HEALTH AND SPORT COMMITTEE

Wednesday 24 September 2008

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
22nd Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Kay Barton (Scottish Government Public Health and Wellbeing Directorate)
Dr Harry Burns (Chief Medical Officer for Scotland)
Ron Culley (Convention of Scottish Local Authorities)
Councillor Ronnie McColl (Convention of Scottish Local Authorities)
Dr Jonathan Pryce (Scottish Government Primary and Community Care Directorate)
Shona Robison (Minister for Public Health)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 24 September 2008

[THE CONVENER *opened the meeting at 10:00*]

Subordinate Legislation

Plastic Materials and Articles in Contact with Food (Scotland) Amendment Regulations 2008 (SSI 2008/261)

National Health Service (Travelling Expenses and Remission of Charges) (Scotland) Amendment (No 2) Regulations 2008 (SSI 2008/288)

National Health Service (Optical Charges and Payments) (Scotland) Amendment (No 2) Regulations 2008 (SSI 2008/289)

National Health Service (Charges for Overseas Visitors) (Scotland) Amendment Regulations 2008 (SSI 2008/290)

The Convener (Christine Grahame): Good morning, everyone, and welcome to the 22nd meeting in 2008 of the Health and Sport Committee. I remind all members—given what happened last week, this advice has particular direction—to ensure that their mobile phones and BlackBerrys are switched off.

Apologies have been received from Rhoda Grant, who has a clash with another committee obligation.

Agenda item 1 is subordinate legislation. There are four negative instruments for consideration.

Scottish statutory instrument 2008/290 exempts victims or possible victims of human trafficking from national health service charges that are normally levied on overseas visitors. The regulations also amend the definition of services that are subject to that and other exemptions. The Subordinate Legislation Committee brought the regulations to our attention on the ground that further information was sought and received from the Scottish Government, with which that committee is satisfied.

SSI 2008/289 amends the National Health Service (Optical Charges and Payments) (Scotland) Regulations 1998 to reflect forthcoming changes to the benefits regime. The regulations were not brought to our attention by the Subordinate Legislation Committee.

SSI 2008/288 amends the National Health Service (Travelling Expenses and Remission of Charges) (Scotland) (No 2) Regulations 2003 to reflect changes in the benefits regime. The regulations were not brought to our attention by the Subordinate Legislation Committee.

SSI 2008/261 provides for the enforcement of European regulations that set transitional migration limits for plasticisers in gaskets in lids that come into contact with food. The regulations also correct errors in the principal regulations. The Subordinate Legislation Committee brought the regulations to the committee's attention on the grounds that there is a doubt about whether parts of the instrument are intra vires, because of the failure to adequately justify their coming into force less than 21 days after the instrument was laid before Parliament; there was a failure to provide the Presiding Officer with such an explanation when the instrument was laid; and there was an apparent failure to provide transitional arrangements for substance reference 74560.

The Subordinate Legislation Committee wrote to the Minister for Parliamentary Business on 17 September to express its serious concern about the handling of the regulations. A copy of the letter is enclosed with members' papers. No comments have been received from members and no motions to annul have been lodged.

Do members wish to make any comments on the regulations? I will hear from members first and then go through the procedural options.

Mary Scanlon (Highlands and Islands) (Con): I will probably state the obvious, but I will do so for the record. I am not sure that I have ever seen such strong criticism of an organisation by the Subordinate Legislation Committee. The Food Standards Agency seems to have broken almost every code and rule in the book. A member of the Subordinate Legislation Committee said, "The position is extraordinary." Apparently, officials knew about the errors in April but failed to rectify them by June. There is concern about how the FSA has handled the matter and its failure to answer the Subordinate Legislation Committee's questions. It misapplied and breached the 21-day rule. The convener of the Subordinate Legislation Committee, Jamie Stone, has asked the Minister for Parliamentary Business, Bruce Crawford, for a response by 14 October. The rules have been well set in the years for which the Parliament has been in existence, so I am surprised by how badly the regulations have been managed.

Ross Finnie (West of Scotland) (LD): I seek clarification. I agree with Mary Scanlon's comments and the criticisms laid against the FSA. However, I am slightly puzzled as to who actually drafted the instrument and who laid it. It would be rather odd, given the obvious frailties of the FSA,

and I would be slightly surprised if—I stress if—it was Government draftsmen who drafted the instrument and therefore the minister who laid it. If they did that, I wonder why. Surely they, too, must have been aware of the difficulties with the FSA.

Ian McKee (Lothians) (SNP): What option is open to us?

The Convener: I want members to have their say and put comments on the record before I tell them what the options are.

Helen Eadie (Dunfermline East) (Lab): I was present at the Subordinate Legislation Committee meeting when this issue was raised, as was Dr McKee. As members will note from the papers before us, Jackie Baillie expressed her concern at the meeting about the validity of the instrument if it was progressed further. I note also from the papers that the FSA said that it

"does not consider this error to have a significant effect. There is no substance with Ref. No. 74530 listed in Annex III to the Directive which will minimise the risk of confusion."

The FSA has put its hands up, therefore, and acknowledged that a serious error was made. However, it has said that, although the error was serious because the correct procedure was not followed, it will have no significant impact.

The Convener: I will clarify for members what our options are. Our reporting deadline for all the instruments is 6 October, which means that SSI 2008/261 could come back to the committee at our next meeting, on 1 October, if members are so minded. Our options are as follows. First, we could press the Government to respond to the Subordinate Legislation Committee's letter in a shorter timescale than that requested by that letter; we could press for a response either in time for our next meeting, or in time to allow for a motion to annul to be lodged for that meeting should members be unhappy with the Government's response—in other words, by this Friday.

Alternatively, we could take evidence from Government officials at our next meeting, although that would in effect commit the committee simply to noting the instrument. If any member were to lodge a motion to annul, a Government minister would come to the meeting for a debate on the motion. As a member of the Scottish Government is entitled, under standing order rule 10.4.2, to debate a motion to annul an instrument, I could not permit a motion without notice at this meeting.

The feeling I get from the committee is that there should be a severe rap on the knuckles rather than a nuclear option.

Members *indicated agreement*.

The Convener: Is the committee therefore content for us to press the Government to respond in a shorter timescale than that requested in the Subordinate Legislation Committee's letter? I suggest that it should respond by this Friday. The response could then be circulated to committee members. That would leave our options open. Is that agreed?

Members *indicated agreement*.

The Convener: Thank you for your co-operation.

Health Inequalities Inquiry

10:08

The Convener: Item 2 is to take oral evidence for our health inequalities inquiry. I welcome the first of two panels to the meeting. We have Councillor Ronnie McColl, Convention of Scottish Local Authorities spokesman for health and wellbeing, and Ron Culley, the COSLA policy manager. I thank the witnesses for their helpful written submission. I invite members to put questions to them.

Mary Scanlon: I wonder whether the witnesses can talk about the historic concordat that we are told about every week.

Michael Matheson (Falkirk West) (SNP): Hear, hear.

The Convener: We are not in the chamber now.

Ross Finnie: Is there an opt-out?

Mary Scanlon: As a member of an Opposition party, I took time to get information on Highland Council's single outcome agreement, which is a document that is about 1.5in thick. Sticking to the health inequalities agenda, will you advise me how I, a list member for the Highlands and Islands, can measure from the single outcome agreements whether progress has been made throughout Scotland? Will COSLA measure that? Will the single outcome agreements measure health inequalities? Will you give me a wee bit of advice on how we can audit and monitor progress under the new system?

Councillor Ronnie McColl (Convention of Scottish Local Authorities): It will be audited and monitored by the Government first of all, but we will also audit and monitor it. This is the first year of single outcome agreements and the system will take a wee bit of time to bed in. Next year, there will be a better focus to the single outcome agreements and a better range of measures of health inequalities because all the community planning partners, including the national health service, will be involved in the formation of the single outcome agreements and all the health partners will be subject to them, not only local government.

It is not just about considering the single outcome agreements on social work; we need to consider the agreements on education, housing and the environment—the whole range. If the health inequalities task force did one thing for me, it showed me that health inequalities are not based only on issues that the NHS and social work deal with on their own. We need to consider the range of single outcome agreements and the matters that they address.

Ron Culley (Convention of Scottish Local Authorities): The question is a good one. We probably need to start with the concordat and the relationship between Government and local government that it has defined over the past year. From a local government perspective, it made a difference in three central ways: it reduced the amount of ring-fenced funding; it introduced single outcome agreements; and it recognised that it is right and proper that local government should be part of policy development in the policy areas in which it has an interest. That has been taken forward through the work on health inequalities. We were a part of the task force from the beginning so, rather than simply endorsing the product of its work—"Equally Well: Report of the Ministerial Task Force on Health Inequalities"—we were party to its creation and embedded in the process that led to it.

How that work will be articulated through the single outcome agreements is a good question, and we are working on that. We are now at the stage of translating policy frameworks that have been politically endorsed by the Government and COSLA's politicians into action. In fact, along with colleagues in the civil service, we have undertaken to produce an implementation plan. As part of that, we will speak to the appropriate officer groups to ensure that we can make the transition from broad political principles to more focused local action. A key part of that will be speaking to local authority chief executives. The best vehicle for that purpose is the single outcome agreement. We recognise that single outcome agreements will evolve with time, not only in the indicators that we use to measure success but also in the contribution of the community planning partnership as a whole to the process.

On how we measure success throughout Scotland, COSLA will have a role in measuring progress against manifesto commitments. It is for the Government and individual councils to consider individual single outcome agreements and then for the Government to take whatever lessons come from each of the 32 single outcome agreements and consider them as a whole. There are more things in heaven and earth than are contained in a single outcome agreement. It is about articulating a council's priorities, which the Government agrees with, and being able to take that forward over the course.

10:15

Beneath the single outcome agreements will be robust performance management structures, which will take account of the whole of a council's activity. The two things combined give some assurance that we will be able to continue to monitor success. The crucial difference with single

outcome agreements, though, is the fact that we are now able to consider the benefits that are accrued by individual members of the community. Instead of measuring process inputs and outputs, we are now measuring the achievements that individual councils and the Scottish Government are taking forward together.

The Convener: Did you say "individual members of the community"?

Ron Culley: Absolutely. Ultimately, that must be what the Scottish Government and individual councils are working towards—how we benefit people in communities. The single outcome agreements are, ultimately, a way of describing that.

Mary Scanlon: I have a final supplementary question. I support much of what you say. Thank you for your helpful explanation. However, I am struggling with this. You have said that there are a range of issues across education, leisure and health. There is also a wide range of partners and a wide range of single outcome agreements across all the local authorities. I am not saying that progress is not being made; it is just not easy to monitor.

Will the implementation plan follow the single outcome agreements? Are councils themselves going to monitor how many boxes they have ticked? You have said that COSLA will measure that. Will COSLA produce a report card at the end of each year, showing what individual councils have achieved or what they are on course to achieve? Alternatively, will there be some sort of annual review by the Government, as there is of the NHS, for example?

I support what you are saying, but I am struggling to see how the process can be democratically scrutinised, monitored and measured. If the process involves a wide range of partners, topics and councils, it will be impossible for one person to measure the outcomes. I acknowledge that the commitment is there and I support single outcome agreements, but I want to be able to see whether my council has done well or whether it could do better. How can we be better informed about that?

The Convener: How will we know whether the single outcome agreements are working?

Ron Culley: I think that COSLA's role will be limited to measuring progress against the manifesto commitments as articulated in the context of the concordat.

The analogy with the NHS is interesting. There is a difference between single outcome agreements and the relationship that the Government has with the NHS. The Government performance manages the NHS, but it does not have the same relationship with local government. Essentially, underpinning the concordat is a recognition that there is local democratic accountability, which allows councils to identify local priorities and needs and to tailor their services accordingly. It is in recognition of that fact that each individual council will have an agreement with the Government.

You are absolutely right to say that the Government will have 32 of those agreements. However, it is for the Government to decide whether, individually and collectively, councils are meeting expectations and delivering in the manner that the agreements set out.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I want to ask about something that we discussed last week. How do you identify the communities that are going to be your test sites? We have been informed in evidence that 35 per cent of deprivation in urban communities but only 16 per cent in rural communities can be identified using the Scottish index of multiple deprivation. What is the situation with the test sites? How will they be identified? Your submission does not mention community health partnerships, but it seems to me that partnership arrangements will be important.

Councillor McColl: Various councils have been asked to submit reasons why their area should become a test site. We will seek to identify a range of different test sites, both urban and rural. My council area has serious problems of drug and alcohol abuse, which contribute to health inequalities, so we may do something along those lines. I understand that a substantial number of council areas have applied to become test sites. There will be duplication, so we must ensure that we have a good range of indicators of health inequalities to provide us with the best possible information.

Ron Culley: Dr Simpson was right to mention CHPs. Health inequalities can be tackled only in partnership. CHPs will be fundamental, as they bring together health and local government. Community planning partnerships have a different but important role. In taking forward this work, we were aware of the importance of partnership and of the need to engage at CHP and CPP level.

On the test sites, there has been a good response from across the country. As Councillor McColl said, our ambition is to ensure that, when selecting the test sites that we will ultimately support, we cover equally a range of the issues that have been articulated. We want to ensure that we take work forward in different contexts. That means taking into account not just the urban-rural divide but the way in which "Equally Well" is broken down. One test site may focus on early years, but another may focus on smoking.

Through that process, we will begin to explore what really works in tackling health inequalities. We must use the support and evidence base that we have generated recently to work out how best to move forward.

Client pathways will be fundamental to the test sites. We need to establish how clients engage with different services and partners, and to ensure that partners are arranged in such a way as to allow a seamless transition between the various services that people with manifold problems often need to access.

The Convener: It would be useful if Richard Simpson would ask the minister when she appears before us what progress has been made on identifying test sites. I allocate that task to him.

Dr Simpson: It is now clear that the test sites relate to different projects and that the aim is not to identify a specific geographical area or community in which to test approaches; that will be a matter for local authorities.

The Convener: Mr Culley is frowning. Is Richard Simpson correct when he says that the tests will focus on subject headings rather than localities?

Ron Culley: They will relate to both.

Dr Simpson: Yes, because the projects will be applied to deprived communities.

Ron Culley: It is wrong to think of the tests as projects, as we are hoping to achieve change in mainstream service. It is not about piloting ideas; we are seeking the transformation of service provision.

Dr Simpson: I applaud your ambition, although I think that there are two problems with it, and I would like you to comment on them. First, if you are going to focus on alcohol and drugs in one area and smoking in another, as Councillor McColl said, that does not sound to me like an integrated, holistic approach. However, it might be that I am getting the wrong story—if so, I would like you to correct me.

Secondly, we will not know the outcome of the early years work for 19 years, so it is as important to have tough input measures and process measures as it is to have outcome measures. We all want to move to outcome measures, but that will not happen overnight. Early years interventions might have smoking reduction as an outcome, but you will not get improvements in relation to cardiovascular disease, which is one of the themes of your paper, for 40 years.

The Convener: I ask you to comment on those two aspects—first, that you are not comparing like with like, and secondly, how you will monitor things, given that it will be a long time before you know what has happened.

Councillor McColl: It is not just about monitoring the outcomes. Dr Simpson is correct—in many areas of health inequalities, it will be 10, 15 or 20 years before we know the outcomes and can determine whether our work has achieved its aims. However, the work is partly about getting the various delivery agencies to work in an integrated fashion, and we can learn quickly whether that is happening. If that part of the process is working, it will start to inform the debate so that we can take things forward throughout the country. It will also help to protect the public pound. There is not a lot of money for the work at the moment—there is certainly not extra money for it—so we have to ensure that we use financial and human resources in the best manner.

One of the main purposes of the test sites is for us to find out what works best. They will also enable us to ensure that services are integrated. In many cases, both the NHS and the council provide services and, although they do not work against each other, they are both providing the same thing. We want to have the best use of the resources in any particular area. When the test sites report back—within about two years—it will be more about that side of things.

Ron Culley: Dr Simpson's question is a good one. The two parts of it are linked, because process will be important. The change that we are trying to make locally cannot be only about outcomes. It must also be about processes and pathways, and we will absolutely need to consider that. We hope to establish a learning network whereby we are able to compare and contrast and share knowledge about what works and what does not. It is important that we can fail on some of the issues as well. The learning network will be fundamental because it will allow us to compare and contrast the test sites, but it will also allow us to map out the processes and changes that happen locally.

Dr Simpson's observation in his question on outcomes is correct, but we should hold on to the fact that we can have short, medium and longer-term outcomes. Although he is right to say that we might not observe a reduction in coronary heart disease for 40 years, there are shorter-term measures that we can put in place.

The Convener: The ban on smoking in public places is an example of where we have seen benefits in the short term—in fact, almost immediately.

Dr Simpson: Yes. I wish the local authorities luck, but I produced papers on integrated care for drugs and alcohol problems, to which Councillor McColl referred, when I was the minister in charge

in 2001. We are supposed to have a co-ordinated system. We have had the drug and alcohol action team system for 10 years, and the paper on integrated care for drug and alcohol problems has been out for seven years, but here we are, seven years later, still talking about test sites. We need a degree of realism in the process.

I welcome the renewed commitment, but I remain sceptical.

The Convener: That is a healthy position to be in.

10:30

Michael Matheson: One thing that has struck me in the course of our evidence taking is the need for good partnerships between health services agencies and local authority departments. I want to pick up on an issue that Richard Simpson raised. I have a degree of scepticism about all this, given that I am a health professional who worked in local government during the time of community care planning, which was meant to foster greater joint working between local authorities and the health service. After that, we had the joint future initiative. Some pilots were successful but others were unsuccessful—by and large they did not work. We did not manage to break down the barriers between local authorities and health services, despite the pilots that tried to develop that strategy. What is different with this strategy?

Councillor McColl: One of the main differences is that everybody has bought into the strategy right from the start. We have been careful to keep council leaders informed about what is being asked for, so councils are aware that they are going to have to work in partnership and that it is not about protecting their own budgets or retaining jobs for themselves. The strategy has to be worked on holistically throughout all the partner agencies in an area. Some community planning partnerships have started to work well, although others are not working so well. If the strategy is going to work, it must work well throughout the country.

The NHS has taken a similar approach to local government. We have held meetings with chairs of health boards throughout the process to explain what is happening. They, too, have said that they are up for it and I have no reason to doubt them. We are encouraged by the response from health board chairs and council leaders. Dr Harry Burns has spoken to council leaders at the Convention of Scottish Local Authorities.

Everyone is fully aware that they have to work in partnership, because that is the only way that we will address health inequalities. Nobody has a budget that would allow them to address the problem on their own, so there is a realisation that we should work together. We have all been involved right from the start. It is not a case of national Government coming to tell local government what it has to do. We have been involved in the formation of the policy, so it is in our best interests to ensure that it works.

Ron Culley: The issue is bigger than just health inequalities; it is about the relationship between the NHS and local government. To an extent, we are in a new era of partnership working. The next round of single outcome agreements will be taken forward through the community planning process and will bind the partners into a common vision of what needs to happen in a community. That will require political leadership and leadership from senior officers. It has to be recognised that there is a new context for this type of work.

It is not just about health services and local government; we have to consider all the partners. The police will also have a role in tackling health inequalities. Parts of "Equally Well" talk about violence among young men, for instance. We need to take a holistic view.

That said, we appreciate absolutely that there is more to do on the working relationship between health services and local government. The Scottish Government has recently asked for research to be undertaken on CHPs to discover why some have worked while others have been less successful, and to identify the challenges in that regard. Some of the answers will emerge from the research. We need to be able to capitalise on that when we find out the detail.

I appreciate where Michael Matheson is coming from, but we have a new context and a new enthusiasm for partnership working. It is about being able to capitalise on the structures and processes that are in place so that we can embed partnership working and develop it.

Michael Matheson: You referred to creating the new structures that will be necessary for delivering partnership working, which was discussed during most of my professional career in health and social work and is still being discussed. Can you give me an idea of what COSLA's vision is of the structures that will be necessary to deliver the policy effectively and to overcome the difficulties that we have had in the past? Directors in health and social work departments can sit down and agree that they want to work jointly and that they might pool limited budgets, but when it boils down to what happens on the ground, it is often up to individual officers whether that happens.

Councillor McColl: The main thing that must happen on the ground is developments coming through the community planning partnerships. The health inequalities agenda must be the main focus of the CPPs, which have senior people at the table

who can and will deliver. Councils normally lead the CPPs, so processes within councils must be audited or checked to ensure that the proper resource goes through that channel. In my council area, we get detailed reports of what happens at the CPP. That keeps all the members of the council signed up to the agenda and ensures that they know what it is. They realise, for example, that they cannot say individually, "I want such-and-such spent. Why's it gone there?" They know that there is a reason behind that and that there are proper processes. We must ensure, therefore, that we keep our organisations well informed and that everybody is clear about the process for delivering on the agenda. The main way to do that is through the CPPs.

Ron Culley: That is right. We want partnership at every level because we can build on that. We have partnership at the political level, which has taken us forward, and we have it at strategic level and operational levels. Admittedly, we have not seen the change that we would have liked to have seen over the past few years, as Michael Matheson pointed out, but we must ensure that we can take the structures forward.

The relationship between COSLA and the Scottish Government is about ensuring that we have an appropriate policy framework and that political leadership is provided to ensure that we get the relationship that we want between the NHS and local government. For instance, we need political leadership to ensure that a policy such as shifting the balance of care happens. We also need engagement at senior officer level and operational level to facilitate that.

I acknowledge that there are difficult issues involving the flow of resources through the public sector and how the NHS and local government work together. That is why the shift towards an outcomes focus is useful. It is less about the NHS thinking "These are our patients", or the councils thinking "These are our clients" and more about their considering together what would benefit individuals and families. Generally, we can be optimistic that we can build on the structures that we have in place and work even more closely together in the future.

Ross Finnie: Like Mary Scanlon, I find your responses helpful, but I am still having a little difficulty in understanding to what extent interim measures are required to achieve the outcomes, given—as Richard Simpson said—that we will not know the outcomes of some measures for 20 years. I accept your proposition that if we do not have interim annual measurement, we will be kidding ourselves.

You talk about community health partnerships and community planning partnerships, but they are not new. The outcome agreements are undoubtedly new, but they are inputs, not outcomes. The signing of such an agreement is only a commitment to achieving the outcome. I am still struggling to get my head round where the change is that will produce a difference in outcomes.

On health inequalities, you talk about greater partnership and about the sense that everyone is committed to addressing the issue and that we are all working together, which is extremely valuable. I do not want to diminish that in any way, but I am having great difficulty in getting my head round where there is a hard-edged change that will result in outcomes in the short, medium or longer term. I have a horrible sense that, despite all the good will and the enormous amount of time that COSLA is putting into the process, we are still circling the problem with a lot of words and good will. As I look at the centre of the issue, I am not clear about where the measurements are.

I would like to pursue the question that Mary Scanlon put. We have the outcome agreements and everyone accepts that that is where we should be, but will we continue just to talk about the outcome agreements or will we start talking about outcomes? When will that happen?

Ron Culley: That is a good point. There are two separate questions to answer. The first is about what single outcome agreements are for and what benefits they have, and the second is about how we give effect to the aspirations that are described in single outcome agreements and ensure that change happens.

On the first question, single outcome agreements strengthen accountability within the public sector in Scotland, in the sense that councils can now articulate clearly their accountabilities to Government and to local communities. In other words, they can set out what their aspirations are, what changes they want to give effect to and how they propose to do that over the course of the single outcome agreement.

The second question is difficult. How we give effect to the change that is sought will depend on the area that we are looking at. On health inequalities, we have a range of mechanisms that we hope will result in change. The "Equally Well" report makes 78 recommendations, and our ambition is to be able to implement them on a partnership basis at local level. In addition, we want the test-site process, which will enable us to learn about the challenges that we face in addressing health inequalities, to lead to change. Against the background of "Equally Well", there is reason to think that we can give effect to the change that we want to see.

The Convener: Councillor—

Ross Finnie: I will welcome the views of the elected councillor, but before I do, I want to press Ron Culley on his answer.

Single outcome agreements allow councils to articulate their aspirations and so on. I have got that, and I do not disagree that that is what the agreements do, but they are inputs, not outcomes—they measure the outcomes that the Government is striving to achieve. I wholly support the Government in those efforts, but constantly talking about the agreements—of which a very large number have been signed—and what is in them presents us with a difficulty. Each signed agreement is an input, not an outcome. There is real urgency about this. I am not being critical—it is a new system—but we must stop talking about the inputs and start focusing much more harshly on what the Government is driving all of us towards, which is producing and measuring outcomes.

10:45

Ron Culley: Absolutely—you will not get any argument from us about that.

Ross Finnie: But that is not what I am hearing. Perhaps my question is not very well couched but, with respect, your response seems to be, "Yeah, this is great. We've got the outcomes. It's wonderful. We've signed the agreements." Instead of that, I want to hear about where we are going now. We have a mountain of agreement; how are we going to translate the agreement—narrowing it down to health inequalities—into outcomes, rather than just discussing what is contained in it? Now that we are 15 or 18 months into the parliamentary session, how will local authorities begin to do that? Other organisations are involved, too. Councils are not alone; I accept that there is partnership working involved. We know what the agreement is—it is down on paper—but how is it going to translate into genuine outcomes for the community?

The Convener: Mr Finnie directed his question at Mr Culley, so I will let him answer first. Mr McColl may then comment—he has been very patient.

Ross Finnie: I am sorry, Mr McColl.

The Convener: It is not personal, Mr McColl.

Ron Culley: The question is a fair one. The second part of it was about how we effect change and make a difference to the outcomes that people experience. When it comes to health inequalities, we have the answers in "Equally Well". It sets out a series of recommendations and proposals around test sites. As a consequence, we hope that there will be improvements at local level whereby health inequalities will ultimately reduce. We accept that we might have laboured the point about the structures, but we do have an idea about how to give effect to the changes that we want to happen. That is what "Equally Well" is all about.

Councillor McColl: The focus that Mr Finnie spoke about tends to come from national politicians, not local politicians. We in local government are focused on how we deliver to our local communities. We have the 32 outcome agreements—we need 32 of them, because different areas do not necessarily have the same problems or need the same focus. If one council happens to be delivering very well on something, it will tend not to include that in its outcome agreement because it will not feel it necessary to improve on it. Each local authority considers what it needs to deliver, then sets out the structures to do that.

We will see whether outcomes are being delivered as we go through the process. That does not mean getting to the end of outcome agreements; some of the plans that are set are not necessarily for the short term—for a year, for instance. There are also two-year, three-year or even five-year plans. As we go through the process, we will start to find out whether we are achieving the desired outcomes.

Under the agreements, if something is not being delivered, we can quickly alter the way in which we are trying to achieve the outcome. In the past, the process mainly involved targets for spending money on our own, like the NHS has targets to spend on its own. The current process makes it incumbent on us all to work together as a group of deliverers of services and to deliver an outcome for an area. We do not just work in our own wee silo any more—the process does not allow us to so we must work together.

Ross Finnie: I wholly agree that you are all working together, but I am still not clear how I can know that things are going well. The process has to be remodelled. In the past, we tended to measure inputs. I was part of that; I spent 20 years in local government so I know how besotted we became about measuring inputs. However, we are now tasked with changing the process round and considering outcomes. That is healthy, but I am not sure that we have refashioned our processes so that we can know that we are achieving outcomes rather than just measuring inputs. Central Government and local government invested a lot of time and money in measuring inputs, and I am not wholly persuaded that we have turned things round so that we are addressing outcomes.

The Convener: I will ask questions on test sites and I hope that the answers will be helpful to Ross Finnie. When do the test sites report?

Councillor McColl: In 2010.

The Convener: I presume that we will then have a measurement of outcomes.

Councillor McColl: Yes.

The Convener: The COSLA submission states:

"In determining what Test Sites are approved, COSLA and the Scottish Government are looking for proposals that could be delivered in other contexts."

I do not know whether that is helpful to Ross Finnie, but it is helpful to me. I agree with everything that Ross and others have said about good will, but the test-site reports will be tangible—they will be a kind of litmus test. The test sites have been chosen for particular reasons and, as you suggest, the outcomes could be applied elsewhere. We will be able to see whether the proposals have failed, worked or been neutral.

Councillor McColl: Absolutely—but you have to remember that we are at the beginning of a process both with health inequalities and with single outcome agreements. The agreements were signed off as recently as early summer, and it is now only September. We have to allow time for them to bed in.

The Convener: Should we be looking at the test sites? They have not been chosen at random, and the outcomes will be measured and may well be applicable in other contexts.

Councillor McColl: Yes—but if we see that something is working and there is evidence of significant short-term gains, we will not have to wait for two years before applying it elsewhere. That is the idea behind the test sites.

Ron Culley: When considering the various applications for test sites, we and our colleagues in the Scottish Government were clear that transferability would be a key component and that the test sites would have to be capable of being evaluated. We feel that we have built in something that will allow us to learn a lot about how best to tackle health inequalities and about how to give effect to the type of change that we hope to achieve for communities.

Ian McKee: I would like to follow up on some of Michael Matheson's points. As is the case with other conditions, the health inequalities in cardiovascular disease have their origins in many different aspects of society—such as upbringing, housing, poverty and health service provision. Health inequalities may even have widened over the years rather than narrowed, despite all efforts.

Much is said about partnerships and agreements, but previous partnerships have either not worked or have worked only sporadically. They have depended on the good will of individuals working together, and such arrangements have not been easy to replicate.

Is it time to think outside the box and be a bit more radical? The structures that are laid down in this country should not be set in stone. In other countries—Japan, for example—local authorities have total responsibility for dealing with health inequalities. The local authorities have the budgets and might employ the health side for health aspects so that if there is a desire to prescribe statins to reduce cardiovascular mortality in areas of health inequality, they will be commissioned. In such a system, whether a health or local authority intervention is needed, the local authorities know about the health inequalities in their area and are responsible for tackling them. Would that be a way of getting over the hump? People do not seem to be working in partnership here. However many kind words are said, when it gets down to the nitty-gritty, partnership working does not happen.

Councillor McColl: If you are talking about giving me the NHS budget, I will happily take it.

There is evidence that the diseases that you are speaking about are practically pre-set and pre-determined by the birth circumstances of the child and the living circumstances of the child's parents; indeed, they are possibly pre-set pre-birth. The NHS tends to have more involvement than councils have, from the unborn child through to the school-age child, but it is important that a range of services and local service deliverers is involved.

The issue is not who holds the budget; rather, a partnership should decide what is best and people should inform one another what is happening. That process is more important than who holds the budget and runs the service. It is important that we are all informed. Before a child goes to school, we should know whether there are medical or social problems in its family, and the NHS should be told by us if we know that it is likely that a child will be born into chaotic family circumstances. The most important thing is that the process is joined up.

Ron Culley: I understand the question. The sentiment behind it is correct. We should ensure that the correct structures are in place, and we should not be complacent. However, I, too, think that the structures have not been in place for too long in community health partnerships and even the community planning partnership process. There may come a time when we have to ask such a question, but the question now is how we can make the structures that are in place work better, and we and the Government have undertaken to pursue that matter.

Ian McKee: No one can fault such aspirations, but from my experience, those aspirations have existed over the years. People who have spoken about past set-ups have said exactly the same

thing. I would love to be wrong, but I think that we will say in a few years' time that the local authorities and the health service have not co-operated properly. I am not trying to give a total package that shows how things should be handled, but is there not another way of doing things? I am afraid that I am suspicious that things might not work.

The Convener: That is really an observation; I do not know whether the witnesses want to comment on it. However, I am obliged to my colleague for suggesting that the committee makes a trip to Japan. I fully endorse that suggestion, but I hope that he will write the submission for the Conveners Group, as it would be quite tough to get money for such a trip.

I want to move on, if I may. Helen Eadie has a question. We will try to keep within our timetable.

11:00

Helen Eadie: Having been a councillor in Fife for 13 years before I became an MSP, I agree with my committee colleagues' scepticism. Like others, I am concerned at the intangible nature of the single outcome agreements. For me, the jury is still out on whether they are actually the solution and the holy grail that we all seek. We are not disputing the clarity of the aspirations—indeed, I think that we all feel comfortable with the higher level aspirations—but problems tend to emerge when it comes to translating them into action on the ground.

For example, at a meeting less than a month ago with community health partnership people in Fife, I discovered that they had not even been consulted on the local plan. Given that we are now 18 months into the single outcome agreements, the fact that they have not been consulted on such a fundamental issue suggests that there is a real problem.

You say that, as far as accountability is concerned, the jury will give its verdict at election time. However, has there been any thinking in the interim on how we might empower people to tell us the difference that the agreements have made to them? For example, I represent Lochore, which is the data zone with the highest degree of poverty in the whole of Scotland, and I do not believe that anything at all in the fine words that we have read and the documents before us will address any of the inequalities there. How do we ensure that capital spend fits in with the local plan and the community health partnerships?

Ian McKee was absolutely right. In Japan—and, I believe, in Denmark—councils have total control of the health budget. To what extent does this issue ultimately come down to who holds the purse strings? Moreover, as far as joint futures are concerned, there is no better example than the Fife Council area, where the health board was coterminous with the police authority and all the other agencies. However, even though we in Fife have had community planning for more than 10 years, we have still not addressed the inequalities in some of the areas with the greatest deprivation. In fact, I do not see any inroads being made into that; I certainly do not know whether there are any plans to fit some of those areas into the spend.

Given that your budget of £145 million is for 2008-10, I have no idea how you will reach any conclusion on the measures that should be taken by the end of 2010. Surely you cannot make any such decisions until some time after that.

As well as commenting on those observations, will you expand on the suggestion in your submission that

"we need to be more sophisticated in our approach to early intervention"?

The Convener: I hope that the scepticism shown by members around the table will not make you go looking for a stiff drink. I am sure that you share a little of that scepticism, but, like many of us, you are still optimistic enough to keep trying.

I think that Helen Eadie's questions centred on how you will do all this by 2010 and—an important point that has not yet been raised—how you will be

"more sophisticated in … identifying children at risk".

Ron Culley: There were a few other questions in there.

The Convener: I am mindful of the time, so I ask you to address those two questions just now.

Helen Eadie: I would also like to hear why the CHPs have not yet been consulted on the local plan.

The Convener: Okay.

Ron Culley: After hearing the chief medical officer speak about his latest research, COSLA politicians and chief executives were persuaded that early intervention was an important area in health inequalities. Hopefully, we have been able to articulate that in the context of "Equally Well". "Equally Well" must sit alongside a couple of other areas of policy development: the early years strategy, which we are taking forward with Government, and the anti-poverty strategy. Those three areas of work are complementary and must be considered together.

I understand that early years work is focusing on a number of areas, including service integration, how to build universal services around young children with a range of needs, and how to move from crisis management to crisis avoidance—

anticipatory care and prevention. We do not deny that those are difficult issues. To some extent, we face the same issues in the context of "Equally Well"; no doubt we will also face them in our anti-poverty work. In taking forward together those three policy platforms, we hope that we will be able to come up with a convincing narrative on how best to intervene during early years to prevent subsequent challenges to an individual's health.

You asked who holds the purse strings for the community plan. That is a valid question. If our partnerships are expressed through single outcome agreements, both the NHS partner and the local government partner, each of which holds resources, are accountable for the same outcome. In other words, if both local government and health have an aspiration to reduce health inequalities, it is incumbent on those partners to ask how best they can use their resources together to produce the outcome that they want. With single outcome agreements, the difference between where we are now and where we used to be is that we are now in a position to answer the fundamental question of whether we are succeeding or failing. We were less able to do that before, when we focused on processes and inputs.

Helen Eadie: I am sceptical about what you have said. You mentioned health outcomes and local authority outcomes. If the health board and the local authority are not talking to each other about the development of the local plan—and clearly they are not—the local authority's capital spending programme will go in one direction but the health board will fund a GP surgery somewhere else. The answer for the community may be to have a community facility, rather than two separate strands. That is what is happening in my neck of the woods, where the local authority and the health board are working in opposite directions. I had to sit them down round a table to tell them that that was not right. Why are single outcome agreements not addressing such issues?

The Convener: Is that not an issue that could be investigated in test sites? You said that tests could focus on locations rather than topics—or on both together.

Councillor McColl: That is why it is important that much of the work comes through community planning partnerships. The two main players—the NHS and local authorities—are at that table. Both sign up to the agenda of CPPs, the process for implementing it and the outcome to which it aspires, so they should work together. That may not be happening in Helen Eadie's area, but evidence that I have received from across the country suggests that generally it is. In the past it did not happen in the way in which it should, because there was a tendency for people to protect their budgets. The main players who should have been at the CPP table were not there, so people tended to work independently of one another.

However, the process now makes us work as a team to deliver for an area. That is especially important at a time when we do not have unlimited finance or resources—it is not just finance that is important, but the fiscal resource of staff. Councils often staff services that were previously delivered by our health partners, and vice versa. If the work is done through the CPPs, there is a better chance of things gelling and people working together.

The Convener: I want to bring the session to an end. According to my schedule, we have overrun by about 15 minutes.

Thank you for your evidence, which was very good. You withstood the scepticism and depression of the committee. If we did not ask about something that you wanted to cover, you can send your comments to me in writing and I will distribute them to the committee.

I thank Helen Eadie for mentioning Denmark. Someone suggested that we should split the committee into two, but I do not see why we should do that. I foresee a world tour as our grand finale.

Councillor McColl: We would be happy to come.

The Convener: Somehow, I knew that you would say that. You are very welcome to come along if COSLA foots the bill.

We will have a short break.

11:11

Meeting suspended.

11:21

On resuming—

The Convener: Our next item of business is further oral evidence on health inequalities. I welcome Shona Robison, the Minister for Public Health. She is accompanied by Kay Barton, the deputy director of the Public Health and Wellbeing Directorate; Dr Harry Burns, the chief medical officer for Scotland; Dr Jonathan Pryce, the head of the Primary and Community Care Directorate; and Will Scott, the head of the long-term conditions unit. I welcome you all.

I understand that the minister has some short opening comments to make.

The Minister for Public Health (Shona Robison): It is more of a tantalising offer, convener—

The Convener: If it is not an offer of a trip to Japan or Denmark, or a similar venue, we are not interested.

Ross Finnie: We should go straight to a vote on that.

Shona Robison: I am aware of the work that the committee has undertaken in compiling its report, which I think will be ready by the end of October. If the committee is so minded, we would like its recommendations to form part of the submission to the national coronary heart disease and stroke strategy consultation, which will end on 24 October. That is a mechanism for feeding the work that you are doing into a live consultation. It is for the committee to decide, but the offer is there.

The Convener: That is a grand offer. It is a pity that it is not an offer of a trip abroad, but we will settle for it. The committee can discuss that at its next meeting.

I open the meeting for questions to the minister.

Helen Eadie: Last night, I attended a meeting of the cross-party group on cancer, at which concerns were raised about the perception that cancer is not being given the same profile as cardiovascular heart disease and stroke in the keep well programme. The group talked about poor diet in the poorest communities in Scotland and how we can tackle that among men. We all agreed that women will pick up a women's magazine and understand the issues around eating five portions of vegetables and that it is not good to eat too much red meat; yet we regularly watch our husbands tucking into enormous plates of meat. How can we address that within the equally well agenda and ensure that the issue gets the profile that it should get?

The Convener: I will give you a bit of leeway, Helen. Our health inequalities inquiry is focusing primarily on cardiovascular disease; however, I can probably allow your question.

Shona Robison: I am happy to respond to that. The cancer plan will be launched on 24 October and will re-emphasise the things that need to happen in order for us to deal with the issues that you have identified.

Active discussions are continuing about how the bowel cancer screening programme can better reach men, among whom there is a lower uptake than among women, and those who are in harder-to-reach groups. At the moment, people get a letter asking them to send in a sample. That mechanism works for some groups, but the evidence is that it is not working for other groups. We need to consider other ways to reach the people who we are not reaching currently, whether through contacts in primary care, the voluntary sector or support groups. We have to consider ways of reaching men in particular. We will have to learn lessons from keep well about how to get men more involved in the screening programme. I assure you that we are aware of the issues that you raise. Cancer remains a key priority. I hope that you will see that when the action plan is published on 24 October.

Helen Eadie: I return to the core issue on the agenda, which is community health partnerships working with local authorities. You might have heard from the previous evidence session that we have real concerns about how we can move the discussions from a high level within councils to further down the food chain, so to speak, so that we can ensure that there is co-operation and that the aspirations that we all share are realised. I gave an example of where the community health partnership had not even been consulted on the local plan. My concern is that although discussion is taking place at a high level, it is not filtering down. How are we going to achieve that?

Shona Robison: A few weeks ago, I spoke at a conference of community health partnerships. I gave them a number of key messages, one of which was the absolutely critical need for better local partnership working. There are good examples of that happening, but in some areas it is not as far along the track as it needs to be.

At the end of the year we will review partnership working in community health partnerships, to look at why certain things are working well, as well as how to make changes to overcome the barriers where things are not working well. We are very much aware of the issue and work is in hand.

Helen Eadie: Will you provide us with a note of the examples of best practice?

Shona Robison: I would be happy to do so.

The Convener: I think that that was mentioned earlier.

Helen Eadie: The minister seems to be suggesting that some things are working well, so it would be useful to know about them and about the barriers to which she referred.

The Convener: Perhaps an unintended consequence of your audit of CHPs will be that those that are not working well will start to work well, because they are about to be looked at.

Shona Robison: One would hope that they have already got the message on that.

Dr Simpson: The committee has heard a lot about smoking, diet, exercise and alcohol—the secondary prevention measures, as it were—in adults, as well as the success of the keep well programme. However, I am interested in the lecture that Dr Burns gave to the urban

regeneration group about the effect that is not related to those factors, and the disproportionate effect that those factors have in conjunction with deprivation—there are things that neither those factors nor deprivation can account for. Early years intervention is a factor in coronary heart disease that we have not considered before, and I find it fascinating.

Local authorities will have test sites for the various programmes that they are running. How will those programmes differentiate from the previous programmes of sure start Scotland and "Home-Start Scotland", the work of family centres, community schools and nursery schools and all the voluntary support systems that have been put in place to improve parenting and early circumstances? What will draw that together? What will change? What will the Government do?

11:30

Shona Robison: We have had a fantastic response from local partners, across all the issues raised in "Equally Well", for bids for the test sites. That is a positive start. We are in the process of finalising those that we will take forward and we will announce that in due course.

I will give you a sense of some of the things that are new about the approach. As you heard earlier, buy-in and leadership at the highest level right from the start is important. It is not Government saying, "We want you to get on and do this." It has been a joint effort and people have said, "We need to do this."

One thing that we looked for from the test-site bids was that local staff had been involved in making the bid, so that it would be about what they want to do as practitioners working across health, social care and so on to deliver change, improve pathways and create a better public service for the most vulnerable. The bids also had to show community involvement in developing the bid. It is not about doing things to people; the community must be involved and must want those service changes. It is about not throwing out what is already there, but building on it and about changing and developing services and maximising the opportunity to pick up children at an early age.

Harry Burns has talked about the formative years of zero to three. Unfortunately, despite very good on-going projects, there is not systematic support for vulnerable families and children—support tends to be provided at times of crisis. We want the test sites to provide a redesigned service and for staff to work on the front line with those families to see what impact the changes have. We want the test sites to demonstrate a gain for vulnerable families and a gain for public service that could be taken up elsewhere.

Dr Harry Burns (Chief Medical Officer for Scotland): My philosophy on this is that if you keep doing what you have always done, you should not be surprised if you keep getting what you have always had. We will have to do things differently to influence what is going on in the family home. Be in no doubt that policy can only set the context. Unless the future changes for the child who is in difficulty this morning because a parent or carer is under the influence of drugs or alcohol, nothing will change in the health of the population. All that we as health boards, local authorities and so on can do is facilitate such one-to-one engagement.

We must therefore come up with a different approach. The interventions that Dr Simpson mentioned tend to have been managed on a project basis, whereby a chunk of money is given to an interested group of people. We let them go and do something for three years and then we come back and evaluate it. We usually find that not much has changed, so we move on to the next thing and the learning from the process is lost, but the project may not have made any difference because the dose of intervention was not high enough and was not kept going for long enough. The idea of a learning network has therefore been born. The term "learning network" undersells what I hope it will do. We want to bring a dynamic approach to early years work in particular, but to the whole health improvement agenda. We have structures, community health partnerships, joint budgets and so on, but this approach means that the people who are taking the intervention to the individual learn from the one-to-one engagement. Instead of having a randomised control trial with 200 people in each group, this is a one-to-one trial. The trial is about the social worker, the community nurse or whoever, going in and finding something that connects with that individual and sharing it quickly with others in the system, so that other people can learn and try things out. It is a different way of learning.

The other element that is important is the need to keep the enthusiasm and momentum going. What has tended to happen is that, when major organisations get the money to do a project, the chief executive's mind is away elsewhere. With the best will in the world, the senior management in organisations are not in day-to-day touch with what I would argue is the most important bit of their business. We need to keep the enthusiasm very visible so that everyone in an organisation is aware that some tangible benefit was observed in relation to, for example, three children or four families. That must be fulfilling not only for the front-line staff but for everyone in the organisation.

It is important to change the culture of the way in which we do this kind of work. Simply changing the structures is just rearranging deckchairs on the

Titanic. It is important to change the way in which we energise the processes. I am conscious that, in order to keep that happening, I will have to be very visible, because I have to be whipping the chief executives along to ensure that they are still engaged, and the minister will also have to be visible. At all levels, we will have to work with our closest contacts to make them aware that this is the most important game in town in relation to health improvement. If we cannot sort out the children who are being born in chaotic circumstances, we will leave ourselves vulnerable in the future. I believe that we can do what is necessary, but we have to work differently and change our processes. As long as the structures permit the processes to change and we are able to keep our eye on the ball and keep persevering, we will get there.

I would be extremely careful not to specify what the processes are. I have read a lot about the benefits of the nurse-family partnership, the High/Scope Perry pre-school project and so on, but we need to focus on what happens in places such as West Lothian, the east end of Glasgow and central Dundee. The issue is about getting local people to construct locally sensitive pathways. It is important that we do not prescribe what needs to be done. I am happy to guide people in the right direction, but you have to set the ground rules and then step back and allow the solutions to emerge.

Dr Simpson: I do not disagree with much of what you have said. We have to try something different, because what we have been trying up to now has been successful only in patches, if at all.

I am concerned about the fact that we have a system in which there is a fundamental difference between the social care side and the health side. The fundamental difference is that, on the health care side—particularly in primary care—no family's case file is ever closed and they are permanently with one primary care team whereas, on the social work side, there is intervention at the point of crisis and, after the crisis has been dealt with, the client's case is closed.

We have had considerable success in changing the learning disability system from institution-based care to community-based care. However, the fact that cases can still be closed when the individual has a permanent, long-term condition is a fundamental problem. The difference between the two care systems is great and it is difficult to see how the matter can be resolved.

Dr Burns: When I appeared before the committee in April, I talked about the need to change the way in which we handle information. The fact that information exists in silos means that it is difficult for health workers to know about social problems and for education workers to know about health problems and so on. That is an impediment to people's ability to do the right thing for extremely disadvantaged children. That is still something that I feel strongly about, and I agree with the point that you make. We need to ensure that there is a seamlessness in the service and a holistic approach to the understanding of the problems that children are battling with.

Michael Matheson: In the evidence that we have taken so far, there has been a strong message about the need for partnership working between local authorities and health professionals. I worked through the introduction of community care planning in health and social work, and the services have also gone through the joint futures exercise. I hear what you are saying about changing the processes, and I am entirely with you in terms of what you are trying to do. However, I am sceptical about whether something different will happen this time to ensure that we create the effective partnerships that will enable us to deliver care to those in our communities who need it, which, to a large extent, we have failed to do over the past 10 or 15 years.

Shona Robison: I also worked through the introduction of care in the community, and can say that that was a million miles away from what we are trying to do. At the time, that was seen as a centrally imposed philosophy that was not backed up by work on the ground. It was poorly introduced, as well. I could talk for hours about the problems with that policy.

The Convener: Please do not.

Shona Robison: The principle of the policy was good, but the implementation was not.

Our policy is a million miles away from that because it is about engaging staff on the front line in order to work out better pathways of support for families. For example, some of the best changes in the health service happen when you bring together in one room all the people who are involved in, say, a cancer pathway—from the receptionist through to the oncologist and the surgeon—and ask how the patient's pathway can be improved. The results of that approach are dramatic because people are able to ask why certain procedures are followed. The culture of the test sites is about asking what everyone who is involved with a vulnerable child, family or whoever can do—no matter who they work for or who holds the budget—to improve the support pathway.

We have not done that before. Instead, people have been presented with a policy and told to implement it. Our approach is about empowering people on the front line by giving them a context to work in, providing resources for the test sites, involving the communities in which the test sites will be located, and then standing back a bit.

My gut instinct tells me that that is the right approach. People on the front line want to do their best for the people with whom they are working, but they sometimes feel held back by the structures in the system. We want to give them a bit of freedom to come up with new solutions and better pathways.

The presentation that was given to us by the violence reduction unit demonstrated clearly that the current structures work against the sharing of information, which means that we fail vulnerable children. In the presentation, it was easy to see the opportunities for intervention in people's lives that had never been taken because of information being held in silos. We are making a start towards changing that situation. It will not be possible to do so overnight, but we think that we are taking the right approach.

Michael Matheson: I agree that, often, bringing together people who work at the coalface is the best way of coming up with innovative ideas of tackling problems. That was certainly my professional experience.

Dr Burns talked about not getting caught up in structural reforms—I agree with what he said about rearranging the deckchairs on the Titanic. However, I think that some structures will impede some of the processes that might be necessary if we are to deliver change. That may in part be driven by self-interest in certain organisations. What can the Government do to drive home the message to local authorities and health boards that they must address any impediments to allowing the processes at the coalface to change to meet local communities' needs, and how will the Government check that that happens?

11:45

Shona Robison: The test sites in the learning networks will identify any structural barriers. We expect any barriers to be resolved as part of the way in which the test sites are taken forward. The learning network will learn the lessons from that to ensure that, when the work is developed in another area, those barriers are removed from the outset. That is all about the learning networks, which is why political buy-in and leadership at the highest level in COSLA are important. If there are barriers to something working, people need to say, "Let us consider how to remove them." We do not believe that a bit of structural reform will change the way in which services are delivered—that has not been my experience. A much better approach is one in which people change the way in which they deliver services and any structural barriers are removed along the way.

Michael Matheson: That grass-roots approach is potentially threatening to those at senior management level, who, in the past, have set what happens, rather than being told what should happen and how services should be shaped.

Shona Robison: That is why political and senior management leadership is important. There is a win for senior managers, too, because if they get it right, the clients—the community or the public—will get a better service and resources will be used in a better way to achieve better outcomes. That is a win-win situation for a senior manager who is trying to manage finite budgets—there are incentives. The learning network will be important when we do the social marketing sell. We can say, "Look what this approach has achieved in area A." There will be buy-in from senior managers, who will think that they could have the same in their patch.

The Convener: To add to that, if that worked, the staff would feel valued and rewarded in all circumstances.

Ross Finnie: I am still wrestling with the concept of the normally reserved Dr Burns rushing round whipping people up.

Shona Robison: But in a nice way.

Ross Finnie: I am glad that the minister added that caveat.

The Convener: I hear Dr Burns saying sotto voce that we have not seen him when he is training.

Ross Finnie: I will pick up on Michael Matheson's point. As Richard Simpson said, we accept Dr Burns's detail and the minister's confirmation of what we are trying to achieve at the pitface. The need for buy-in by leadership has been referred to frequently and the minister referred to the need for buy-in by COSLA. We have just heard from COSLA witnesses and it would be completely wrong to misrepresent their evidence—they were enthusiastic and keen. There was a sense of realisation that work must be done across boundaries. However, one difficulty with their evidence was that they seem to have become understandably focused on the change of process brought about by the outcome agreements.

I support the outcome agreements and believe that the Government was right to move in that direction but, to be blunt, every time we pressed the COSLA representatives, their answers gave the sense that, somehow, everything will be resolved by the outcome agreements. There is a difficulty getting them to go over the wall from the outcome agreement to the outcome itself. The minister and Dr Burns have talked about the outcome itself. If we are to get buy-in not only from the people at the pitface, but from everyone—which Michael Matheson asked about—we must

get over that wall and understand that the outcome agreements are an input and not an outcome. I wonder whether you feel that yourself, minister.

The evidence is clear: COSLA is having difficulty getting beyond what has been a big change. I do not want to be overcritical about that, but there is a big hurdle if we cannot get over the wall and see that where we are trying to get to is the delivery of outcomes, not simply saying that as long as we have an outcome agreement we are okay.

Shona Robison: The single outcome agreement sets the context for all the work that happens on the ground within the local authority and demonstrates, in a visible way, what we want to achieve—the milestones and outcomes that we expect to be achieved. It is about the single outcome agreement in the local authority being translated to the coalface.

We were quite reassured by the level to which health inequalities outcomes featured in the first round of single outcome agreements. We expect to see more of that in the next set. The single outcome agreement is the big picture that will guide the priorities of the local authority. What matters is how those priorities are addressed at the coalface by the staff, and this work is about empowering them to do that in the most effective way.

So, the outcomes are achieved as they are set out in the single outcome agreements and will be achieved only if the work on the ground delivers them. It is about delivering the theory into practice.

Ross Finnie: I agree with that, but I am concerned about the timescale. I appreciate the fact that this is a big change, and I do not want to be overcritical because of that, but when local government representatives tell us in evidence, "We have had the first agreement and that was very new. We are now working towards the second agreement, which we hope will be slightly better," it leaves people like me sitting here thinking that we are a long way from being able, in a relatively short period, to get the people at the front doing what you are saying they should be doing, which the committee agrees with. There seems to be a bit of a gap there.

Shona Robison: The test sites will start very quickly and will run for two years to create the learning to translate elsewhere. There will be no delay in that. The work of the test sites will sit in the context of the single outcome agreements—they will have synergy with the single outcome agreements. There will be no delay.

Kay Barton may want to say a bit more about the test sites and the timeframe.

Kay Barton (Scottish Government Public Health and Wellbeing Directorate): Yes. Drawing on the test sites, I can make some general observations about how we will know that every area in the country is working towards a reduction in health inequalities.

Some national outcomes are already part of what the Government negotiates with councils on health improvement and the reduction of inequalities. There are two recommendations in "Equally Well" that should help local authorities understand what action they need to take and the sort of things that they should include in their single outcome agreements. One recommendation talks about the high-level health inequalities measures that we expect to see shifting at a national level over time. In the next few weeks, we will publish details of exactly how we define those high-level measures. They are the 10, 15 or 20-year measures where we expect to see change.

To help local authorities know what kind of things they should put in their single outcome agreements, recommendation 72 talks about mapping the more medium-term outcomes, the things that we need to see happening locally across the big themes of "Equally Well" and the sort of things that we expect to be included in the single outcome agreements next time. Those may include the contribution that improving people's chances of employment makes to improving their health and reducing inequalities; dealing with things in their physical environment that need to shift; and early years services.

We will produce recommendation 72, on mapping the more medium-term outcomes, to set a template of options from which local areas can pick, which will be the evidence-based good and right things to which they all ought to attend. It is not just a question of the test-site areas tackling the big problems and leading the way; all areas must assess their local needs, identify where the problems are locally and have in place an understanding about which agency within the CPP will do which actions to get us to the outcomes.

Shona Robison: The implementation plan, which we will publish by the end of the year, will set clearly at a strategic level who will take the lead on various parts of "Equally Well".

Ross Finnie: That is helpful, although I failed to get to recommendation 72—I apologise for that—and that leads me to ask whether we are in danger of making the process rather complex. The issue under discussion is only one element of an outcome agreement and we have an official quoting recommendation 72—rather excellently, though. This is beginning to sound a bit like a discussion on legal statute, along the lines of, "Para 103, subpara 5, subsection 6—I'm amazed

you didn't know what that meant." Is this not becoming just a bit too complex?

Shona Robison: We would expect a document that deals with a complex issue to be in its entirety for those whose business it is to lead the change. We would then translate it to the easy-read version for people who require that level of information. It is clear that those who will pore over the recommendations will be those whose job it is to do so to translate the recommendations into actions. The implementation plan will be clear about who has the lead to do what, and it will leave no doubt about how the recommendations at a strategic level will translate into actions. I hope that that will be an easier read for Mr Finnie.

Ross Finnie: I can see a role for Dr Burns's whip.

The Convener: I do not know whether Mr Finnie is flattered that you will give him an easy-read version. I do not know whether he likes that description.

Ian McKee: I want to narrow the focus from generalities to something more specific. We are concentrating on health inequalities in cardiovascular disease. As the minister will know, much of the work in primary care to ameliorate the burden of cardiovascular disease involves taking blood pressures, checking cholesterol levels, giving health advice and prescribing statins, where that is indicated, and so on. The nature of those who suffer from health inequalities means that they are not always as able to co-operate with health initiatives as people from more affluent areas. In addition, professionals who work in less-affluent areas deal with people who have non-cardiovascular situations too, which makes it difficult to get people to have their children immunised, for example. There is a much higher burden of work in such areas.

It strikes me that the national terms and conditions of service for primary care still fail to recognise that heavier burden of work, so we end up with the people who work in the areas of highest need getting the least income or taking on a much higher burden of work to maintain the same income. Are we not giving aspiring, talented young doctors and nurses the message that they should work in an affluent area, where they can meet much more co-operative people and have a much lower burden of work than if they worked in an area where the need is greatest? Would it not be better to have a system whereby people who worked where the need is greatest received more income in recognition of that status?

12:00

Shona Robison: I will ask Jonathan Pryce to give more detail in a minute, but I will make a couple of quick comments first.

Ian McKee has a point. "Better Health, Better Care" said that we need to grapple with the issue he raises. He will be well versed on the minimum practice income guarantee and the fact that it does not reflect the additional needs of practices in deprived areas. Jonathan Pryce can say more about how we are taking that issue forward.

There are incentives in the system: allowances are available for general practices in deprived communities—up to £7,500 for the most deprived areas. Some aspects in the system can help, but in "Better Health, Better Care" we recognised that there are issues.

Dr Jonathan Pryce (Scottish Government Primary and Community Care Directorate): We certainly recognise that there is a lot of inequity in the way resources are currently distributed to GP contractors across Scotland. There is a Scottish allocation formula, which in the main determines how resources should be distributed. It takes account of a number of elements, including one to do with morbidity and deprivation. It perhaps does not give quite enough weight to the deprivation elements, but they are included.

It may be helpful to spell out the elements in the deprivation weighting: the unemployment rate in the area; the proportion of elderly people claiming income support; the standardised mortality rate among people under the age of 65; and the number of households with two or more indicators of deprivation.

As the minister said, the biggest problem that we face is that, just before the contract's introduction in 2004, a late addition was made with the minimum practice income guarantee, which ensured that GP practices continued to receive the same income as they had received under the old contract. The new incentive arrangements on the equality and outcomes framework were then added on top.

The underlying Scottish allocation formula does not yet play through into the income that GP practices receive. That has a particularly bad impact on practices in deprived areas. It is therefore a priority in our negotiations with the general practice committee of the British Medical Association to address that problem and to begin taking MPIG away. MPIG certainly acts as a brake on tackling inequalities and providing a fair distribution of resources.

The Convener: Let me be clear about this. The existing income of practices was protected. When that froze, it was not fair—to put words into your

mouth—to GPs in deprived areas, and that is still underpinning—

Shona Robison: It is continuing the old inequities.

The Convener: That is exactly the phrase I was aiming at. How do you deal with that if it is a United Kingdom issue?

Dr Pryce: It is a UK issue, but it is a priority for all four health departments across the UK.

Ian McKee: I have two points. First, are the terms and conditions of service not a devolved function?

Dr Pryce: Yes, they are.

Ian McKee: So it is not a UK issue unless you choose to make it a UK issue.

Secondly, the majority of general practitioners do not work in deprived areas, so negotiating with the BMA might mean negotiating with a load of people who have the time to take part in BMA activities but are not in the areas in question. Ultimately—I will put this as politely as possible—it is your responsibility to look after the health care of Scotland rather than sectional interests that may not have the wider interests at heart. What is your reaction to that deliberately provocative comment?

Shona Robison: The first thing to say is that we inherited the negotiating machinery that we have. Obviously, there are some difficult negotiations to be had, but all four Administrations agree about that and we want to take the matter forward on that basis because it seems logical to do so. If that were not the case, we would take a different approach.

Dr Burns: Having been director of public health in Glasgow, I am well versed in Professor Graham Watt's analysis of the workload and so on. It is that understanding which led to the creation of the keep well programme. It seemed to me that we needed to find a way to enhance capacity in primary care, not just by improving GPs' salaries or the number of GPs but by enhancing all the other practice resources that give GPs time to deal with people with complex co-morbidities. The idea that we came up with was the keep well programme, whereby money can be put into deprived areas in different ways and we can assess how it is used.

The learning from the keep well programme, when it is available, should help Jonathan Pryce in his negotiations about how capacity can be enhanced to meet the needs of people who are not getting their cholesterol or blood pressure controlled or whatever. There is a body of work that will help us to drive things forward.

The Convener: The final set of questions will come from Mary Scanlon.

Mary Scanlon: I would like to get back to ground rules, structures and prescribing. My question is about the obesity action plan, which, as you know, I welcomed. We can safely say that it relates to cardiovascular issues. With Nigel Don, I was at last week's meeting of the cross-party group on obesity, which had a large attendance. We have the obesity action plan, but there is concern that while people in some areas can see their GP and be referred to a good, all-encompassing service, people elsewhere in Scotland find that there is nothing.

We heard about implementation plans earlier. To remain on the subject of GPs for a moment, someone said that GPs are incentivised to measure or diagnose obesity, but there is nothing to incentivise them to support, treat or advise people. Are you thinking about moving that forward? Also, is there a role for community pharmacies, representatives of which are in the public gallery today? They are on every high street, so it is easy for people to drop in to them.

Now that we have the action plan on obesity, where do we go next on the issue? When will we have equality of access throughout Scotland, not just for the people concerned but for their families?

Shona Robison: You make some important points. Interestingly, quite a lot of work has been done on the links between obesity and health inequalities. The one clear link is with women in deprived areas. There is less hard evidence about men and children, but the evidence on women is clear.

The point about translating the obesity action plan and ensuring that it fits in with the work to tackle health inequalities is important. The roll-out of the counterweight programme throughout Scotland is important because GPs will be able to refer to that programme people who come through the GP route. That is why we decided to roll it out—so that there is a clear pathway for people to get support. That approach was tested with the keep well programme and it was shown to be extremely helpful, along with the other signposting to weight management programmes, smoking cessation and so on. We regard the counterweight programme as an important resource to which GPs can refer people.

Kay Barton: Other aspects of the implementation of the obesity action plan include the fact that GPs will be able to refer people to exercise programmes independently of the counterweight programme. We are considering how to make that work in practice.

Mary Scanlon: I have heard excellent reports of the counterweight programme, but it is not

available throughout Scotland. Do you have a timescale for when it will be available? Is it really the only show in town? Will GPs and community pharmacies play a role, other than just in signposting?

Shona Robison: There is potential to consider that. We have allowed some flexibility around the services that have grown up in the area. The counterweight programme is available and it can easily be adopted and rolled out, but if local partners want to come up with other solutions, there is flexibility for them to do so.

Community pharmacies play an important role. We have already evolved the contract to include such things as chlamydia testing and smoking cessation, and there might be scope to consider the role of community pharmacies as a reference point so that things are not channelled only through general practice. We can certainly consider that.

Mary Scanlon: What is the timescale for the roll-out of the counterweight programme?

Kay Barton: Boards now have the resources to introduce it everywhere. We are discussing with the counterweight programme how to make that happen. We will write to you with the date by which it will be available everywhere.

Before the end of the year, we will produce some support material for boards on healthy weight strategies. We will define what ought to be in a good local healthy weight strategy, such as referral to the counterweight programme or the use of others in the private sector to help with weight management. Boards will be able to adapt the template to suit their local needs. That will at least enable them to have a comprehensive think about all the things that they should have in place.

The Convener: Thank you. If you are writing to the committee, please write to me, as convener, so that your letter can be put on the committee's web pages and circulated to committee members.

I thank the minister and her officials. Mr Scott was very quiet. He had an easy time of it. We will remember that and pinpoint him next time.

That concludes our business in public.

12:12

Meeting continued in private until 12:22.

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