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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 21 June 2011

Session 4

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HEALTH AND SPORT COMMITTEE
2nd Meeting 2011, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Jim Eadie (Edinburgh Southern) (SNP)
*Mary Fee (West Scotland) (Lab)
*Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING GAVE EVIDENCE:

Sir Harry Burns (Scottish Government)
Derek Feeley (Scottish Government)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 21 June 2011

[The Convener *opened the meeting at 10:00*]

Subordinate Legislation

National Health Service Central Register (Scotland) Amendment Regulations 2011 (SSI 2011/265)

General Pharmaceutical Council (Continuing Professional Development and Consequential Amendments) Rules Order of Council 2011 (SI 2011/1367)

The Convener (Duncan McNeil): Good morning, and welcome to the second meeting of the Health and Sport Committee in the fourth session of the Scottish Parliament. As I usually do at this point, I remind members and the public to turn off all mobile phones and BlackBerrys. There are no apologies for absence.

The first item on our agenda is consideration of two statutory instruments. Members have received a note that sets out the purpose of each instrument. The Subordinate Legislation Committee had no comments to make on the instruments and committee members have given us no indication of any problems. Do members agree that we do not wish to make any recommendations to the Parliament on the instruments?

Members *indicated agreement.*

Scottish Government Priorities

10:01

The Convener: Agenda item 2 is evidence on the Scottish Government's priorities. I welcome Nicola Sturgeon, Cabinet Secretary for Health, Wellbeing and Cities Strategy, who is accompanied by Derek Feeley, acting director general for health and social care and chief executive of NHS Scotland, and Sir Harry Burns, chief medical officer for Scotland. I am sure that I speak for all the committee in offering congratulations to Sir Harry on receiving a well-deserved knighthood in this year's birthday honours list.

I invite the cabinet secretary to make her opening remarks.

The Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon): Thank you, convener. I congratulate you on your appointment as committee convener and I welcome the committee. It is good to see two old faces and several new faces. I look forward to working constructively with the committee, as I believe I did with your predecessor committee.

As I look ahead to a second term as health secretary and consider the many challenges that that will entail, it is important and a useful starting point to reflect on the solid foundations on which we will build over the next few years. Thanks to the work of many people in the national health service, we have seen over the past few years a number of important achievements, which will stand us in good stead as we face up to the challenges ahead.

For example, we have seen dramatic improvements in waiting times; we now have in place a world-leading patient safety programme, which is starting to make a real difference to standards of care and hospital mortality; we have made progress on issues as varied as access to dentistry, support for people with long-term conditions and outcomes for cancer, stroke and heart disease; and we are producing improved outcomes for people through shorter stays in hospital, faster recovery and longer life expectancy.

We also have in place our quality strategy, which is delivering real progress in terms of positive impacts for patients. For example, improvements in care for people with long-term conditions have resulted in a significant reduction in rates of emergency bed days in hospital for people aged over 65. Improvements in safety have resulted in a 7 per cent reduction in hospital standardised mortality rates since 2007, and, of

course, we have achieved a reduction in the rates of Clostridium difficile of more than 70 per cent since 2008. Those are all solid achievements that are down to the work of people on the front line in the NHS.

As we look ahead, however, we know that we face a number of challenges and that the demands for healthcare and the circumstances in which we will deliver it in future years will be radically different from those in recent years. If we are to continue to deliver high-quality healthcare services, as we are determined to do, it is important, as I said in Parliament a couple of weeks ago, that we respond to the most immediate and significant challenges that we face. I have identified three broad challenges: first, our public health record; secondly, the changing demography that we face as a nation; and, thirdly, the economic environment in which we live.

On public health, we have made good progress on cancer, heart disease and stroke, but we face big challenges in improving health-related behaviours. The past three decades have seen a considerable increase in the harm caused by alcohol, for example. Deaths from liver disease in Scotland are the highest in western Europe, which is why the Government has said that we will continue to prioritise action to address our relationship with alcohol.

On demography, over the next 10 years the proportion of over-75s in our population—we should remember that they are the greatest users of NHS services—will increase by more than 25 per cent. We will see a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple long-term conditions and complex needs such as dementia. That is why the Government has identified care for older people as a significant priority, with a focus on improving care for people with dementia, a wider programme of work to reshape and improve care for people with multiple and complex conditions, and the integration of health and social care. We have a big job to do to ensure that older people receive, in a sustainable way, the care, compassion, support and dignity that they need and deserve.

The last of the three challenges that I have identified is the economic environment and the financial situation that we face. We know that we face and live within a context of a fall in Scottish public expenditure in real terms. Within that, and in relative terms, the revenue position of the health service has been protected. However, as I know everybody appreciates, and as I am sure members will point out, that protection needs to be seen in the context of global pressures on health spending, such as demography, drugs costs, changes in national insurance and VAT, and rising energy costs.

To meet such pressures, health boards in this financial year are working to release cash savings of around £300 million, which will be retained locally for reinvestment in services. We have also developed and are implementing an efficiency and productivity framework to assist boards in identifying and realising opportunities for cost savings.

An important point that I have made before and which no doubt I will make again—I am sure that everybody agrees with this—is that efficiency and quality are very much two sides of the same coin. Quality is paramount. Although that is always easier to say than to deliver, delivery of quality care, covering all aspects of quality, is a priority. However, I also believe—this is fundamental to our approach—that more efficient care is often higher-quality care and, indeed, vice versa: the highest-quality care will also be the most efficient care. The relationship between efficiency and quality, and delivering that relationship in practice, will be an overarching theme of the Government's approach over the next few years.

Audit Scotland has made it clear that just doing more of the same or just making incremental savings will not be enough. That is why, as I said in Parliament a couple of weeks ago, it is important that we create and develop a shared vision for the future of the NHS that best meets future healthcare needs in a sustainable way. In Parliament, I called that a "20:20 vision". It is very much a vision of a system in which we have integrated primary and social care and which has a focus on prevention, anticipation and supported self-management in order that people can live longer and healthier lives—and can do so, whenever possible, at home or in the community. We need consensus that, when hospital treatment is required—when treatment cannot be delivered in a community setting—day care should be the norm, but that, whatever the setting, we should provide healthcare to the highest standards of quality, safety and experience. We should have a firm focus on ensuring that people get back into their home or community environment as soon as appropriate, with a minimal risk of readmission.

Those are some of the challenges that we face, and I have given a brief outline of the Government's approach over the next few years. What I have outlined in general terms will throw up a number of specific questions and challenges over the period to come. I hope that we can work together constructively whenever possible to address and face up to those challenges.

I am more than happy to answer members' questions.

The Convener: Thank you, cabinet secretary.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I almost do not disagree at all with the cabinet secretary's analysis. The pressures of demography and on funding are clear, although we can argue about the precise figures for reductions and so on and about the ability of the Government to protect against NHS inflation as opposed to standard inflation. I do not disagree particularly on the public health issues, either.

How does the cabinet secretary think we can proceed on the fairly specific area of waiting times? Much of the work of the past 10 years—almost since devolution—has been directed at waiting times. In 1997, the public were, correctly, appalled at the repeated publicity that showed people waiting on trolleys and waiting years for hip operations. The Labour-Liberal Administration and the Scottish National Party Government have done a huge amount to reduce waiting times.

My question is in two parts. First, will we continue with the current waiting time targets? In England, the tolerances have been reduced for the accident and emergency target. I know that if the tolerances are too tight, the marginal costs to health boards are extremely high. I would like to hear the cabinet secretary's view on how we can manage that.

A related and important issue is Parliament's agreement in 2001-02 on delayed discharges. The figure at the time—3,000—was appalling. It was ridiculous that we had 3,000 beds occupied by people who were fit to be discharged. As the cabinet secretary knows, we negotiated a target for delayed discharge of six weeks, to allow local authorities time to assess and get a package in place. The target was reached by 2008. Although I have been quoted in the past as complimenting the Government on reaching our jointly agreed targets, no progress has really been made since then. What will the cabinet secretary do about the fact that, today, 790 people who should have been discharged have not been? That is almost double the number involved three years ago.

The Convener: Those questions took two minutes.

Nicola Sturgeon: I will try to keep the length of my answer proportionate to the length of the questions, which are both pertinent and good, and I am happy to address them as fully as I can.

First, on waiting time targets, I have recognised openly in Parliament and in public that the progress we made over the past four years on waiting times was a continuation of progress that had been made under the previous Administration. It is good that there has been so much consensus on the need to reduce waiting times in Scotland.

On general waiting times, we are working to the 18-week referral-to-treatment target, which is due to be delivered by December this year. The most recent ISD Scotland statistics suggest that we are on track to meet that delivery date, although a lot of work will continue to go on to ensure that that happens.

We set tolerances around those targets, not just in terms of the marginal costs to health boards but so that we can deliver waiting time targets that also protect quality of care. It is not the case that meeting a target for every single patient is necessarily the best way of caring for every patient. With the 18-week target, for example, we have set 95 per cent as the tolerance. We have no plans to change that. Obviously, we keep those things under review. However, unlike the developing situation in England, I believe that giving people certainty about how long they will need to wait for treatment is an important aspect of the quality of care.

Obviously, it is not for me to comment on developments south of the border although, as you have probably guessed, I am about to do so—to a limited extent, I hope. We are already seeing some worrying signs south of the border of rises in waiting times and breaches of waiting time targets as the focus comes away from waiting times. That is not a road that I want to go down in Scotland.

10:15

I have two final points to make on waiting times, to try to put the issue into context. First, on the quality strategy, we have explicitly recognised that although waiting times are important, speed of access to treatment is not the only aspect of quality of care. We have put the issue into that wider context and recognise that there are other aspects of quality that are as important to patients.

The second point is about where we might go after we reach the 18-week referral-to-treatment target. We have not set a target beyond that, although we will keep matters under review. As we all know, the delivery of healthcare does not stand still. I am anxious to ensure that we focus on meeting that target and sustaining delivery of the target and the other waiting time targets, while implementing the quality strategy more generally.

To go on to cancer briefly, we all accept that speed of access to cancer treatment is very important, but one of our big challenges in Scotland is earlier diagnosis of cancer. If someone has reached the later stages of the disease by the time that they are diagnosed, no matter how short the waiting times are, the chances of treating them to the point at which they recover will be less good. We will put a lot of focus into earlier detection and diagnosis of cancer.

We have made huge progress in reducing delayed discharges, and rightly so. The six-week target was inherited from the previous Government and we have worked to meet it. By and large, we are meeting it, although considerable effort continues to be required in that direction. We will say more about that in the weeks, months and years to come. I have already said that care for older people is a priority. That sits within the context of our developing thinking about how we shift the balance of care and improve all aspects of care for older people.

If I am being completely honest, as I will always be with the committee, a six-week target is not what we should be aspiring to in the long term. Having someone in hospital, fit for discharge, for six weeks is not where the peak of our ambition should be, and many people get to that point before they are discharged. I hope that, with all the work that we will do over the next few years to reshape care for older people and integrate health and social care, we will be in a position to work to a target for delayed discharges that is well below the current six-week target.

The Convener: Mary Scanlon has a brief question.

Mary Scanlon (Highlands and Islands) (Con): You mentioned cancer, cabinet secretary. I welcome the detect cancer early initiative in the SNP manifesto but I am slightly concerned that in the first instance the initiative will be directed at lung, breast and colorectal cancers. Late presentations—if that is the issue—quite often include testicular cancer. Young men do not know that something is there until it is almost too late. I am concerned about that patient group.

Nicola Sturgeon: I hope that I can allay that concern. It is not the intention to prioritise any group. We have identified those three cancers for the first stage of our detect cancer early initiative because they are the big cancers in Scotland in terms of the numbers and where we can make the biggest impact. This is not about saying that we will focus on those three cancers to the detriment of all others; it is about a general approach.

This is not just a Scottish phenomenon; it is a United Kingdom one. Harry Burns can talk about this much more knowledgeably than I can, but the league tables for cancer survival throughout Europe show that we lag behind in survival rates for a lot of cancers, not because of the treatment that we give cancer patients or the length of our waiting times but because of the stage of presentation. That is why we need to up our game much more at the detection and diagnosis stage. I do not know whether Harry Burns wants to add to that.

Sir Harry Burns (Scottish Government): The league tables are a particular hobby horse of mine. We are one of the few countries in Europe that counts cancer survival accurately. Many other countries have legal impediments to proper linkage between death certificate data and cancer registration data, which means that they underestimate the mortality rates that they experience.

I agree with Mary Scanlon that testicular cancer often presents late but, fortunately, it has a high survival figure. The cancers that we have picked on are the big killers; they remain the main causes of premature death associated with cancer. We are setting an exciting challenge to do something other than organisational change. This is about cultural change in the population and the health service and, if we pull it off, it will have a huge impact on public health in Scotland.

Jim Eadie (Edinburgh Southern) (SNP): On the detect cancer early initiative, given that a target has been set to increase by 25 per cent the number of cancers that are detected at the first stage, is it intended to have a new health improvement, efficiency, access and treatment target for NHS Scotland and health boards across the country, on the basis that what gets measured gets done?

I am also interested in how the success of the detect cancer early initiative will be evaluated. How will we disseminate good practice throughout the NHS?

Nicola Sturgeon: Those are pertinent questions. We have no plans for a HEAT target. However, the committee will appreciate that we are working up the plans for the detect cancer early initiative. When we publish them in the relatively near future, I will be more than happy to come back to the committee and talk in detail about how we will measure and evaluate the initiative. Although I have said that there are no current plans to translate the initiative into a HEAT target, we are not ruling that out. We will consider the best way to monitor and evaluate how much progress we make against the objective that we have set in the detect cancer early initiative.

On HEAT targets more generally, which we might or might not get on to in more depth later, we intend to align the HEAT target system with the quality strategy. What members have seen during the past couple of years is a reduction in the number of targets and an alignment with the objectives that we have set in the quality strategy. We want to continue in that direction of travel.

The Convener: I have a brief question about your opening statement and the financial challenge, which was one of the three top challenges. Can we take it from what you have

said that, despite the financial challenge, we will not see a budgetary impact on the waiting time initiatives?

Nicola Sturgeon: Notwithstanding the budgetary challenge that everyone is facing just now, from which the NHS is not immune, our commitment to the waiting time targets that we have set is solid. We are not moving away from that.

Gil Paterson (Clydebank and Milngavie) (SNP): I have two short questions. I will ask one and then perhaps follow up later with the other, because they are on two distinct areas.

I know that the Government wants to revisit minimum pricing. Will that be done through fast-track legislation or do you intend to go back to square 1?

Nicola Sturgeon: We intend to go through the full parliamentary legislative process. During the previous parliamentary session, before we introduced the Alcohol etc (Scotland) Bill, there was a debate around whether we could have introduced minimum pricing through secondary legislation. Technically, we have that ability, but we came to agree with the view of the Parliament and the Opposition parties of the time that that was not the correct way to introduce as significant a policy as minimum pricing. That is still my view. We will have plans for the reintroduction of minimum pricing proposals in our first legislative programme, which will come after the summer recess. The bill, in whatever form it takes, will go through the full legislative process.

Gil Paterson: As you know, I have an interest in palliative care. Do you have any comments about the living and dying well strategy? Do you intend to put any additional resources into it over the next five years?

Nicola Sturgeon: I have discussed living and dying well many times, not only with Gil Paterson but with the committee's predecessor. In my opinion—and in the opinions of the experts in the field—it has been progressing extremely well and we intend to continue with it. A report on it was published not long before the election and we continue to see improvement in palliative care services—regardless of diagnosis and in the most appropriate setting for patients—as a priority and will continue to ensure that it is resourced and receives the right leadership and commitment.

Mary Scanlon: I appreciate that it is difficult for you to cover every health issue in an opening statement. However, I want to ask about two particular issues. First, the Scottish National Party's election manifesto says:

"We are sympathetic to calls for a new Mental Health Bill"

and makes it clear that the matter will be discussed. I feel very strongly about mental health—indeed, it raises many issues—but which particular concerns would you wish to address in such a bill?

Nicola Sturgeon: Your question raises a couple of issues, the first of which is whether there is a need for a mental health bill to address certain concerns that people have expressed about the workings of the legislative framework and the tribunal system, as set out in the Mental Health (Care and Treatment) (Scotland) Act 2003. I, along with Mary Scanlon, was a member of the then Health and Community Care Committee when that act went through the Parliament. We are looking at whether a relatively focused bill might be required to deal with the matter. Our manifesto says—and our view remains—that we are sympathetic to such a move and, although I cannot give full details of what might or might not be in our legislative programme, I can say that the matter is obviously under consideration.

The more general question is whether it is time to refresh the mental health strategy to look beyond the law at any broader aspects. We are examining that just now and might well go out to consultation on a refreshed mental health strategy at some time over the next period.

Finally, given her interest in mental health, I know that Mary Scanlon is well aware of our health improvement, efficiency, access and treatment—or HEAT—targets for accessing treatment under child and adolescent mental health services and psychological therapies. Both of those targets are in the current system and boards are working towards delivering them.

Mary Scanlon: As I said, I appreciate that you cannot cover everything; however, I also want to raise the issue of obesity. I have read both the obesity action plan and the obesity strategy and note that in your manifesto you say that you will be working on implementing the strategy. I do not mean to be critical, but I have to say that what was introduced was not exactly a strategy; it did not, for example, contain any targets, if that is the right word. It made a lot of good sense, but I am not sure how by the end of five years you would be able to say that it had been implemented. Indeed, I am not convinced that I really know what course we are taking to help people who suffer from obesity. Although the Counterweight programme in Glasgow seems to have a very good reputation and is evidence-based, I know that in other parts of Scotland the doctors simply say, "Away and join WeightWatchers."

I am concerned not only about the cost to the NHS, but about the Scottish intercollegiate guidelines network guideline on obesity that I mentioned in my speech in the health debate in

Parliament and which refers to anyone with a body mass index of over 35 with one co-morbidity. Apparently, more than 100,000 people in Scotland are in that category; 24,000 of those people are willing and able to get bariatric surgery, but at the moment it is offered to only 200 people each year. I know that you will want to emphasise prevention rather than surgery, but there is a problem in that respect and I am not sure about the path that we are going down to help people.

10:30

Nicola Sturgeon: That is a big question. I will have a go at answering it, but if the committee wants more information and detail on how we will monitor and measure the actions in the obesity strategy and the action plan that accompanies it, I am happy to arrange for that to be provided in writing.

Of course we want short-term and medium-term results, but everybody recognises that obesity is a longer-term challenge. Mary Scanlon is right to think about an entire spectrum and pathway of approaches, starting with prevention—with a lot of focus on that, we hope—and going right through to treatment options. I touched on that point with the previous Health and Sport Committee. We have been increasing capacity for bariatric surgery. For example, the Golden Jubilee hospital now has capacity to do that.

The aim of the obesity route map, which was published back in February 2010, is clear—it is to have the majority of our population in a normal weight range throughout adult life. That is a big overarching objective. The route map identifies four key areas in which action is likely to have the biggest impact: energy consumption, energy expenditure, the early years and working lives. We then have the route map action plan, which has specific actions against each of those areas. I absolutely appreciate what Mary Scanlon is saying. I know that she will appreciate that, because of the long-term nature of the challenge, hard measurements are not as easy as they might be in other areas. Nevertheless, we want to be able to demonstrate progress.

I am more than happy to give more detailed information on that. We might want to return to the discussion at some stage.

Bob Doris (Glasgow) (SNP): I want to ask about structures. I appreciate that it is outcomes that matter rather than structures, and that the structures are there to achieve relevant outcomes. Where does the structure of health boards and community health partnerships sit in the work of the Christie commission, which must be fairly close to reaching conclusions?

Nicola Sturgeon: That is probably a question for the Christie commission, rather than for me. As members are aware, the Christie commission is considering public sector reform generally, so it might have recommendations that have relevance to the delivery of health and social care. I do not yet have an insight into what those recommendations might be, but Bob Doris is right that the commission is due to report reasonably soon.

I have two overarching views on structural reform. First, structural reform in itself does not always lead to more efficient service delivery or cost savings. Looking back over many years, there will be evidence to suggest that structural reform often costs money in the early period rather than saving it. Secondly—I am going completely to the other side of the argument here—we should not get caught up in structures. We should have the mindset that we want structures that follow and best support the delivery of services. If better, more efficient and higher-quality delivery of healthcare services in future years demands a different structural approach in the health service, we will not be ideological about that but will be open to the arguments.

This year, we have already set differential efficiency targets for some of our special health boards in recognition of the fact that not all health boards do the same things. For example, NHS 24 and the Scottish Ambulance Service are working increasingly closely together and now have a joint medical director. That is an early example of how we are ensuring that we have a structure that follows the substance, rather than the other way round. We will wait and see what the Christie commission has to say and we will respond to that.

Bob Doris: I agree with what you said about structures, but my question was more about the timescale. The committee obviously wants to plan its work, so it would be useful to know when we can expect any recommendations that relate to our remit to be in the public domain.

Nicola Sturgeon: I think that the Christie commission is due to report by the end of this month, and we will reflect on its recommendations. No doubt it will make recommendations for across the service, and we will respond from the health portfolio perspective. I am happy to come back to the committee to discuss the matter. Given the timing, that would probably be after the summer recess, and it would be about how the commission's recommendations affect my portfolio, or about whether we have any thoughts in addition to what Christie might recommend.

As I said in my opening remarks, one of our big priorities is integration of health and social care. That is an objective on which most of us agree.

Different views have been expressed about how to achieve that, and we have given the matter some careful thought. It is obviously not for me to say what the committee will wish to discuss with me in the future, but the more general context of public sector reform might provide a worthy subject of discussion for us after the summer recess.

Bob Doris: That leads me to my next question, which is on health and social care. You, more than most people, will be aware of a cultural resistance—although I do not wish to apportion blame—that can come at health board level or at local authority level, and it concerns the pooling of resources and integrated working. If we can break through some of that cultural resistance, can we expect more of the workforce to be in communities, rather than in hospitals? How does that sit with overall workforce planning?

As the committee proceeds with its work, I would like the focus to be on outcomes. Is the issue about how many nurses there are or is it about what those nurses are doing? If there is more care in the community, do we need fewer nurses? I am thinking about how the committee can take a constructive approach to discussing those matters with you.

Nicola Sturgeon: Before the convener reminds me of it, I repeat that it is not for me to tell the committee what to investigate, but if you ask me what I think might be a useful area for the committee to delve into, it is the practical and tangible manifestations of the shift in the balance of care. We have spoken about it under successive Administrations, and we have started to achieve that shift to some extent, but there is a long way to go.

We easily agree about the need to have more resource, more services and more staff working in the community, so that more patients can be treated there. I do not think that any of us have any difficulty signing up to that. Things get difficult where the implications of that for the acute sector start to manifest themselves. Shifting the balance of care involves doing more in the community; the other side of that coin is that we do less in hospitals. As I said in the debate a couple of weeks ago, a reduction in the number of acute beds—as long as it is for the right reasons and it is appropriate—should not be opposed; we should welcome it, because it will show that more treatment is being given in the community.

If the committee's approach—as it works with the Government—gets into some of the thornier aspects of shifting the balance of care, that would be welcome.

Bob Doris: I stress that I was speaking as an individual; the committee as a whole will deal with its work plan.

Nicola Sturgeon: I do not intend to tread on that.

The Convener: The deputy convener is almost on to his fourth question there. It has been important to address this significant area, however, and there is a lot of interest in the matter. I invite any supplementaries on the issue.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I was pleased to hear the cabinet secretary speaking about closely aligning the HEAT targets to the quality strategy. It relates to a point that was made earlier: the structure exists to deliver a health service, not to exist as a structure on its own.

As far as integration is concerned, I am concerned with how we ensure that the measurements that we use for health targets and for care targets align. As I hope Sir Harry will agree, we should be speaking much more about measuring quality and the wellness of someone before they leave hospital, rather than measuring the fact of their having an operation and recovering from it. Were they well enough to go home? The issue is about wellness and how health and social care targets meet in order to help to deliver that.

Nicola Sturgeon: I could see that Harry Burns was getting a bit animated in agreement with you, so I will bring him in in a second to talk about wellness and suchlike.

In response to the first part of your question, integrating HEAT with the quality strategy and making sure that the community and social care aspects of that are also integrated is part and parcel of integrating health and social care. We are already talking to the Convention of Scottish Local Authorities about health and care targets as part of that approach. On the earlier point about structure being about delivering a system, and not the other way around, the same is true for health and social care. It should not just be about structural integration and change—the focus should be on what we are trying to deliver.

Sir Harry Burns: Increasingly—and almost philosophically—I am moving away from talking about health improvement to talking about life improvement, with health as a subset of a full, rich and complete life.

One of the areas that we are getting into is patient-reported outcome measures. The outcome of the system, whether it be health or social care, should be an increased sense of wellbeing and control over one's life. Clearly, it is not entirely straightforward to do that, but there are moves to establish such things as patient-reported outcome measures and self-assessment of general health by asking people how they feel at the end of a period of care, whether it is predominantly social

care or health care. Again, we are getting into exciting new territory and I fully support the idea.

Dr Simpson: A shift in the balance of care is fundamental. The integrated resource framework programme seems to be important in that respect. How do you see that developing and rolling out? How is it going to be used to manage the variation to which I referred during my speech in the debate in the chamber? On general practitioner testing, for example, one of the questions that was answered during the previous parliamentary session showed a massive variation in funding of primary care practices to undertake patient testing and supervision close to the patient. In some cases it was zero; Forth Valley NHS board was the leader. How is the IRF is going to work with that? It seems to be fairly fundamental. How are you going to incentivise people to use it to reduce the massive variation between areas?

Nicola Sturgeon: I will bring in Derek Feeley in a second. The integrated resource framework work in the pilot areas has gone a great deal of the way towards allowing health boards and local authorities to understand better the totality of spend across health and social care. That has been useful. The next stage for that work is to ensure that the totality of that resource is used in a genuinely integrated and joined-up way. The future stages of that work relate closely to how we implement the integration of health and social care. We talk about that in general terms, but one of the fundamentals of a genuinely integrated system is genuinely integrated budgets.

Although we better understand the totality of spend, because of the structures we have, too often we have separate budgets that are not subject to the same governance arrangements and, whether intentionally or unintentionally, are protected. The next stage of that work must be about ensuring the genuine integration of those budgets and then using that totality of budget to do the kind of things that Richard Simpson is talking about, to ensure that we have the shift in resource to support and follow the shift in the balance of care, which will give us more consistent community and primary care services across the country.

10:45

In parallel with that work, we are in discussion with GPs, through the British Medical Association and the Royal College of General Practitioners, about patient pathways and reducing variation in GP behaviour. I am keen, and I know that GPs are keen, to move away from discussions that tend to be about the amount of money that is spent on the GP contract, important though that is, to a discussion about the £3 billion or so of the total health budget that is influenced and driven by the decisions that GPs take, to ensure that the right decisions are taken and that levels of variation are reduced so that there is consistency, whether that is in relation to outpatient referrals, admissions to hospital or prescribing. That work is separate from the integrated resource framework, but it is important that GPs be seen as part of the bigger picture.

Derek Feeley (Scottish Government): I agree with Richard Simpson that the integrated resource framework gives us lots of analytical intelligence about how to get the most out of the spend. There are also good data from the multi-agency inspection of services for older people, which gives similar data. I think that we understand much better how to invest for the best outcomes.

The change fund has been an important first step in using the data in a directed way. People are thinking about how the money is spent and what outcomes we get for a good investment, and they are building that thinking into their change plans. As the cabinet secretary said, we have a clear focus—in our quality strategy and in our efficiency and productivity framework—on managing variation.

Much good experience is emerging about the importance of peer challenge, by getting the data back to people and saying, “Explain to us why your spend looks different from everyone else’s and why your practice is different from everyone else’s”, and by encouraging peers to challenge each other on the data. There are a number of strands that we are pulling together, which will make an impact.

The Convener: How quickly can we get reassurance on the continuation of the change fund? There seems to be a bit of an issue about that.

There is anxiety about the shift in the balance of care. We all face a political challenge. I think that we have all portrayed local services as the hospital, rather than talk about truly local services. Is there a wider strategy for re-engaging with people, so that they understand that “local services” does not necessarily mean the local hospital?

Nicola Sturgeon: In response to your second point, I think that that will take a lot of determination and—dare I say it—courage on the part of all of us, whether we are Government or Opposition politicians.

I believe in having hospital services that are fit for purpose and as local as possible. I am the health secretary who saved the A and E units at Monklands hospital and Ayr hospital, and I stand by those decisions, which were the right decisions. It is not about reducing necessary hospital services on which people rely in their

communities. However, we know and we have mounting evidence that admitting someone, particularly an older person, to hospital when that could be avoided will not deliver the best outcome for them. We need to act on and respond to that evidence.

There are two sides to the coin. Particularly in tight financial circumstances, if we build up and improve the services that people get in the community—and if we do so properly and successfully—there will be reduced demand for acute services. That is a good thing, but there is no point in doing that if we are not releasing some of the resource from that reduced demand for acute services, so that we can reinvest it in the community.

The approach throws up difficult issues. I will be the first to admit that when I was in opposition I had a go at the reduction in acute beds, as Opposition politicians do these days. However, there are good reasons for the reduction in the number of acute beds. As long as the reduction is appropriate and reflects a genuine shift, we need to get out of the political mindset that leads us to hit one another over the head about things that, deep down, we know are the right things to be doing.

The Convener: Kerr was telling us about that in his report some years ago and what he said about emergency admissions is still an issue.

To be fair, the cabinet secretary has acknowledged the challenge that all politicians face in getting behind shift that is appropriate. A central issue is how we fund the change fund and how we demonstrate that the approach can work.

Nicola Sturgeon: We did not throw the Kerr report out when we came to office—for the avoidance of doubt, it is David, not Andy Kerr. We have continued to seek to deliver the Kerr report and the principles that underpin it. We rejected two specific aspects, which I suppose were extrapolations from the report, involving the closure of accident and emergency units, which we did not think was correct.

The change fund, as Derek Feeley said, is being sensibly and wisely used. Partnerships around the country regard it as a catalyst opportunity to see, as Derek Feeley said, where you get the biggest bang for your buck and how you start the process of changing the pattern of service delivery. I appreciate the partnerships' anxiety about the future, but members will appreciate that I cannot pre-empt the spending review and the budget process. We said clearly when we set up the change fund that it was a first step in a direction of travel. It would be very strange, given everything that I have said, if we did not continue firmly down that road.

Mary Fee (West Scotland) (Lab): I have two questions for the cabinet secretary on NHS funding cuts, the first of which has several questions within it. Given that the estimated funding cut is 3.3 per cent in real terms, can the cabinet secretary assure us that the standard of care will not be affected? What contingencies are in place to ensure that it will not be affected? Will the funding cut have any impact on waiting times? Will there be any impact on, or reduction in, planned surgeries—that is, mainly minor planned surgeries that are day surgeries? Can the cabinet secretary assure us that there will be a consistent standard of care across Scotland despite the cuts?

Nicola Sturgeon: You were right that there are a number of questions. Let me try to take them on. First, health spending has not been cut by 3.3 per cent in real terms. That figure came from a *British Medical Journal* article and we have a letter from the author of the article saying that it was a mistake. I am sure that we can provide the committee with the details of that. I have enjoyed my exchanges with the Health and Sport Committee and I am sure that I will continue to do so. No doubt, we will on numerous occasions have different interpretations of the facts, but it is important that, as far as possible, we work on the basis of facts.

The health revenue budget has not been cut. I am trying to be frank about the challenges that we face. We gave a commitment, which we will honour, to pass on all the consequentials within the Barnett formula that came from increased health spending south of the border, to the health service in Scotland. Certainly, nobody exceeded that commitment during the recent election and I think that everybody agreed with it. We are honouring it this year and will continue to do so.

Given the figure for the gross domestic product deflator when we made the commitment, the result will be real-terms protection for the health revenue budget over the life of this Parliament of an extra £1 billion. Clearly, we do not know what the GDP deflator will be for the life of this Parliament, but if the UK Government—I can say only "if", because I do not speak for that Government—honours its commitment to real-terms protection of the health budget and if the GDP deflator goes up, so, too, should the consequentials that we get as a result, and our commitment to pass on all such consequentials would follow.

So, the health budget, in revenue terms, is not being cut. It is important that we are careful about our use of language in that respect. As I said in my opening remarks, a lot of pressures are bearing down on the health budget, as there always are. Some of those are pressures that we see year in, year out: demographic changes and the costs of

new technology and new drugs. All those things are not new to the health service.

Particular pressures exist now as the result of policy decisions that the UK Government has taken—increased VAT costs and changes to national insurance costs are all adding significantly to the pressures that our health boards face. Another issue is rising energy costs, which health boards—like every family, individual and organisation in the country—must deal with. Those pressures mean that the health service must make efficiency savings. As I said in my opening remarks, such savings will on average be of 3 per cent, which will release about £300 million this year for reinvestment in services.

Mary Fee asked about quality. From what I have said, I hope that my commitment to ensuring that efficiency and quality have an absolutely joined-up relationship is clear. We are explicit about our intention to increase the number of procedures that are done as day cases. When Mary Fee referred to minor operations, I guess that she was talking about the proposal in the NHS Greater Glasgow and Clyde area. The National Institute for Health and Clinical Excellence has produced not guidance but advice about the clinical effectiveness of doing some minor procedures, and it is right for health boards to debate such issues. However, I will insist on the centrality of clinical quality and clinical effectiveness in all such decisions.

I know that I am sitting here and making the situation sound easy, but it is not easy. Over the next period, I am sure that we will discuss many specific difficulties. However, the absolute focus on quality must be the driving force in all the discussions. Healthcare, the pattern of healthcare and how it is delivered change—it must change to deal with some of the issues that we have talked about. What is done in hospital today will not necessarily continue to be done in hospital in the future. We will not necessarily have the same skill mix in our staff or the same numbers of staff in every bit of the health service. However, if we focus at all times on ensuring that we deliver a quality service, all the changes will be seen in a much better context than just that of a debate about cuts, which does not necessarily take us forward.

Mary Fee: Will the cabinet secretary assure us that the figures for workforce projections will be produced soon? It is only 10 days until the summer recess and we do not have those figures. Is there a particular reason why we do not have them yet?

Nicola Sturgeon: We will publish workforce projections, as we did last year, which was probably the first year in which any Government in the Parliament's lifetime has produced workforce projections in such detail. Workforce projections must follow the completion of every health board's workforce plans, which are work in progress. We take a partnership approach to such matters in the NHS in Scotland, which was lauded not that long ago as the best in the UK in research by the University of Sheffield—no, it was by the University of Nottingham; I am getting confused with Sheffield's minimum pricing research. Nottingham's research into our partnership arrangements said that we had the best workforce relations anywhere in the UK.

The workforce plans and their detail must be discussed with staff. When the figures are in the right form to be published, they will be published. We have had much transparency about the figures. ISD Scotland publishes workforce figures retrospectively, which are about to be published more frequently, so complete transparency applies.

After we published the projections last year, I established the quality group—the national scrutiny group—which involves all the unions, to ensure that the relationship between efficiency and quality is delivered in practice. As always, there will be complete transparency when health boards have managed to work through their workforce plans.

11:00

The Convener: How does the no compulsory redundancy guarantee impact on the workforce plans? What concerns have boards raised with you with regard to how you proceeded on that good practice?

Nicola Sturgeon: Are you asking whether health boards have raised concerns about the no compulsory redundancy agreement?

The Convener: As it impacts on their workforce planning.

Nicola Sturgeon: Having a no compulsory redundancy agreement, whether in the NHS or anywhere else, clearly has an impact not on the content of a workforce plan but on how that plan can be delivered, because we are saying to health boards, "You will not make staff compulsorily redundant."

It is open to health boards, if they want to, to look at voluntary redundancy schemes in partnership with their staff, but to date very few health boards have gone down that road.

The no compulsory redundancy agreement is very important. It is important to give staff in post in the health service job security to allow them to get on with the difficult and stressful jobs that they do. More generally—this applies more broadly than the health service—no compulsory

redundancy agreements also help with the process of economic recovery. If you have certainty around your job, you will no doubt be in a better position to consider taking on a mortgage or spending, and all that helps the process of economic recovery.

I am sure that there are people who would argue that no compulsory redundancy agreements make things more difficult for big organisations trying to manage their workforce, but the benefits of such agreements far outweigh any difficulties.

The Convener: I understand that and I understand the impact of the no compulsory redundancy scheme, but I wonder what information has come through the national group that looks at workforce planning. Have any concerns been raised about the implications of the scheme for workforce planning?

Nicola Sturgeon: Health boards are perfectly content to plan within the context of the no compulsory redundancy agreement.

The Convener: Are there any concerns that people might wish to leave? How do health boards fill those—

Nicola Sturgeon: A no compulsory redundancy agreement does not stop people from leaving if they want to leave.

The Convener: That is my point, cabinet secretary, if you will allow me to finish it. If someone leaves an area, how do we fill that gap? If someone leaves an area—

Nicola Sturgeon: A no compulsory redundancy agreement—sorry, I hope that I was not interrupting.

The Convener: If somebody volunteers—

Nicola Sturgeon: I was not sure whether you had finished your question.

The Convener: Given the pressures and the impact on the health service budget, which is mainly people, people volunteering to leave can have a significant impact. Without your intervention, it is likely that there would have been some redundancies. How do we shift people around the health service and use them effectively? How do we retrain them to go into other areas so that they are being used usefully? How do we ensure the quality of patient care when staff in some areas wish to leave and those who remain are asked to do more? I am very surprised that there is no workforce planning that has taken that into account, unless there is no movement at all.

Nicola Sturgeon: There is. You asked me whether concerns have been raised about no compulsory redundancies. I was answering that question.

The Convener: I think that I said,

"As it impacts on their workforce planning."

Nicola Sturgeon: I was not suggesting that a lot of work does not go into workforce plans in health boards. First—I know that you were not suggesting otherwise—people are free to leave. The turnover rate in the health service is, not surprisingly because of the job market conditions, now slightly lower than it has been in recent years, although it is still in the region of 6 per cent. There is clearly turnover, which allows health boards to manage their workforce.

A no compulsory redundancy agreement does not remove the ability of health boards to redeploy people to different areas or different jobs with the appropriate training, so there are still ways in which health boards can not only come up with their global workforce plans, but ensure that they have the right staff in the right place. Health boards do that as a matter of active discussion on an on-going basis.

Richard Lyle (Central Scotland) (SNP): I left the NHS at the end of last month. I used to work as an out-of-hours driver. I will ask a question on that, but I will also point out that I agree with your comment about the A and E units at Monklands hospital: in the four years since you kept the accident and emergency department open, over 200,000 people have been treated at Monklands.

The committee previously considered petitions about GP cover in remote and rural areas. I remind everyone that out-of-hours GPs take over after the doctors finish at 6 o'clock at night, and at weekends. As Richard Simpson said earlier, most of those doctors refer people to hospital and use the ambulance service. Where should we be going with GP cover, especially in rural areas?

Nicola Sturgeon: I am delighted that you left the health service because it is the result of your being elected to the Parliament, which is a good thing in my view. As you rightly say, in the previous parliamentary session the committee held an inquiry into out-of-hours services and I gave evidence to it. We agreed a number of things in response to the inquiry's recommendations. I will not rehearse them because I know that everybody round this table knows the history of out-of-hours care and about the changes to the GP contract in 2004 that removed the obligation on GPs to work out of hours and placed the responsibility for delivering out-of-hours services on health boards.

GP involvement in out-of-hours care is fundamental, but out-of-hours care is not just GP care. A number of health professionals are part of the delivery of out-of-hours care, such as nurses, allied health professionals and the ambulance service. NHS 24 now also plays a big part in out-

of-hours care provision. The job of health boards is to ensure that they have the appropriate arrangements in place to provide quality of care, but a one-size-fits-all approach is not necessarily taken—for example, how that package of out-of-hours care might look in central Glasgow is different to how it might look in a particularly remote part of the Highlands. In parts of the country we now have first responders—volunteers who play a part in delivering out-of-hours care. The quality of that care is what matters most.

One of the things that I agreed in advance of the Health and Sport Committee report was to look again at the standards for out-of-hours care. NHS Quality Improvement Scotland, which is now called Healthcare Improvement Scotland, had standards against which out-of-hours services were measured. There was a legitimate concern at the time that boards focused on their processes rather than on the quality of care. We agreed to look again at that. I am looking at Derek Feeley to find out what stage that work is at. We will come back to the committee with an update on that work.

GPs are fundamental to out-of-hours care, but other health professionals have to play a part too. The job for health boards is to ensure that they have high-quality out-of-hours care in place that reflects the local circumstances in whatever part of the country they operate.

The Convener: I think that everyone has had the opportunity to ask a question, but I have a couple of bids for additional questions from Mary Scanlon and Richard Simpson.

Mary Scanlon: My question is about an area that has not been covered today. The previous committee did a report on child and adolescent mental health services that highlighted the role of health visitors and others. I am not entirely clear about the family nurse partnerships that you mention in your manifesto. You mention young mothers and teenage mothers three times, state that they will be supported for up to two years after their pregnancy and say that you will roll out family nurse partnerships across Scotland.

I do not understand where the family nurse partnership, which you have taken from the United States, sits in relation to our own health visitor system, provision for which, as we know, varies across Scotland. Will this partnership replace health visitors? If so, who will carry out the health and development checks that the committee strongly recommended be carried out frequently on young children? If I remember correctly, Shona Robison said that an additional check would be carried out at between 24 and 30 months. Perhaps you can provide a written response, but I am just not seeing the whole thing clearly.

Nicola Sturgeon: I will bring in Harry to say something about this—

Mary Scanlon: Sir Harry.

Nicola Sturgeon: I am sorry—I mean Sir Harry. [*Interruption*.] You have thrown me off course now, Mary.

Although I am happy to provide more information in writing, I will make a few brief comments. The family nurse partnership does not replace the health visitor system and all its accompanying aspects, including the developmental checks that you referred to. This partnership that we are trialling in Edinburgh —it is furthest down the road in Edinburgh; it is at an earlier stage in Tayside and an even earlier stage in Glasgow—works with a particular cohort of teenage mothers and fathers. Evidence from the States, where the initiative comes from, has demonstrated the success of providing very intensive nursing support before the child is born and during the first two years of its life and ensuring not only that aspects of the child's development are properly catered for, but that young parents are helped to get back into education, find employment or avoid having further children, if that is what they want. We will obviously evaluate the trial and, assuming that the results are as good as I expect them to be, we intend to introduce it in other parts of Scotland in due course.

I will let Harry Burns—Sir Harry Burns—add to that, if he wants.

Sir Harry Burns: Family nurse partnerships are really quite distinct from the standard health visiting programme. As the cabinet secretary has said, it specifically helps with a number of parent-child development issues. After all, there is now extremely strong evidence that if you get the early years right you will have a mentally, physically and socially healthy adult.

The partnership has been impressive in its universal availability to all pregnant teenage girls—it is not specifically targeted at deprived areas although in the normal course of events most teenage pregnancies will occur in such areas—and in the fact that the nurses, who usually come from a health visiting background, are specially trained in a series of methodologies that aim to build up the attachment between mother and child. It supports not only the baby's development but the mother in taking charge of her life to ensure that she is not sidetracked into unhealthy or unhelpful behaviours and, as I say, what I have seen of it so far has been extremely impressive. Of course, it is not the only programme available; for example, there is the Australian-based positive parenting programme—or triple P—which seeks to do slightly different

things, and we will look at a number of other projects that have evolved over the years and support them where appropriate. However, the family nurse partnership has proven to be very complementary to the standard health visiting programme. I agree with Mary Scanlon that that programme should continue to measure developmental and other aspects of child health, and we should react to its findings.

Mary Scanlon: I do not want to go over the review of nursing in the community and the various other attempts to change health visiting. I understand that the family nurse partnership is complementary, but will there continue to be a universal health visiting service? Will these health and development checks be carried out at all stages throughout Scotland? Indeed, has the 30-month health check already been implemented or is it on its way?

Sir Harry Burns: It is being implemented increasingly throughout Scotland. However, something in which I am very interested—and which we have been discussing—is taking a more creative look at measuring the impact of our interventions and getting really quite ambitious about monitoring how the development of children in Scotland can be improved. I hope to discuss that in the course of the coming year.

11:15

Bob Doris: I just wanted to explore a little bit more the link between health and poverty, given that anti-poverty measures are part of the cabinet secretary's remit, too. I was given something that Sir Harry Burns wrote when I visited Cambuslang healthy living centre the other day. The head of the centre talked about an assets-based approach to health and wellbeing, and about health and wellbeing being something that is not done to you but which is grown from the grassroots as part of community empowerment. I was interested in that and I will make a point of reading the comments that Sir Harry made about it. However, I was more interested in how all that wraps around the anti-poverty measures, which have a direct link to health, which this committee would be interested in taking forward.

Nicola Sturgeon: I will let Harry Burns respond, given that you referred to him, and I will maybe add something at the end.

Sir Harry Burns: There is powerful evidence that an individual's sense of control over their life is a very health-promoting feature. Individuals who become disempowered—I do not like that jargon, but it expresses exactly what happens—and are passive recipients of things being done to them are more likely to have abnormal stress levels and are more likely to feel a lack of control. Therefore, we have turned round the notion of doing things to people to doing things with people and helping them take control over their own lives. The voluntary sector is very good at that, because it spends a lot of time with individuals helping them develop, learn new ways of being in control and shed unhelpful lifestyles and so on.

We are trying to evolve, and not just in Scotland—this approach is being taken in England, too. We are involved in the production of an assets-based document for the World Health Organization in Europe and so on. An assets-based approach is seen as something that has been missing from our attempts to improve health and wellbeing over the past few decades. Bob Doris is absolutely right. The policy response to an assets-based approach is not to write a big strategic document that tells people to go out and do X, Y and Z but to create an enabling environment that allows local solutions to problems to be developed and, critically, to allow some of those attempts to find solutions to fail. We try it, if it works we learn from it and if it does not work, we learn from that, too. Therefore, there is a kind of organic growth of an assets-based culture.

Nicola Sturgeon: More generally, in response to Bob Doris's question, the relationship between our objectives around health and health improvement and our efforts to tackle poverty is central, which is why both elements lie within my portfolio. We have tried to see our work around early years, the equally well strategy, our anti-poverty strategy and, more recently, our child poverty strategy as part of a package of approaches. The evidence is well understood that if you tackle some of the underlying causes of poor health, you will have a greater impact on health than you would have if you just tried to treat the symptoms.

Dr Simpson: I have a quick comment on that. The healthy living centres attempted to create that enabling environment. I know that some of them have failed, but it would be very interesting to get some information on where we are with that and where you think we are going. If we are trying different things, we need to look at that.

My question is on workforce. One of my concerns is that we are still training large numbers of people, but the ability of allied health professionals and nurses to get into the workforce will be limited. Given the cuts that will occur in foundation years 1 and 2 and specialist training for doctors, it looks like we might well have unemployed doctors going forward. What will the cabinet secretary's approach to that be?

I know that we do not control the intake of allied health professionals, but if we qualify lots of physios, occupational therapists and the rest and then there are no jobs for them, that will not create

a sense of wellbeing. We have cut the midwifery intake from 183 to 100, and yet we know that in UK terms there is likely to be a shortage of midwives. How are we collaborating with our UK colleagues in that aspect of workforce planning?

Nicola Sturgeon: As I have said before in committee, workforce planning is incredibly important. It encompasses the whole spectrum from young people going into universities to the decisions that health boards make about recruitment and overall size of workforce. It is an art rather than a science, and it is difficult. What underlies workforce planning is now much stronger and more robust than was the case in past years, but it is an area in which we are always looking to improve.

I will run through the different professional groups that Richard Simpson mentioned. We do not control the intake to universities for AHPs, but we work much more closely with the educational institutions involved to ensure that we are balancing the intake with the projected demand for AHPs. We have reduced not just midwifery but nursing intake numbers for this year.

I made a comment earlier—I hasten to add that it is not directed at any individual; it is a general comment—about the fact that we know that reductions in acute bed numbers are not necessarily bad but we nevertheless get into political fights about them. The same can sometimes be true with reducing intake numbers. Sitting round this table, we can agree that we need to do that to balance supply and demand, but when those decisions are taken they can be criticised politically in a superficial way. That is another example of the need to be honest with one another about what needs to be done.

It may be useful for me to give the committee an update on the reshaping the medical workforce workstream, which sees us attempt to move from a service delivered by doctors in training to a service delivered by trained doctors. It will see an increase in trained doctor reliance in future years, and therefore a potential increase in the number of trained doctors. I do not think that they will all be consultants; there will be a mixed economy of doctors delivering the service.

We need to ensure that the decisions about the numbers of students going into our medical schools and specialist training programmes fit with that shift in provision. That is a big package of work that has to hang together, so I would be happy to give the committee an update on it in due course. It is work in progress, but over the next few weeks there may be a timely opportunity to update the committee.

Dr Simpson: I do not doubt the difficulty of workforce planning: as you say, it is an art and not a science. However, I was critical of the midwifery issue not on the numbers but because of the knock-on effect, which I am concerned about. If you close down midwifery in two medical schools in the northern region, as you have done, the effect on the nursing and midwifery teaching units is significant. The changes were made rapidly, with very little notice. I appreciate that you have to take action, but I will continue to be critical of the process, even if we have a debate on the numbers. I am interested in the process.

Nicola Sturgeon: I am more than happy to look at the process. Obviously, we do not work in isolation on midwifery courses: the institutions that deliver those courses are closely involved in discussions. I am not speaking for them on the intake numbers for midwifery students; the institutions can speak for themselves, and no doubt they will do so if they think that I am misrepresenting them in any way. We work closely with the Royal College of Midwives; from memory, I think that it gave a supporting statement about the decisions on numbers that we took last year. We seek to be as open and consensual in the process as we can, but I am always open to suggestions on how we can do things better.

Jim Eadie: I return to the issue of health inequalities, which was raised by the deputy convener. Sir Harry, you have emphasised the need to improve healthy life expectancy. I was particularly struck by something that you wrote in your most recent chief medical officer's report, which states:

"Unless Scotland accelerates gains in life expectancy, particularly amongst the poorest communities, it will continue to fall behind other countries."

You went on to say:

"new approaches to health creation need to be considered."

Since that report was published, what new approaches has your department considered and implemented? What has the evidence base been for that? How do we target resources so that they follow the people and communities that need help the most?

Sir Harry Burns: I am not sure that I can answer that in two minutes, as it is a huge topic, but I am happy to give colleagues a private briefing or something at some point if that is appropriate.

The question comes back to the idea of an assets-based approach. That is not about concentrating only on building people's internal resources and resilience to cope with adversity, or on building community assets, such as green space and opportunities for exercise, or even, at national level, on the assets of a healthy economy. All those things have to hang together, and it is an

extremely complex system. The way in which we deliver the approach is critical.

I have already mentioned that doing things to people, which is what we have done for the past 30 or 40 years, does not work. The trend lines for the rate of improvement in life expectancy in affluent and deprived individuals have been diverging since the 1950s. Nothing that has been attempted has bent those trends in any way. Therefore, we need to do different things over a prolonged period.

A key intervention that we have had on the go for the past couple of years is a programme called equally well, which has been funded to support a number of areas to tackle issues that are of specific relevance to them. We did not specify what we wanted the areas to do, because we wanted them to look at their communities. For example, in the east end of Glasgow, there were issues about healthy town planning. Local people were involved in looking at the state of the area and changing it. In Kirkcaldy the other week, I saw a programme that deals with young people's alcohol consumption.

The interesting thing is that, although the projects started off looking at one thing, each of them has mushroomed into a range of supporting activities. The trick now is to learn from that. The programme is actually about a learning network. It is about learning what worked and what things emerged and developed in each area that are transferable to other areas. I would be wrong if I said that there is not a wee bit of not-invented-here syndrome in Scotland, with people thinking, "Oh, they are doing that over there, but it would never work here." My task is to ensure that some of the clever things that I have seen in some areas are picked up and applied where appropriate.

The history of health improvement has been about the grand gesture, for example on smoking. Tackling smoking helps, but the issue is not all about that; it is about hundreds of things all acting in concert. We must create a climate in which people can build an environment that leads to healthier and better lives.

As members will gather, I could talk until the cows come home about the issue. I am happy to do so at a future date.

The Convener: I think that the committee would welcome our doing that in a more structured way. We will set aside an hour or so, or maybe a day or so. Perhaps I will live to regret that.

To come back to earth with a bump, I have two quick questions that relate to the work programme. First, the cabinet secretary said that community health partnerships have to change, but how and why? Secondly, given the events that have been in the press in the past couple of weeks, is the cabinet secretary confident that the care inspection regime has sufficient capacity and can deal with the issues such as the Southern Cross Healthcare and Elsie Inglis care home stuff? I want to get your comments on those issues on the record so that we can include them in our planning discussions.

11:30

Nicola Sturgeon: I will try to be as brief as possible, as I am sure that we will come back to both issues and discuss them in much greater depth.

I am not of the school of thought that says that CHPs have delivered nothing of any benefit. We can go to many parts of the country and see community health partnerships or community health and care partnerships that have delivered a great deal in developing and building up community services and improving joint working between health and social care services and the link between primary and acute care. I do not subscribe to the view that such partnerships have been a complete waste of time. I would always take issue with that view, but there are particular areas in which CHPs have perhaps not worked as well or as quickly as might have been envisaged when they were first set up back in 2004.

I will try to summarise matters by focusing on two key areas. The first is the success of the partnerships in bringing together health and social care; the second is the involvement of clinicians in general and general practitioners in particular in the link between primary and acute care, which will vary from one part of the country to another. We need to look at those two key areas and see how we can reform CHPs. It is clear that the reform of CHPs cannot be separated from our work on integrating health and social care, so we are factoring the broader role for and future of CHPs into that work. Once we are in a position to do so, I will be happy to come back to the committee and talk to it at greater length about that.

On the inspection regime, there are a number of issues relating to elderly care that are not all connected but which nevertheless come together to raise concerns in people's minds about standards of elderly care. We have a number of workstreams—I do not like that word either, but I will use it to address these matters. Your question was about the inspection agency—Social Care and Social Work Improvement Scotland, or SCSWIS. I do not like that name either.

The Convener: Hear, hear.

Nicola Sturgeon: However, that is what we have. Perhaps we should consider changing the

agency's name. I will call it the inspection agency for the purposes of this discussion.

Of course the inspection agency has my confidence, but we need to continue to ensure that it has the resources, capacity and the right approach to address people's concerns in a proactive way so that we hit and maintain the standards of care in care homes that people have a right to expect. That is a key focus and a key piece of work for us.

When we talk about elder care, it is important that we do not talk only about care in care homes. I have asked the chief nursing officer to pay particular attention to the standards of care that some of our older people get in general hospitals, which is one of my concerns. We saw the Mental Welfare Commission for Scotland report about Tayside, and we need to be mindful of standards of care, perhaps particularly, but not exclusively, for patients with dementia. It is important to talk about care homes, but we should also ensure that we have the right standards and quality of care for older people in general hospitals.

The Convener: I welcome the cabinet secretary's comments on that. I know from personal experience that situations in general or receiving wards are difficult for our most vulnerable elderly people.

As we have no more questions for the cabinet secretary, I thank her, Sir Harry Burns and Mr Feeley for being with us. We look forward to working with you constructively in the future.

European Union Reporter

11:34

The Convener: Agenda item 3 is the appointment of a committee member to serve as the committee's European Union reporter, whose role will be to act as a champion for EU matters in the committee. I expect that members have read their committee papers, which contain a description of the role.

I invite nominations for the role of EU reporter.

Mary Scanlon: Has anyone expressed an interest in being the reporter? I would be pleased to nominate them.

The Convener: No one has directly expressed an interest to me, but the role is important. If no one wants to make a nomination, can someone volunteer?

Mary Scanlon: Is any member of this committee also a member of the European and External Relations Committee?

The Convener: No, I do not think so.

Mary Scanlon: Such a member would have been the ideal person to be our EU reporter.

The Convener: They would have been.

Bob Doris: Is there a timescale within which we have to make an appointment? One or two members of the committee might consider volunteering, but they might also like to consider the time commitment that would be involved. Does an appointment have to be made during this meeting?

The Convener: Given that we do not have a nomination, do members agree that we should defer the matter until next week's meeting?

Members *indicated agreement.*

The Convener: As previously agreed, we will take item 4, under which we will consider our work programme, in private.

11:35

Meeting continued in private until 12:32.

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