meeting continued in private until 11:58.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba