The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 25 October 2011

Session 4

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HEALTH AND SPORT COMMITTEE
8th 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 ALSO PARTICIPATED:

Professor David Bell (University of Stirling)
Sir Harry Burns (Scottish Government)
Professor Susan Deacon (University of Edinburgh)
Graeme Dickson (Scottish Government)
Dr Roger Gibbins (Kerve Coaching and Consultancy)
Professor John McLaren (Centre for Public Policy for Regions)
Nanette Milne (North East Scotland) (Con) (Substitute)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 25 October 2011

[The Convener *opened the meeting at 10:02*]

Interests

The Convener (Duncan McNeil): Good morning. Welcome to the 8th meeting of the Health and Sport Committee in the fourth session of the Scottish Parliament. I remind all those in attendance—members and members of the public—to turn off all mobile phones and BlackBerrys to prevent them from interfering with the sound system.

We have apologies from Mary Scanlon; Nanette Milne is substituting for her. I welcome Nanette and, in accordance with section 3 of the code of conduct, invite her to declare any interests relevant to the committee's remit. I remind her that any declaration should be brief but sufficiently detailed to make clear to any listener the nature of that interest.

Nanette Milne (North East Scotland) (Con): I will be extremely brief, convener. Apart from my medical background, I have no declarable interests relevant to the committee.

The Convener: Thank you, Nanette.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I advise the committee of an additional interest, which I have now declared on my register of interests. I have been appointed to the board of Nursing Home Management Ltd, which is a company that manages a single nursing home in England.

Decisions on Taking Business in Private

10:04

The Convener: Next, the committee must decide whether to take items 6 and 7 in private. The items relate to the committee's consideration of its approach to the scrutiny of the forthcoming legislative consent memorandum on the United Kingdom Welfare Reform Bill and of the forthcoming alcohol (minimum pricing) (Scotland) bill at stage 1. Do members agree that those two items should be considered in private?

Members *indicated agreement.*

The Convener: Does the committee also agree to take consideration of a draft report on the Scottish Government's draft budget 2012-13 and spending review 2011 in private at future meetings?

Members *indicated agreement.*

Draft Budget 2012-13 and Spending Review 2011

10:04

The Convener: I welcome our first panel of witnesses: Professor John McLaren, economist at the Centre for Public Policy for Regions; Professor David Bell, professor of economics at the University of Stirling; Dr Roger Gibbins, an independent coach and consultant at Kerve Coaching and Consultancy, was a member of the Christie commission and former chief executive officer of NHS Highland; and Professor Susan Deacon, honorary president of the school of social and political science at the University of Edinburgh and former early years children's champion.

At this point I am supposed to invite members to ask questions, but it seems that I have to lead off this morning. I am very pleased to have all the witnesses here. Thanks for your attendance.

Although we have an interest in looking at preventative spending and other detailed issues, I will start on the overall budget. It has already been stated that the resource spending projected in Scotland will not meet inflation over the next three years. The forecasts that were made in March will have an impact and further allocations to the budget may be necessary to maintain funding at the same level as UK funding.

Do the panellists have any comments on the general statement that we are facing a tight budget in the health service?

Professor David Bell (University of Stirling): The budget is certainly tighter than it has been for the past 10 years or so since devolution was instituted. There is a big difficulty in knowing whether there is a real terms increase, because of the problem of the deflators that we apply to the cash amounts that have come through in the draft budget.

The key issue is what the applicable rate of inflation is for the health service in Scotland. Half of the money is salaries and those will be pretty much fixed. It is the non-salary items that will pick up most of the cash increase. It is very early to say, but I think that we have been misled for a long time by the use of gross domestic product deflators in making assessments of whether there is a real terms increase in the health budget, because the cost profile in health is so different from other parts of the Scottish budget.

Professor John McLaren (Centre for Public Policy for Regions): I add that there are a number of different inflation estimates. For this year, the GDP deflator is the lowest and the retail price index is quite a lot higher, so the figure will probably be pushed up in the November autumn statement. In that sense it is looking worse for the national health service but, as Professor Bell said, if you take out wage inflation, because wages are largely being held constant, that frees up more money so, in effect, you will probably have more money to spend if you can keep wage inflation down this year than would otherwise have been the case. In that sense, there is probably a real increase in spending available.

The Convener: You will have heard that we are conducting an inquiry into care of the elderly. Will wage freezes on the one hand and increasing demands for such services on the other balance each other out?

Professor McLaren: Those factors should not have such a large impact over one or two years, but they will be important five or ten years hence. It is necessary to put in place now measures that mean that the inflation impact does not build up, with the result that we are under more pressure in the future.

There will be factors that are largely unknowns at the minute, such as how NHS budgets or social work budgets in certain areas will have knock-on impacts for people who have to be moved to different places. I suspect that the big increases in pressure will come from those idiosyncratic movements.

Dr Roger Gibbins (Kerve Coaching and Consultancy): The demographic pressures on the health budget are obviously significant. When the members of the Christie commission sought information from the Government on the calculation of that impact, we were struck by the fact that there were no figures or data available, even though the issue was well recognised.

When I was chief executive of NHS Highland, in the absence of anything more sophisticated on the demographic pressures, we did some fairly back-of-the-envelope calculations as we developed our budgets. Broadly speaking, the number of older people in Highland was increasing at about 5 per cent a year. As older people consume about 50 per cent of the health budget, that meant an immediate pressure of 2.5 per cent on the health budget that had to be addressed just to stand still. That is never factored into any of the calculations when the budgets are put together.

Professor Bell: We know, especially from the experience of free personal care, that much of healthcare and long-term care is, in effect, rationed and that there is unmet need out there. When services are changed or expanded, it is difficult to predict what the reaction will be of people in the community who might be getting by some way or other. If new programmes are

instituted, unexpected shifts in demand can result that had not previously been anticipated.

The Convener: With a tight settlement and increasing demands, can efficiencies and productivity gains close that gap?

Professor McLaren: There is no evidence from the UK level that the health sector achieves productivity gains over time. We would expect that if efficiency gains were made, they would follow through into productivity gains. There is no Scottish data on that, but the evidence from the UK level is that, since 2000, there has been no increase in productivity in the health service. That suggests that it is difficult to concur with the claims about efficiency savings that are being made in Scotland and England, as the National Audit Office and Audit Scotland have said. They may be happening, but it is difficult to see where the evidence for that is. The 2 per cent efficiency savings line is the major budget line on health savings, but that does not tell us anything.

Professor Bell: It is important to make the point that when we talk about productivity gains, we are talking about quality as well as quantity. It is about the quality of the throughput, not just the throughput.

Yesterday, I talked to one of my colleagues who works at the health economics research unit at the University of Aberdeen, which is doing work on readmissions following an intervention such as surgery. In a sense, it is deemed a failure if someone has to be readmitted. The unit is looking at ways of reducing the number of such events. We need to think about quality as well as quantity.

10:15

Professor Susan Deacon (University of Edinburgh): I will take a slightly different tack.

It concerns me that—perhaps necessarily—in any debate on any budget a great deal of time is spent discussing the numbers and all the claims and counterclaims about what those numbers tell us. In addition—this is particularly true at the present time—a lot of time is spent blaming various parties, with a big P and a small P, for the existence of certain pressures.

Although all that is legitimate, I suggest that we ought to take as an absolute given what the convener's question reinforced, which is that we all know that there are inordinate pressures on the Scottish budget—those pressures are greater than ever. We also all know that we have shedloads of knowledge and evidence about ways in which services can be organised better and more effectively. In addition, increasingly, we are all signing up to a more preventative approach—although a lot of signing up to that has been done over many years, which has not necessarily been followed up with the necessary action—and there is a crying need to do that, as has been underscored by the Christie commission.

My strong exhortation to the committee and others during the budget process is to spend as much time as is practically possible looking at what we do now, because there has never been a greater need—or, dare I say, opportunity—to do things differently from how we have done them before. Even the discussion that we have had so far has echoes of discussions a decade ago, when I was sitting on the other side of the table. I strongly believe that we must move on, and the Parliament's committees have a fantastic opportunity to think about ways in which we can do that.

The Convener: That is helpful, because the final of my series of questions is about the Christie commission. It focused on a shift towards prevention, greater integration of services at local level, workforce development and improved performance on productivity. From what you know of the budget, can we achieve any of those objectives? How soon can we achieve them? Are you convinced that the budget, as it stands, will allow us to progress towards that preventative agenda? Does the budget make such a shift?

Professor McLaren: At this stage, I do not think that it does. A huge change is needed in the attitude of politicians in general—not just those in Scotland—to make that move. Whether we are talking about care of the elderly, early years intervention or even preventative spend within the NHS, those areas do not have the required budget, so they have to get it off someone else, whose budget is already being cut. They do not have a base, if you like, of a minister or a department to support them, or of powerful bodies that are already in place to support spend moving to them. Without that, there will always be the issue of politicians—particularly those in finance or budget departments—asking whether the benefits of preventative spend will be obtained in five, 10 or 15 years and saying that they are not sure that they want to wait that long.

Just before the last UK election, I was asked by George Hosking, who runs the WAVE Trust, on behalf of Iain Duncan Smith, who was going to be one of the Chancellor of the Exchequer's advisers, to go to an event to discuss more investment in early intervention. It went very well but, as ever, the bottom line was, "When will we get the benefit?" We could see that although they wanted to pursue the idea, they were basically saying, "Well, we'll see what we can do." That will always be the challenge. In the debate on the issue, I have seen small indications that people want to move that way, but I have seen no sign of the big

change that is needed if spending is to follow the evidence on preventative spending.

Professor Bell: I would argue that the Health and Sport Committee is not in a particularly good position to make the case because it is not sufficiently well informed. Yesterday, I got the level 4 budgets by e-mail; £8 billion is to go to the health boards. There is a whole lot of detail about where the rest is to go, but the committee is presented with massive bills for each health board. It is possible to get the detail subsequently by trawling through the Information Services Division website. For example, it is possible to find, ex post, the figures on how Highland NHS Board spent all its money in 2009-10, but there is no linkage back to the process that the committee is going through now in looking at the budget. Given the information that is in front of you, there is no way that you can compare the productivity of different health boards in Scotland to find out whether there are potential efficiencies and whether resources can be released for preventative spending.

Dr Gibbins: There clearly are areas of preventative spending in the health budget. For example, there are health promotion activities on alcohol, smoking and healthy weight; primary care work on early cancer detection and intervention; and the keep well initiative on coronary heart disease. In hospital care, there is prevention work in infection control and patient safety. Preventative approaches to services for older people and early years are also beginning to emerge.

Those are all to be welcomed. The question is whether they add up to enough of a difference to enable us to balance the budget for this parliamentary session and, indeed, over the period that the Christie commission considered. I agree with my colleagues that they do not add up to a sufficiently radical reform agenda to make that difference.

There are three areas on which we could focus more. First, we do not take an assertive enough approach to tackling inequalities and their impact on the demand for health and social care from the most deprived communities. That is where generational levels of increased demand come into play, and we need to tackle that.

Secondly, there is not enough focus on integration and coordination between agencies in the way that the budget is constructed and driven forward. Although there are still efficiencies to be achieved in a complex system such as the NHS, more efficiencies can be achieved by looking at health and social care together across the NHS, local government and other bodies. That also requires greater emphasis.

The third area that I do not see anywhere in the spending review or in Government targets is the reduction of demand. I appreciate that that is a difficult target but, fundamentally, the only way that we are going to square the circle is to reduce the number of people who need health and social care and to have fewer people coming into our healthcare systems. To provide less care is a difficult agenda and target for the nation to have but—coupled with the agenda on community empowerment, individual empowerment and developing resilience, independence and autonomy—that is the way to balance the budget in the long term.

Professor Deacon: The fact is that, in the lifetime of the Parliament, the NHS budget in Scotland has almost trebled. The amount of public money is substantial and we need to focus on how it is spent. There is a need for significant shift in Government resource—in substance and as a signal—not only in health but in other policy areas, such as education, to demonstrate a meaningful move towards prevention.

Policy formulation is still hugely influenced by those who shout the loudest. For example, in health, political representatives are likely to back a campaign against the closure of an accident and emergency department. However, at the same time, community-based projects often scrap around for far smaller sums of money and close down for want of them despite the fact that there are vast amounts of evidence—clinical as well as financial—that we should shift to such services.

Some big system shifts are needed at a higher level but, underneath that, you must also examine where many of the costs are incurred within our public services and public policy formulation. There are veritable industries being set up, many of which are spawned by debates about the preventative agenda or the need for service integration. Whether it is academics or consultancies doing yet more measurement, evaluation and review or whether it is work within our public services or local and national Government, there is seemingly endless analysis and articulation of what needs to be done. That locks up not only millions of pounds but vast amounts of time and energy and cascades down to all levels as people get lost in interminable discussion about what needs to be done rather than doing it.

I am sorry to labour that point, but I examined it intensively in connection with early years services for the Scottish Government last year. I almost wept—in fact, I did weep at one point—to see the amount of energy that is being sapped in that way and, alongside that, to see the fantastic work that is going on in communities throughout Scotland but is not getting the resource that it needs.

To be frank, there is a huge issue about power and control. That is more subtle than simply looking at the top line budgets; it requires thinking about the ways that we work and requires culture change. It is not rocket science, but it requires us to have a different type of discussion on public spending and the way that we run public services.

The Convener: I will open the discussion up. However, I will give the witnesses the opportunity to respond to those points at the end of the evidence-taking session or subsequent to the meeting. The committee is trying to find a way to ensure that the principle of preventative spending is protected throughout the budget process. That is the committee's interest and we would welcome any ideas on that from the witnesses.

Dr Simpson: I feel like we are in "Groundhog Day": the Health and Community Care Committee in session 1 could have heard the same answer to the problems in its consideration of the very first budget. The big difference and the most salient point is the tripling of the health budget without a productivity gain.

The big hope of this austerity budget is that wages austerity will prevent us from going over the cliff. Is that correct or will there be a problem with increments? Although there is a wage freeze, there are still increments within the system. Also, we have not quite completed agenda for change—there are still live appeals—and we have still not dealt with equalisation. The witnesses said that pay is a big factor but also that it may be controllable for the next couple of years. I ask them to dig into that and help us with it a bit more.

I have another question on efficiency savings. Last year, our predecessor committee tried to get into efficiency savings and discovered all sorts of exciting little things on which people were spending money and claiming efficiency savings. The best illustration of the point is that, when NHS Tayside came before the committee, its representatives said that the health board was going to merge its disabled equipment pool with that of the local authority. However, Forth Valley did that 25 years ago.

The Christie commission report is wonderful but, if we are going to achieve it, what mechanism can the committee suggest to the Government to ensure that, on early years services, technical services such as equipment pools and all other services, best practice is followed and followed speedily? There is fantastic good practice but it is always stuck; it never seems to move. That is a really big problem. Perhaps that question is for Dr Gibbins.

I have one other question, but I will ask that later because it is slightly different.

Professor Deacon: Having nodded enthusiastically throughout that question, I feel duty bound to comment on it first. It reinforces the need to have a different type of debate on budgets. I am sorry to repeat that point, but part of the problem and part of the groundhog day scenario is the fact that the way that we discuss budgets has not changed. We are not thinking about how we change practice.

The example that Richard Simpson gave about equipment stores is excellent. The point is practical, real and has been reiterated time and again under various Administrations locked up in grand, fancy pronouncements from Government, in guidance and in goodness knows what.

There is a fundamental problem: there is insufficient attention and scrutiny at every level around what public bodies are doing in practice to make those changes. As long as we continue to spend our time having these rather high-level discussions and do not get down to the level of discussing what people are doing in practice to drive that change, we will not make the shift.

10:30

I will not go through them all, but in the report that I wrote for the Scottish Government at the end of the early years work, I listed about a dozen practical suggestions—I think from memory that they are on pages 29 and 30 of the report if you want to check—relating to issues of system and culture. If we bring together groups of knowledgeable and committed people in Scotland, of which we have many—I include in that practitioners, policy makers and, critically, people who run community organisations or who organise or manage public services within their locality—and bang their heads together to get them to think about how we can effect some of those changes, and if we give them ownership of taking that forward so that we get away from it being a rather desk-based exercise led by policy civil servants in the main, we can start to create a different dynamic for change. In certain policy areas, where some of that has been done, change has been driven more effectively.

I used the word "control" earlier. You have to pass over some control and recognise where some of the knowledge lies, which is often much closer to home than among the supposed experts who have high-level discussions about the issues.

The Convener: Richard, that was a long answer, so I will allow others to come in.

Dr Simpson: I just want to ask a specific supplementary. One of the shifts in the budget is to do with the access fund, which related to waiting times, which were the major problem that was faced in 1999—you faced it as a minister—

but which have now been largely, although not completely, tackled. Almost all that fund is now being passed to the health boards—to give them flexibility, it is said. Do you think that it might have been better to retain that fund and to say that it will now be used specifically for prevention, particularly where community people are dealing with specific things? Do we need that to be driven centrally, or do we just hand the money to the health board and say, "We hope you'll do it"?

Professor Deacon: There is a need for elements of central resource that can help to drive and lever change. In my experience—as a politician and a practitioner and someone looking at these issues from an academic perspective—without such change funds, there will be a real difficulty because, even where people are committed to driving change, they just will not be able to get their hands on resource that will help them do so.

That needs to happen at a national level, but the same principle applies at NHS board and local authority level and so on. It can be done in a number of ways, but we are in the business of wheel reinvention here. Forgive me for giving a nod to my former, ministerial, life, but more than a decade ago we set up the national health improvement fund, which put £100 million over four years into precisely that kind of work, which subsequently became mainstreamed and disappeared into the system to some extent. We keep repeating these mistakes, if you like.

Some element of central resource is needed to drive that change but, alongside that, I would advocate minimal prescription from the centre as to how that resource is used and very light-touch audit, inspection and evaluation.

Dr Gibbins: Dr Simpson raised a number of specific points. The cost of incremental drift in wages in the NHS is a significant factor that is often overlooked. When there is a headline figure of a wage settlement of 2 per cent, the assumption is made that the cost of the wage bill goes up by 2 per cent, but it does not; it goes up by 2 per cent plus the cost of the incremental growth. Unless they are at the top of their pay grade, every member of staff will get an increase as they go up their grade. Economists or human resources people will give you the precise figure, but my recollection is that it is between 1 and 2 per cent of the pay bill.

Dr Simpson: That assumes that new people are being brought in at the bottom.

The Convener: Excuse me, Richard. We are under pressure of time and I have a list of people who want to speak.

Dr Gibbins: There are technical points to do with that but, at the moment, the workforce is pretty stable and turnover has reduced.

The more significant issue on which you asked me to comment was the efficiency agenda. You used the example of equipment stores and asked for suggestions as to which interventions the committee might want to consider recommending in order to take forward the agenda. Although bringing equipment stores together will have some benefits, they will be pretty much at the margins.

Before I left NHS Highland, we did some major work on the full integration of health and social care, which is where the big benefits can be gained and where we can overcome some of the perverse incentives that exist at the moment whereby somebody occupies an acute hospital bed for the sake of a few hours of home care, because the cost of home care sits in one budget and the cost of the hospital bed sits in another budget. If we put those two budgets together, nobody in their right mind would have somebody sit in a hospital bed, with the associated cost to the health system, if they had the money to buy that person home care. I cannot emphasise enough just how important the integration agenda is. The committee might want to pursue it.

A second issue that you might want to pursue is the change fund for older people, which is a significant plank of the Government's approach to prevention. The change fund is a top slice of the NHS allocation, which is then released on the basis of plans from local systems to show how services can be shifted towards community and preventative care, rather than acute health care. The emphasis is more on change than on fund, because the money is already in the system. If something does not change as a consequence of spending the money, in effect all that will have happened is that another £70 million will have been spent. The idea is that, by developing alternatives to in-patient care, an equivalent or greater amount of that care resource can be released. If that is the case, next year it can be reinvested again, so that one gets a virtuous cycle of investment that can begin to turn the system around. As Professor Deacon said, the implication of that is that resources have to come out of acute care, so that the number of beds and perhaps hospitals reduces in acute care, and there are issues with how that is achieved in the health system. It might be worth while for the committee to follow through the impact of that opportunity to turn services around through the change fund.

Professor Bell: Wages, particularly in the health service—although not teachers' pay, for example—are determined outside Scotland to quite a considerable extent. I noticed that the £24 million merit awards are in the level 4 budget that

we were sent yesterday. I think that those awards are a UK-based system that the cabinet secretary might want to get rid of. An interesting question that has not been raised is whether there should be a greater degree of local control—in this case Scottish control, I guess—over how pay and conditions are set.

Professor McLaren: In the public sector in particular, it is very difficult to measure efficiency savings in certain areas, but there is a role for Audit Scotland or some such body to be more directly involved in agreeing what people should give in as efficiency savings, assessing what efficiency savings have come from, and using that information to spread good practice, whether in education or health authorities. I have quite a lot of other stuff on that, but I will leave it there, as we are pushed for time.

Bob Doris (Glasgow) (SNP): I start by apologising to Professor Deacon. This will probably sound a little bit like "Groundhog Day", but you would expect me to say this. The convener talked about Scotland struggling to maintain levels of health spending at UK levels. Perhaps he and I are both being groundhogs in that respect. It is reasonable to say that over £800 million of Barnett consequentials for health have already been identified in the budget for the next three years in the spending review. It is important to put that on the record. It is also important to put on the record that health's share of the overall Scottish budget over the spending review period will go from 34.1 to 34.5 per cent. Perhaps that gives us a reality check. The deal for health is always challenging because of increasing demand and the GDP deflator, which we have heard about, but it is a remarkably good deal compared with those for other departments. It is important that we all remember that. That is the "Groundhog Day" bit finished, Professor Deacon. I apologise for that.

I want to look at the numbers in a way that is different from the one that I think Professor Deacon would suggest. There is £1.9 billion sitting there for Greater Glasgow and Clyde NHS Board, for example, and the local authorities have several billion pounds of spending on social care. We have the level 4 figures. It was suggested that what we should scrutinise is not the figure but what that money means for service provision on the ground. Should the Health and Sport Committee do year 2 scrutiny as standard around this time? Should we have, say, the head of Greater Glasgow and Clyde NHS Board, Robert Calderwood, in front of us, and ask him what the money has been spent on? I am interested in your view on that type of scrutiny. It has been said that change funds—or, if we are being honest, ring fencing—are important to drive change, but it has also been said that the centre should not micromanage and dictate. As the Health and Sport Committee, we are sitting at the centre. How can we deal with those challenges? I want to consider services on the ground, how the money for them is allocated, and how that drives preventative spend and early intervention. The committee would greatly appreciate any advice that you can give on how we can drill down on that.

Professor Deacon: I do not think that there was anything groundhoggish about that. It is important that we constantly reflect and consider not just trends in spend but trends in practice over a period of time, as short-termism is another thing that has bedevilled us. We need to focus much more on longer-term sustainable change.

On the specific point that Bob Doris raises, the key is to get the balance right. I do not think that we have got the balance anything like right between having the resources, drivers and incentives at the national level to go in a particular direction—let us say in the direction of prevention as a catch-all, although I am talking about more than that—and having the means to allow people to access some of those resources at a much more localised level and to drive change locally.

There is a really radical thing that a parliamentary committee might consider doing—or it could find ways for this to be done more in the parliamentary process. It would be radical to conduct more of the discussion by not only asking an NHS chief executive to come in and say how money is spent but bringing in community organisations and front-line practitioners, perhaps retired ones, where possible. It is difficult to do that with people in post, as it can be a bit career limiting for them. People can be brought in who can say what the world looks like from their end of the telescope. Hearing about that is much more meaningful. I know that, as local politicians, all committee members will regularly take such an approach in their constituencies. A trick would be to shine more light on the local experience of what is really happening with resource allocations and so-called priorities. More of that could be brought into the national forum, and more understanding could be created of the things that really get in the way of change. Some of those things are as basic as the procedures—the hoops and hurdles—through which community organisations in particular often need to go to access very small amounts of money from the proliferation of funding organisations. There is a job for a parliamentary committee to consider that matter and to be shocked sometimes, I hope, by what people must go through to do the very things that successive Governments have said that they want more of to be done.

10:45

Professor Bell: It seems to me that much of this is about the failure to properly inform the Parliament and the people of Scotland about how £10 billion or £11 billion is really being spent. Members could get a chief executive in front of them, but one body that they might want to have in front of them is the Information Services Division, which used to be based down in Trinity, because it can do comparisons of how health boards use their money. I have already referred to that. The ISD produces reams of statistics that only nerds such as me ever look at. No single document about how we did last year compared with how we thought we would do in health is produced and discussed in the public domain. If you asked the man in the street what HEAT targets were, they would give a completely blank look. There may be genuine reasons for differences in how health boards spend their money and allocate their resources, but I do not think that people know that that is the case, and they deserve to know. I do not think that that happens.

Dr Gibbins: For me, what the money is spent on is less important than what is achieved with that public expenditure. The committee can take an outcome or theme such as the improvement in the life chances of children who are born into deprived communities, say, and have not just the chief executive of a health board but representatives of a local authority and other partners in front of it to show how they work together to deliver outcomes and use the collective resources at their disposal, and consider the public pound for Glasgow, Highland or wherever rather than the health, local authority or education budget. That approach would certainly reinforce the solutions that we have discussed.

Professor McLaren: There is quite a lot of analysis and research on health in general, as you would expect, but there is very little research on the basic numbers on what we get for our funding. For example, the spending differential between England and Scotland in 2007 was 14 per cent—14 per cent more per head was spent on us than was spent in England. In 2009, that figure had fallen to 7 per cent. Why and where did that happen? I have no idea. Nobody has looked at the matter. It may or may not be a mirage but, if the advantage fell in two years, somebody should have noted that and found out what the reason for that fall—valid or invalid—was.

That problem goes through quite a lot of research in the area. A couple of years back, the Nuffield Trust produced a report that contained a number of comparisons that made Scotland look pretty bad, but most of the report was based on bad data. Most of that bad data had been published, but the trust had not bothered to think about it well as a researcher; it simply republished it. The CPPR produced a paper that corrected a number of things, and the Nuffield Trust corrected its paper. All its great claims about how unproductive Scotland was have largely been removed. At the time, nobody came out with a line-by-line analysis and said, "These figures are wrong. Okay, but what are the right figures?" There is not nearly enough analysis in Scotland of how much extra spend Scotland needs, where the difficulties are, what aspects of alcohol abuse need to be addressed, what the Glasgow effect is, how it can be identified a bit more clearly and what the good things to spend money on are to get rid of it.

Bob Doris: I would like us to drill down into the figures. We can argue about whether there has been more spending or less, but the important thing is what the money is spent on. As the witnesses said, we should focus on the outcomes. We can increase preventative spending, but if it does not give us the outcomes that we desire, what is the point of spending the additional money? Would it help if the committee picked one or two of the preventative spend themes and tried to get some figures for them below the level 4 figures that we have, so that we could get some meat on the bones? We could also skip over the bureaucrats and look to see what is happening on the ground and what the outcomes are.

The committee gets various figures, and one group of witnesses says one thing while another says something else. We just want to know the best way to drive change on the ground. I will not ask a follow-up to my question, but I appeal for any other advice that you can give us about drilling down to the local level and how that can be followed through in what the committee does in two or three years' time to continue the work that we are starting with our scrutiny.

Professor Bell: Can I put my nerd hat on again? What you say is absolutely right, but it is difficult to do what you suggest. Some of the outcomes that we might be looking for will be way down the line. Some of them will not be measurable in numbers and can be assessed only in the quality of the outcomes, rather than in the quantity. Also, the effectiveness of an intervention must be measured against the counterfactual, which is always difficult.

Last night, I was looking at what we call self-directed support and how the equivalent in England—it is called individual budgets down there—is analysed. A number of communities were given individual budgets while nothing was done in some similar communities, which became the counterfactual. The two sets of communities were measured in the same way and then compared. That is an expensive thing to do, but it

can be done cleverly and new technology helps with the work. It is not sufficient to look at an initiative and say, "That's a tick. Let's roll it out to the whole country."

Professor Deacon: Picking up directly on the challenge of the question, I will make a practical suggestion of something that the committee might consider. Perhaps it is not for the Health and Sport Committee, but I will suggest it anyway, as I am here. I am concerned by the ever-growing amount of largely anecdotal evidence about what is happening right now, with much of the provision that we are discussing being eroded as budgets are reducing. I saw nods round the table when I talked about community organisations. Many people at different levels are picking up that community organisations are really struggling. We hear a great deal about police numbers, but we hear much less about community midwives, health visitors, speech and language therapists and other services that are fundamental to making a difference to children and families and communities more widely.

The committee might wish to probe what is being done in real time to monitor local provision, because, by the time the formal audit processes catch up, it will be too late and much of the provision will have gone. That is my contention. I do not know whether the committee will find it appropriate to draw that work into its budget consideration, but that is my suggestion.

The Convener: Having read the big pile of submissions, we might need to consider whether we all agree on what preventative spending is. We will come back to that—I am jumping in—but it is important. Someone's view of preventative spending will depend on where they come from. A pharmacist will have a particular view, but someone in another area of work will have a different view. We might need to look into that. However, we need to press on.

Nanette Milne: I will focus on an issue that particularly interests me and, indeed, Mary Scanlon, for whom I am substituting today. I remember when telehealth started in Aberdeen in the 1970s. It has been used quite a lot in the north-east and one or two other places, but it has not been rolled out to its full potential throughout Scotland. Do the witnesses have any comments on that? How can health boards take up telehealth despite the opposition from certain health professionals? It has tremendous potential not only to create savings but to improve patient care for the elderly and people in remote areas. The potential is almost endless.

Professor Bell: I have been involved in a study for the European Commission on tele-interventions. It was meant to be an encompassing study that looked at many of the schemes that have been tried throughout the world. The trouble is that we have exactly the problem that I mentioned a moment ago. A practitioner thinks that a scheme is a good idea, introduces it for a small area, says it is good and writes an article on that basis, but, when we look at it in detail, we cannot prove that it would be effective if it was rolled out throughout the country because, for some reason, it is a specific study.

That is not to say that such schemes are wrong, but let us assume that we could establish that one was effective. I see no reason why that could not be the case if it was done carefully. There are then a number of institutional challenges to the rolling out of telehealth. You might like to invite Dr Hendy from Imperial College to speak to you, because she has looked at the institutional barriers. A scheme is started at a small scale by a practitioner who is really interested, but how do we get from that up to the national scale? It is a problem of management and organisation. I will give you Dr Hendy's details later. She has thought carefully about the problem, which also occurs to a large extent elsewhere, certainly in Europe.

Dr Gibbins: Telehealth probably deserves a debate of its own. There are multifactorial and complex reasons why it has not developed to its full potential. It certainly has more potential, but there are three broad categories of barriers. There are concerns in some quarters about clinical acceptability, and there are still technical issues to do with reliability. Anyone who uses videoconferencing knows that it sometimes goes down, which is unacceptable in a clinical situation. There are also cultural barriers, such as managerial barriers in organisations and the fact that not all patients accept telehealth as equivalent to seeing a practitioner face to face. However, it is certainly an area to watch, and if we cannot use it with the geography that we have in Scotland, where can it be used?

Professor Deacon: This is another classic example of an area in which we have to challenge the orthodoxy, which we have just heard repeated. The orthodoxy is that we have to look at all the expertise and evidence and we need yet another study to tell us whether something really is the right thing to do. I remember, a decade ago, being in a number of Scottish island communities and seeing what telehealth means in real terms to patients. How often do we listen to those voices? Do we hear from the person in Shetland who has been able to avoid a round trip to Aberdeen and all that that means, especially when they are sick?

We should drive change from the point of view of what will benefit patients rather than discussing what the experts, the professionals and the evidence might tell us is the right thing to do. One reason why we are not driving change in the right

direction is that we are not listening enough to real people's voices and commonsense arguments about things that need done.

Telehealth is wonderful. Some people will want to make the round trip from the island to Aberdeen or wherever, and if we were organising our public services more flexibly and doing what we say on the tin in terms of patient-centred care and the like, perhaps we would allow that when somebody wants to do it, but for many people it is transformational to be able to get a high level of advice and support through telehealth. Often, it is also transformational for local health practitioners to be able to get support down the line from a consultant who is based in a specialist unit elsewhere. I am pleased that the issue was raised, like the equipment store issue and a heap of others. This is not new knowledge about the kinds of things that can and should be done to benefit people in Scotland. What stands in the way of making those things happen are attitudinal and systemic obstructions that are sometimes to do with resource allocation.

11:00

Jim Eadie (Edinburgh Southern) (SNP): The committee is keen to make progress in supporting the shift towards preventative spending. We have heard some high-quality contributions from the panel this morning that will help us to address that issue. I am particularly taken by what Dr Gibbins said about how the change fund could begin to unlock some of the resources that are tied up in the NHS, particularly in the acute sector.

Professor Deacon, Save the Children made a specific suggestion in its written submission on which I would like to hear your view. It recommended that

"The Scottish Government should publish and widely publicise an accredited list of evidence based family and parenting programmes to support delivery agencies to invest in programmes that have a proven track record."

Is there a role for the Scottish Government in accrediting and promoting what works so that more money can be invested in those programmes? Could you and your work help us with that?

Professor Deacon: I have in front of me a series of practical suggestions—I am loth to call them recommendations—that the Scottish Government commissioned me to make on how we can make a difference in the early years. One of my practical suggestions is

"Mapping, Sharing and Building on Effective Practice - To develop a clear overview—through the range of information and knowledge which already exists—of the range of projects, activities and services which are in place across Scotland and which work effectively to support young children, parents and families; and to consider how this effective practice can be shared and built upon more systematically in future."

That is a wider statement than Save the Children's suggestion, which focuses on parenting programmes. I would not narrow the suggestion that far. We might not have time to go into it, but I am concerned about the way in which some parenting programmes are being delivered. Some of their messages add to the problem of people feeling disempowered as parents. Although some of them are very good, I worry about focusing on highly engineered, expensive and often imported parenting programmes.

The Scottish Government has the means and resources to do more to capture and understand more about what is being done and what is working well in Scotland so that it can find effective, people-based ways of sharing it. I say "people-based" because, whenever we talk about sharing best practice, the default position is to set up a website, but I am convinced that, in a small country like Scotland, there are others ways to bring people, ideas, and experience together and create more of a dynamic for change.

That was a long way of saying yes.

Jim Eadie: The Cabinet Secretary for Finance, Employment and Sustainable Growth said in his statement to Parliament that money will be ring fenced for preventative spending. The figure that he gave was in the region of £500 million and, of course, early years care and care for older people would have a legitimate claim on those resources. Where would you start with prioritising spend for the early years? Perhaps Dr Gibbins could talk about care for older people.

Professor Deacon: I am pleased that the Scottish Government has run with one of the things that I emphasised in the work that I did for it. I think that we need a bigger network of children and family centres across Scotland. I was one of the ministers who was on duty when the sure start programme was first introduced, and we in Scotland took a different approach from that which was taken south of the border. To prove that I am willing to reflect and learn, with hindsight that approach was wrong.

I understand why we took that approach at that time, but in essence the resource was put out to local authorities without their being given much of a steer about what it should be used for. In some cases, it was used to develop initiatives such as sure start centres as they would be recognised south of the border. In other areas, it just disappeared into the system. We did not develop those facilities in the more systematic way that they were developed in England. Of course, there is now a question mark over their future sustainability. Sometimes our desire to be different

in Scotland is not necessarily helpful. The Scottish Government's commitment to putting £50 million into a sure start fund in order, among other things, to develop children and family centres is to be welcomed.

I want to emphasise the point about children and family centres. We must be careful not always to seek to codify and commodify at a national level what needs to be done. As I am sure that many members have seen, many such facilities that work well in communities across Scotland grew up organically—they were not made to some prescribed model. A couple of weeks ago I visited a project in Fife with the local MP, Gordon Brown. The Cottage has existed for 24 years and it is doing excellent work. In particular, we went to look at what it is doing with young dads and the development of its community garden. When we listen to the testimony of those young men talking about what their involvement in the project means to them and how it has changed their lives, their relationships with their children and so on, we realise that we do not need a tape measure to tell us that that approach really works. We must listen more to such personal testimony and see, feel and touch the things that are really changing people's lives.

If we feel that such initiatives must be measured and quantified, there are lighter-touch ways of doing that. However, some measurement has to be qualitative and we must listen to people when they talk about how to change things. The sure start fund and children and family centres would be a good way to go, as long as we allow organic growth in communities.

Dr Gibbins: To build on that, I emphasise my earlier point about needing to tackle inequalities in those communities in Scotland that are most deprived, where life chances and opportunities are most restricted. I draw the committee's attention to a specific recommendation in the Christie commission report—I am sure that the clerks can find it—on page 59, paragraph 6.28. It talks about targeting the approach on those communities in which needs are greatest:

"We call on the Scottish Government, local government and other partners to work together as a priority to develop specific public service approaches targeted on the needs of deprived communities."

The report talks about understanding the needs of those communities. They could well need early years interventions for the life chances of children, or the community could be characterised by chronic unemployment and have little chance of employment. Some communities are characterised by chronic disease and limited life expectancy. We have talked about older people, but in many communities a lot of people do not reach old age because of the significant occurrence of chronic disease.

It is about taking an holistic approach, understanding communities' needs and working with them to design services that involve them in meeting their needs. All our communities, even the most deprived, have assets and we need to build on those assets to engage, involve and empower people to improve their own and the community's life chances. That is an important recommendation in Christie, to which the committee might want to refer.

The Convener: The change funds do not simply target deprived communities. They are available for people across Scotland.

Dr Gibbins: Exactly. They are indeed.

The Convener: Is that the point that you are making? Are you saying that they should be?

Dr Gibbins: To some extent, my point is that if we are really to tackle the failure to meet the demand that exists in our system, we need to be more forensic about targeting deprived communities. In Scotland, we have a difficulty because we also aspire to provide universal services that everyone should be entitled to. That sends out a mixed message about how we tackle—

The Convener: We have had some evidence about the ownership of the change fund. We are told that half of it already belongs to local government and the health service, but the third sector complains that it has been denied access. That was Professor Deacon's point.

Professor Bell: The critical issue is the allocation formula and how funding is allocated to different health boards. Indeed, I believe that in that respect we are now on what might be called Arbuthnott's second son.

In an interesting Economic and Social Research Council-funded exercise that is being undertaken at the University of Stirling, the English funding formula is being applied to Scottish communities to find out whether the funding allocation would differ. One noticeable aspect is that, in England, more money is targeted on inner city areas with poor health figures, with the result that some of the London boroughs get the most funding. It is, in effect, what is known as capitation. The big question is whether the allocation formula is actually reducing the inequalities that, as we all acknowledge, are desperately difficult to deal with.

Professor McLaren: One issue that is becoming particularly acute with the real-terms decline in the budget over the years is whether provision should be targeted or universal. Indeed, that very issue has been highlighted in early years work, which is based mostly on evidence from a

few American examples from the past. As one of the leading academics in this area, Professor James Heckman, has pointed out in a number of studies, stubborn problems such as intergenerational poverty and areas of multiple deprivation are stubborn for a reason. They are simply too difficult to overcome. As a result, only high-quality and high-cost policies can make a difference. If you are going to take that route, you will need to target the money because, if you do not, those areas will simply fall back into deprivation. The same thing happened with housing and in areas where the housing was rebuilt; the money got spread around too much and not enough of it was put into overcoming the problem. This issue is just going to ratchet up.

Gil Paterson (Clydebank and Milngavie) (SNP): What are the barriers to preventative spending? I am quite sure that, as Professor Deacon suggested, every one of us would be guilty of manning the barricades if a hospital or facility in our area were to be under threat of closure. Should we be setting more stringent targets with regard to preventative spending to ensure that the political focus shifts in that direction and that the political question is more about such targets not being achieved?

The shift to preventative spending would result in the loss of nurses and, perhaps, doctors—although I add that the money would still be there and that those people would not be sacked; they would simply not be replaced. However, that is a very big political issue. Every one of us has been guilty of criticising such shifts when in opposition and of not arguing for the benefits. What are your views on that?

11:15

Professor Deacon: We have to factor the word "leadership" into this conversation, although I should add that I am not restricting the concept to politicians. If our country is serious about translating some of these oft-stated aspirations into practice, anyone who has a platform, who can shape thinking or who can inform debate has got to take a lead and not simply respond to those who shout the loudest.

I am very critical of the extent to which policy has shifted towards certain high-level, high-spend, populist decisions but, to be fair to politicians, I believe that there is also a momentum gathering more widely in our media, in our communities, in public meetings and so on, as a result of which the things that rise to prominence and which people leap to the defence of are not those that actually form part of the fabric and foundation of our society. As I have said, some of those things are withering away when we most need them. Leadership really matters in that respect.

In my early years report, I concluded—reluctantly—that preventative approaches need more of a legislative underpinning. I say "reluctantly" because I believe that over the years the Parliament has been far too trigger-happy with the statute book to tackle complex social issues that cannot be addressed first and foremost through legislative change. I know that the issue is being discussed and that work on it is under way, but I think that there needs to be some legislative underpinning or some of the big shifts that are needed just will not happen.

I am, however, loth to advocate the introduction of yet more targets. The problem is that we simply have far too many targets, whether they be HEAT targets, single outcome agreements or everything else that sits underneath. Frankly, we have ended up in a ridiculous situation. This particular way of thinking and working, which actually goes back 15 or 20 years, has taken over and we need to strip back an awful lot of the targets.

As for early years, I think that there is a strong case for putting in place one or two big national measures. The next panel of witnesses might say something more about this, but a tool called the early development instrument, which is being trialled in Scotland, has been used in some countries as an overarching child health and wellbeing measure that not only policy makers but the public can use as an indicator of whether things are going in the right direction. I am concerned that, as David Bell pointed out, we are gathering vast swathes of data and statistics while at the same time lacking one or two big-picture measures to show us where the nation really is and where it is going in relation to child health. We need to sweep away an awful lot of the fog of numbers and replace all that with one or two big targets that we can collectively buy into.

Dr Gibbins: I have four quick thoughts on barriers to prevention. First, the fact is that we are all very short-termist and look typically at a parliamentary session. However, all preventative measures require a turnaround period amounting to generations.

Secondly, as far as targets are concerned, accountable officers in organisations are to some extent driven by what they are being held to account for, which includes targets and legislation. Indeed, that is why the Christie commission recommended that more of a presumption in favour of prevention be laid on organisations. The situation is changing, which is good, but over the past 10 years the focus in health has been on driving changes in the acute system and that is what we have been held to account for.

Thirdly, one person's spend on preventative services is another person's cost because the benefit is felt in another part of the system or

organisation. The fragmentation of the system itself does not help in that regard. For example, investment in education and community development by local authorities might result in a saving for the social justice system not for the education system or local authorities. That is why I have emphasised throughout the discussion the importance of bringing together budgets and of organisations being more integrated and rounded up.

Fourthly, one consequence of these changes that must be managed is the fact that we will be required to stop spending money in one area and stop something else happening. We have already discussed the difficulties of achieving that in the NHS and in other areas.

Professor Bell: We have—and have had since devolution—a kind of silo mentality and it has been very difficult, even within the Parliament, to deal with cross-cutting issues. Committees have sat together on occasion but such meetings have been few and far between.

We need a big culture shift to focus on preventative spend. For early years, the case is indisputable but it should probably be made across housing as well as health and education. One of the interesting things that the committee might want to examine is resource transfer from the health service to local authorities, which is about £350 million and bigger than the change fund. What is that money being used for and how effective is it? What efficiencies is that big chunk of money garnering within the health service?

Mary Fee (West Scotland) (Lab): I am interested in the panel's views on the commissioning process and what regulation could or should be attached to it. There are a number of inequalities in the process. The private sector delivers the majority of care in some areas, but less so in other areas. Increasingly, through the commissioning process, third sector organisations are disproportionately affected by cuts. It is recognised that the third sector provides a high level of good-quality care. However, the cuts have an impact not only on the third sector organisations but on their staff, with regard to training delivery and staff numbers. What are the panel's views on those issues?

Dr Gibbins: I would make a distinction between a commissioning process and a procurement process. When people talk about commissioning in the examples of care that have just been given, what they actually mean is procurement, because it is about where someone buys a service from. However, ahead of that is strategic commissioning in terms of what assets a community has and what public services are needed to bolster and support the community. The question is, first, how all agencies, including the third sector and communities, can engage in the discussion about strategic commissioning and, secondly, how best we can then procure and deliver the required services. Currently, we lack strategic commissioning that is much more holistic and involves people more. We short-circuit that process by having a narrow procurement process that does not engage people.

Professor Bell: I think that a self-directed support bill will be introduced this year, which will impact on the commissioning service. Previously, local authorities could set up block contracts, but self-directed support will mean that they will not be set up to the same extent, because local authorities will not be sure of having the demand to meet the block contracts. Self-directed support will impact on training and how local authorities set care contracts. There will be even more risk for suppliers—third sector organisations or other suppliers—because it will not be known beforehand whether someone who is to receive care will decide to go with the local authority standards mechanism or with self-directed support.

Professor Deacon: Mary Fee raises a hugely important issue. I totally agree with the points that were made about the impact on supplier organisations, which are often in the third sector. I do not believe that any organisation has a God-given right to continue providing something. However, we must acknowledge the impact on people who use services of some of the big shifts of provider that are sometimes made and the loss of not just knowledge among the workforce but relationships. Again, that is what bothers me about the things that we measure and which we say count.

I would make two points in that regard. First, I strongly encourage the committee to spend time looking at the issue, because it is precisely the kind of systems issue that we need to get underneath. In doing that, you should not take anything as a given. I am struck that we talk as if a lot of the managerial processes that we have in place have to be that way. Such things are not God-given; they are man-made and they can be redesigned and changed. There may be issues with Europe in some of the terrain, but I think that we should push out much further the boundaries of our thinking on the action that we could take to change some of the practices, which often have frankly ridiculous outcomes for both the organisations and service users.

The second point that I want to add—it has not yet been raised and I hope you do not feel that it is too many steps removed from the question—is on the wider question of partnerships. I am talking not just about the typical health and social care partnerships but about creative, innovative

partnerships across all different sectors. I will give you a personal example to emphasise the point, and I hope that it will not detract from my argument in any way—it might even add to it.

I chair an organisation called the Hibernian Community Foundation, a charity that Hibernian Football Club set up. Only a few weeks ago, we partnered up with Community Pharmacy Scotland at a match to look at ways in which we could get men in particular—although it was not just men—to talk about their health. We were thinking about ways of reaching out to different groups and getting across preventative messages, with materials about alcohol for example. We are now looking at ways that we can build on that.

There is not a penny of public money involved; it is a matter of organisations coming together to be creative and think about what they can do. However, if a wee bit of public money could be levered in to encourage such innovative and creative partnerships, it would make it easier to establish more of them. Forgive me for taking the question and stretching it a little, but it is all in the mix of how we get people and organisations to work together to make happen the things that we know need to happen. A really important part of that work is to get underneath some of the resourcing and contractual mechanisms that exist.

Richard Lyle (Central Scotland) (SNP): As a new member, I am very impressed by the panel's evidence this morning. I am particularly impressed by you, Professor Deacon, and your comments on political parties and their dealings with the health service. I take it from your comments that you have come to the conclusion that parties should work together more to improve the health service and to target moneys better to resolve the many issues that we have spoken about this morning. I will broaden out this question to the whole panel: should we have a root-and-branch review of how we do things? There is also the $64 million question: should we consider reducing the number of NHS boards in Scotland?

Professor Deacon: Where do I start? On the issue of structures, my long-held view is that, considering the number of organisations that we have, we are far too cluttered as a small country. Far too much time, energy and money is spent on managing across the boundaries and trying to find ways of making things come together. However, I am incredibly cautious, particularly in the current period, about big structural reform.

It is a pity that in the first decade of devolution there was not more discussion—and, yes, cross-party discussion—about the overall public sector landscape in Scotland. We have ducked a lot of issues, not least the central v local issue. On the one hand we say that we want national standards, but on the other we say that we want localism—and when we have local variation we say that it is a postcode lottery. As a country, we are quite confused about all of that.

That brings me on to Mr Lyle's point about cross-party co-operation. Fundamentally, I do not think that the issues are, or should be, party political. I am not holding my breath, but I would love to see a much less politicised and silo-ised conversation about the public sector landscape and how it could work better.

11:30

As I said, I think we have ended up in a bad place in respect of the organisational clutter that we have, but we have to tread with enormous caution in thinking about restructuring. When I became health minister in 1999 we had just gone through an NHS restructuring process and I lived with and saw up close the cost—both in monetary terms and in lost energy—of the huge dip that we had for a couple of years because all sorts of people were competing for different jobs and there were situations where two chief executives were wondering who would get the one job that was left. I do not think that you can underestimate just how disruptive some of that kind of structural reorganisation is, whether it is in the NHS or local government. That is why I think we have lived with a messy and not particularly efficient system for a long time now; there is a recognition of the difficulties and dangers of going for large-scale structural reform.

Dr Gibbins: As you would expect, we debated this in the Christie commission to some degree at least and reached that conclusion. If you step back and look at the system of public authorities in Scotland, you can see that, for the size of our country, it is very cluttered and complex and it could certainly be simplified. However, making structural change without working through much more carefully what that would involve is not the answer and is likely to get in the way at the moment.

We debated two important considerations in the Christie commission. One was that, irrespective of the number of health boards, police authorities or whatever in Scotland, there is a critical coming together in local areas—how those public authorities work together in the interests of the communities that they serve, whether in a local authority or sub-local authority area, is critical. Whether there are nine police authorities or one police authority, or 16 health boards or three health boards, services still have to work together locally. That is why we emphasised the importance of the community planning partnerships and their development as a way of bringing together a focus on what outcomes public services should seek to achieve with and for their

communities and the individuals in them, and how the totality of public money should be spent. There is still a lot of work to do on what an effective model really looks like and how it can best be introduced.

Secondly, we said that any structural reform that takes place needs to focus on what is the best structure to deliver the outcomes that we need in Scotland. Considerable thoughtful work on that needs to take place over a period of time. Given the time and remit that the Christie commission had, it was certainly not something that we could tackle.

Professor Bell: We have ducked a lot of questions since 1999—we have not addressed them seriously. Having said that, major structural reform is not necessarily the answer. Since the Scottish Parliament was set up, the NHS in England has gone through three or four complete structural changes and it is not clear that they have been beneficial.

There are some things that we have assumed that we have now fixed that they are thinking about south of the border. One assumption is that free personal care fixed the problem for older people, but that is really not the case. There have been several commissions in England, including the Dilnot commission. Nothing has happened, but at least they have looked at the issue seriously. The committee is looking at that again.

There is perhaps less politicisation in England than there has been in the past. Iain Duncan Smith commissioned the Labour MP Graham Allen's report on early years intervention, for example, so there are serious heavy-hitting reports that are not political. I am not sure that we have been very good at doing that sort of thing in Scotland.

Professor McLaren: There is cross-party support in Scotland—and to some extent in the UK—for protecting health funding. Every political party in Scotland believes that the most important thing is to protect the health funding budget rather than to grow the economy or do anything else. However, that is pretty meaningless. If we want to move Scotland's life expectancy away from being the lowest in comparison with other countries in western Europe and elsewhere, that is fine. However, the debate at present is just about numbers and the level of the budget, rather than where the money goes or what it does, which is not particularly good. There is political agreement to some extent, but not on the right things.

It is also important to consider the issue on a UK basis. The NHS comprises four parts, which all do things differently. If I remember correctly, one point of devolution was for the four countries to do things differently, compare methods, find out which country was doing things best and learn from one another. However, we do not do that, because each country does not collect the same data. No country is interested in whether another country is doing things better, because it makes it look as if that country is not performing well. There are things to learn in that regard that could improve matters.

The number of boundaries is an issue. Local government boundaries are different from health boundaries, which are different again from political boundaries. There are now three—or possibly four—political boundaries, which is confusing and wasteful, and uses up quite a lot of money. Scotland, Wales and Northern Ireland spend a lot more per head than England on Government administration. Some savings could be made in that area and the money put to better use.

Professor Deacon: Can I make a brief addendum?

The Convener: As long as it is brief.

Professor Deacon: I promise that it will be.

On the point about structure, an interesting parallel discussion is taking place around higher education—on university mergers, for example. The big message that is coming from that sector is that there is a distinction between top-down, forced change and a more permissive approach that encourages such things to happen as long as they build on pre-existing relationships. There are lessons to be learned from the mergers that have taken place.

I am not sure that we have come up with even a narrative, let alone a model. Organisations such as the NHS and local government in Scotland could encourage some of their relationships to go beyond the sharing of back-room services, and perhaps towards full-blown integration, but only on the basis that it is not imposed on them and that they integrate willingly. There is mileage in that approach.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I have been struck by the whole discussion this morning. It seems that we as a committee and you as professionals and academics are searching for measures to allow us to examine how well preventative spending and integration are working. I was very taken with what Professor Deacon said. As a health information professional, I view evidence as a must. We are seeking measures to enable us to find the evidence, but—again, I say this as a health information professional—we perhaps need to consider what we, and you as professionals, will accept as measures.

We have talked a great deal about the numbers and the need to drill down to different levels. As Professor Deacon pointed out, we need to ask

those who have carried out preventative work and integration for their thoughts on how such approaches have worked. Nevertheless, we still need a measure to ensure that there is an evidence base for the outcome. Is there any research on different ways of measuring these things that we might be able to look to?

Professor McLaren: Measurement and evaluation, particularly of investment in early years, are important for a number of reasons. If such things are not properly measured, the findings will not be very positive. For example, if you introduce an early years education measure that looks only at educational aspects, the work will take a long time and you will not get very much information from it. With such interventions, the biggest impact is felt in law and order, with the reduction in crime through better behaviour; the next biggest impact is felt in health; and then there are impacts in education and employment. There is also what might well be a large impact on the child and on the parent—or parents. If you do not factor in all those impacts and follow them over a long period of time, you will not have a full idea of the benefit that you are getting. We are simply not very good at doing that work. Some of the very few studies on this subject, which come from America, were started in the 1960s or 1970s and concentrate on very small samples; as a result, we have to rely on quite a small evidence base and do not have time to build it up ourselves.

Of course, there are a number of ways of doing this. The Scandinavians, for example, did not really go out and find all the evidence for themselves; they just decided that investment in early years was the right thing to do and put a lot of money into early years and childcare. However, because we in the UK are not going to move to such a system overnight, we have to use what little money we have in the best way we can. That is why we need to use the evidence base and to pilot these things to an extent. It will take a bit of time.

At a UK level, the sure start programme, which came from an American idea, was pretty successful to begin with—indeed, it was so successful that it was lauded and wanted by many. As a result, it was very quickly rolled out to many more people than had been originally envisaged, which meant that there was less money for each child. The subsequent evaluation then concluded that the scheme was not working as well as it had been. Of course, that was because it was not working as it had been originally intended to work; initially, it had been targeted at certain communities and individuals. The point is that this is not just about the evaluation; politics also comes into it. It is about ensuring that the people who are supposed to get the most out of such an approach do so, and that they get enough money for it to make a difference.

Professor Deacon: The issue of evidence is hugely important. Of course evidence matters but we need to unpack a few things about our approach to it. For a start, there is no such thing as an exact science. Evidence is constantly being debated and disputed and I worry that, while we get lost in a debate about the evidence, we take our eye off the ball and do not just get on and do things in the meantime on the basis of our best judgment and the best evidence available.

For example, in the debate on the alcohol legislation, we got lost in a big dispute about the validity of the evidence and so on while most people out there were saying, “Can you not just agree and get on and do something about this?” I know that there were other factors at play in that respect but I think that it is important not to get lost in a debate about evidence—or indeed to treat it, as we often do, as a proxy for action. Just because we are gathering or analysing evidence, we feel as if we are doing something; indeed, we can also use it as an excuse for not getting on and tackling big complex issues by using our best judgment and being informed by whatever evidence exists.

That brings me to my second point, which is about acting on the evidence that we have. In my early years report, I tried to push that message very strongly by consciously not rehearsing the reams of existing evidence, whether it is from Heckman, who has already been mentioned, Perry or—closer to home in Scotland—Suzanne Zeedyk and Harry Burns. We are just stacking up and repeating lots of this evidence, which simply reinforces an awful lot of our innate knowledge about the importance of childhood—even though, almost with each passing day, we understand it better and realise that it is even more important than we thought it was.

Acting on the evidence is a huge issue. My primary concern is that we need to move on from gathering information. I used the parallel of lung cancer. We no longer have heaps of conferences to debate whether there is a link between smoking and lung cancer. We crossed the Rubicon and accepted that there was such a link quite a while back. That does not make public policy decisions simple, nor does it mean that, as individuals, human beings will not do something that they know is not very good for them. However, the point is that we do not spend a heap of time debating and rediscovering that link, which is what we are doing on early years and an awful lot of wider preventative work with older people, for example. We are constantly convening conferences and commissioning reports that just rediscover and re-rehearse the existing evidence.

My exhortation is that we should act on what we know. By all means, let us continue to develop our understanding, but let us shift the balance from analysis and evidence gathering to taking action.

11:45

Professor Bell: I must admit that I have a lot of sympathy for the just do it approach. I completely agree with Susan Deacon—I attend many meetings at which we just go round and round in circles.

John McLaren talked about getting evidence from elsewhere. We do not have to have evidence on the applicability of policies to Scotland per se if we can make a plausible argument for their use, but I offer a word of caution. With a different hat on, I am very much involved in the youth unemployment debate. There has been a big discussion about what are called active labour market policies, particularly those that were introduced in the 1980s, which were meant to improve the working experience of young people. Looking at them 20 years later, with the benefit of time having passed, the consolidated evidence on all those is that they made no difference whatever to the outcomes for young people, so we need to be a little bit careful about assembling the best information set that we can before we proceed with something. That said, I am in favour of the just do it approach.

Dr Gibbins: I very much agree with colleagues. Evidence is important, but we use evidence in quite cavalier ways. An 18-week maximum wait for an operation is now accepted orthodoxy, but where is the evidence that having a period of 18 weeks makes any difference to health outcomes? I agree that the important thing is to get on with what we know now and to accept that the preventative approach is the right one. However, we should not leave it there. It is important to learn as we go and as we act. It is critical that we learn and that we build on that learning. As we go forward, let us build up a body of knowledge on what works and what makes a difference in Scotland so that we can continually improve what we do.

Fiona McLeod: I just want to ensure that I have understood what everyone is saying. I will use a health analogy. Randomised control trials are the gold standard for clinical trials, but they are not applicable across all clinical fields. I had to wrestle with that as a health librarian. Are you telling us that there is no gold standard when it comes to evidence for preventative work or integration, and that there are times when we must go with our instincts, stop drilling down and just accept that the money has produced the outcome that was desired?

The Convener: Can we have short responses, please?

Professor Deacon: Yes.

Professor McLaren: There is a gold standard—it is the one that you mentioned—but it takes an awful long time to get all the evidence that is needed, so it is necessary to pay attention to the evidence that is there. When there is enough evidence, whether on climate change, youth unemployment or whatever, it is necessary to act or we will not solve the problem.

Dr Gibbins: We cannot wait until someone works it all out and tells us that it is an absolute because there is no such thing. We know enough about the preventative approach and the communities and families that public services are continuing to fail in Scotland to act, so we should get on with introducing the interventions, learning as we go so that we improve the lot of those communities.

Professor Bell: I agree.

The Convener: As there are no other questions from committee members, I thank the panel very much for their time. I am sure that, as well as being interesting, their evidence will be useful to us in our inquiry. Thank you very much.

I suspend the meeting briefly to allow the next witnesses to take their seats.

11:50

Meeting suspended.

11:56

On resuming—

The Convener: I welcome our second panel. I apologise for the wait that you have had, but I am glad that you were able to join us semi-informally and have a coffee. I welcome Sir Harry Burns, the chief medical officer, and Graeme Dickson, who is director of health and social care integration for the Scottish Government. Thank you for your time this morning.

We will move directly to questions.

Bob Doris: I also apologise. I think it is the caffeine that is keeping us going into the afternoon. The members of the Health and Sport Committee have their addictions.

You heard quite a lot of the earlier session, so you will have seen that, as that session went on, we stopped talking about the cash spend in real terms or what it should be. Such debates often absorb politicians in a party-political way, which is understandable. We are scrutinising the budget's outcomes and how it makes a difference—we are

not just talking about the cash. Preventative spend has been a core part of that discussion, and £500 million to focus on that has been announced as part of the budget. A variety of other initiatives have trickled out during the past year or so, such as family-nurse partnerships. As we scrutinise the budget, its possible outcomes and the announcements that have been made, where do you think the most useful starting point is?

Sir Harry Burns (Scottish Government): I was struck by the discussion on measurement and the things that we should be monitoring. Academic activity centres around analysis. For example, did a decision that was made five years ago work? Was it helpful?

It is important to start collecting data on outcomes for improvements, things that are timely, things that are happening now and things that will allow us to change. One of the lessons from the Scottish patient safety programme is that if something is measured in real time, it can be influenced and changed. What was done yesterday can be modified by yesterday's outcome and something different can be done tomorrow.

One of the first things that we should look for is an information system that allows the entire public service and third sector system to respond rapidly to what is happening. Five years from now, we do not want to be looking back and saying, "Ah well, we should have done that a wee bit better", or that we could have saved X lives or prevented X number of children from having a difficult and dangerous childhood. We want to know now, so the first thing that we need is timely information. I have some ideas about how we might get that—we can come back to that.

12:00

Secondly, the committee knows about my focus on early years. If we get that right, we will have significant effects on the whole life course of future generations of Scots. The first sign that we are getting things right, and the first thing to measure in a child's life, is birth weight. The single most important influence on low birth weight babies that can be modified is maternal smoking. I am not saying that we should tackle maternal smoking per se; I think that we should tackle the whole nurturing environment during pregnancy and teach young girls who are pregnant to begin to nurture their babies very early on. If we get pregnancy right, we will begin to see an increase in birth weight.

The single biggest avoidable cause of death in the first year of life is low birth weight, so if we see an increase in birth weight, within a year we will see a fall in infant mortality. We currently have the lowest infant mortality of the four UK countries, but the rate is still twice what it is in Norway and Sweden. Let us give ourselves the objective of getting down to Norway's levels, and nurturing pregnancy and the first year of a baby's life will help us to achieve that objective.

In the next stage, we can begin to talk about what we discover at the 24-month health visitor visit and the assessment of development. For example, we discover who has developmental delays. Susan Deacon mentioned EDI, which is about readiness to learn, socialisation and so on at age five. We could see all those markers going in the right direction within five or six years.

If we get things right and see those markers moving in the right direction, we know that there will be less criminality from those children as teenagers. Children who experience four or more adversities—by "adversities" I mean things such as physical abuse, neglect and parental mental illness—are eight times more likely to become alcoholics as adults. Boys who experience physical abuse are eight times more likely to beat up their girlfriends. That propensity develops within the first 18 months or two years of life. If we get things right during that period, we will begin to see significant changes by the time that the children are teenagers.

I am talking about a set of processes: if we put in the processes, there are markers and milestones that can identify progress.

Bob Doris: I am getting a sense that we are starting a process. This is the first year on the Health and Sport Committee for the convener and me—we were on another committee—although I know that other members were on the committee in the previous session. We are therefore looking at cash inputs in health for the first time, and we want quickly to look at qualitative outputs to see whether the cash inputs are working. It does not help if we double the budget for something that is not working: we are just wasting our money. I plead some ignorance as I do not know in enough detail whether the Scottish Government has set the output targets so that we can identify the cash that has been put in to achieve them. Where are the Government's output targets on birth weight, mortality or smoking cessation? Is there a clear set of HEAT targets on those issues?

Sir Harry Burns: We are in the process of discussing targets. The things that are measured are the things that we are talking about implementing. If we are going to set targets, we have to agree with the system about the action that will be taken to deliver them. That is a complex issue because the clear evidence is that we are much better off working with communities rather than telling people what to do to deliver on the targets.

There is no doubt in my mind that we have the evidence that would allow us to suggest the best way to achieve the targets. It is a question of, once we sit down with the early years task force, agreeing with it what suggestions we will give the system on how it agrees and delivers the targets. The early years task force has not yet met, but it will do so soon.

The Convener: Mr Dickson?

Graeme Dickson (Scottish Government): I do not want to interrupt the discussion about younger people. I was going to cover older people, but we can come back to that if Mr Doris wants to continue.

Bob Doris: I want to finish off my line of questioning, because other committee members want to come in.

We invariably come back to cash figures, because that is the reality of budget scrutiny. Sir Harry mentioned positive health outcomes at the local level, which Professor Deacon is also very keen on. I visited a fantastic healthy living centre in Rutherglen and Cambuslang, which is doing a great job thinking about grass-roots solutions.

I look at NHS Greater Glasgow and Clyde's budget of £1.941 billion and wonder where the direction comes from and how it filters money down to the local level. Are we moving towards some accountability for how the money is spent, and towards serious devolved management of resources to the very local level, so that it is not chief executives of health boards and heads of department but community organisations that decide on preventative spend?

Sir Harry Burns: I certainly hope so. When Susan Deacon was speaking I thought back to when she was Minister for Health and Community Care and I was the lead clinician for cancer. In order to transform cancer care in Scotland, she kindly gave me £20 million over two years—or £25 million over three years. In terms of the total budget for cancer, that was a drop in the ocean, but we used it to leverage a whole load of changes around the system. A small amount of money at the margins can have a very powerful impact in changing the way that a system works.

The question is who gets the money to spend. If it goes into a health board's budget, it might never emerge in any recognisable way. If it is given to people on the front line to leverage change, we will see the impact. We gave the money to the clinicians, who appointed nurses and so on. The managers got very spooked by that, because they were not in control of the money, which is precisely the point. Giving money to the front line helps to leverage change.

Bob Doris: I have a very brief supplementary. There is £500 million for preventative spend, the change fund and so on. Are you suggesting that, rather than directors of health boards and chief executives of local authorities coming together to agree how that money is spent—and so filtering it through the bureaucracy—a portion of the £500 million should be bid for directly by the voluntary sector and grass-roots organisations for agreed outcomes?

Sir Harry Burns: Absolutely. I do not think that I would get into bidding for the money. I would give it to them and trust them.

The way that you change a complex system is, first of all, to destabilise it. It sails along doing what it always did and you have to give it a reason for changing direction. We destabilised the cancer system by giving the money to front-line clinicians. Suddenly, they were able to do things that they always knew they should do but which management was always a bit reluctant to let them do. I think that there is a clear parallel here. I have looked closely at the way that the third sector works in changing people's life chances. It is much more effective than a statutory organisation, which works according to protocols and is risk averse and so on. We should use the inventiveness of the third sector much more effectively.

The Convener: The evidence from the third sector is that it does not have access to the change fund. Half of it is already with the health boards and local authorities, and third sector organisations do not feel that they are in any way equal partners in determining where the other half would go. As the budget is presented, and when it comes to health board allocations, there is no solution to that problem. Your ambition, which is probably also the committee's ambition, cannot be met as the situation stands.

Sir Harry Burns: I cannot predict how the change fund will operate in practice, but I am in no doubt that the future lies in a much closer alliance between third sector and statutory organisations. Third sector organisations have a model of change that transforms the lives of the individuals whom they deal with. At best, statutory agencies offer—through a 10-minute appointment with a general practitioner, an appointment with a social worker or whatever—something that is less than a transformative relationship. Both sides must learn a bit from each other, but statutory agencies in particular must learn from the third sector.

The Convener: Mr Dickson offered to speak about elderly care, which interests the committee.

Graeme Dickson: I will address the point about the third sector first and then speak more generally. As you know, we have had a change fund of £70 million this financial year to reshape

older people's care. The evidence from the Scottish Council for Voluntary Organisations alludes to the fact that third sector organisations feel frustrated that they were not full parties in that process. That is a pity, because I agree with Harry Burns that such organisations are a good force for change. That is one reason why we said that third sector partners had to sign off each change plan from the 32 partnerships. The third sector is an equal partner—if such organisations have not signed the documents, the money from the fund has not been released. We will follow that up with third sector organisations and find out how they can be more embedded for future years.

Bob Doris asked about outcomes. The approach to older people concerns two main outcomes: keeping people at home or in a homely setting for as long as we can; and ensuring that, when people require admission to care, the care is as good as possible. As the committee will have seen from the Scottish Parliament information centre briefing, what drives the first issue is tackling the fact that we spend about a third of the budget for health and social care for older people on emergency admissions to hospital. It is clear that, on plenty of occasions, it will be correct that somebody needs to go to an acute hospital, but general practitioners tell us that they would like alternative ways of looking after people who do not need to be put into a big acute hospital, particularly if they have dementia.

For the first year, six national outcomes were agreed with partnerships. We will continue to develop them for next year's change fund. The outcomes include decreasing emergency in-patient days for older people, increasing the percentage of people who live in housing rather than care homes, reducing delayed discharge and increasing the percentage of the last part of somebody's life that they spend at home. The outcomes are fairly clear and have been agreed with most parties—that is the approach that we want to take.

The sixth bit relates to the user and carer experience. As part of the community care outcomes framework, we have collected views in that regard over the years through the talking points approach. The problem is with aggregating the view of a user or carer into something that can be presented as a statistic, but we want that to be part of the outcomes framework.

Jim Eadie: I was struck by what Sir Harry Burns said about giving money to the front line to leverage change. The change fund has a valuable opportunity to do just that.

My questions are to Mr Dickson. In determining how the change fund is distributed throughout local authorities, is weighting given to the regulator's scoring for projects that provide care for older people? Anecdotally, I know that a very good project in my constituency with a very high rating from the care inspectorate is struggling to find the funding to maintain a service that is hugely valuable to the community. I am interested in whether weighting for projects that the care inspectorate recognises are performing well is factored into the decision-making process.

I know that it is early days and that we are going into the second year of funding, but how will you evaluate the impact of the spend that is made?

12:15

Graeme Dickson: On the first question, the allocation is made to health boards on the basis of the NHS Scotland resource allocation committee formula and is then apportioned to their local authority partners, if they have more than one, using the grant-aided expenditure formula. There is nothing specific in the amount of money set to go out to them, but clearly the partnership can take into account any other factors it wants. If there is a particularly good project in the area, you would hope that the partnership would take account of data other than population-type allocations to choose which projects to invest in.

Sorry, your second point was—

Jim Eadie: Can I stay with the first point? That is a very helpful answer, but it rather underlines my concern that good, well-performing projects are perhaps not being prioritised over those that are not performing as well. Is there anything that can be done to address that?

The second question was about what metrics and measures will be put in place to evaluate the impact the change fund is having and how well it is performing.

Graeme Dickson: On the first point, although the national allocation does not take account of such things, a local partnership would, I hope, take account of other data when deciding what projects to fund with its share of the £70 million.

Jim Eadie: Right. I think you can see where I am heading.

Graeme Dickson: Yes.

Jim Eadie: I wonder whether the Scottish Government could highlight that issue to those who are involved.

Graeme Dickson: Do you mean in the guidance that we issue? Yes, that is a very helpful suggestion and we will take it on board, thanks.

On evaluation, as I said, we have some improvement measures and we have asked each of the partnerships to report against those measures towards the end of the year. We are

also discussing how we can put in place a more formal and more academic evaluation of the fund, perhaps jointly with the two new change funds. We will put an evaluation in place.

Dr Simpson: I am really concerned about the reality out there, which is that the third sector is hurting—and hurting badly. Epilepsy Scotland has had its expenditure on staff cut by a third. We are not talking about the third sector tolerating 3 or 4 per cent cuts, but massive cuts. To talk about partnership and so on seems to me to be extraordinary, as that is just not happening.

Let us take the early years to start with. I have heard everything you have said over the years, Sir Harry, and I do not disagree with any of it, but last year we cut the intake of midwifery students by 40 per cent. Why? Because we cannot employ the midwives when they come out. Why not? Because the boards are making decisions that are different from those that you are advising us that they should be taking. When we think about pregnancy, it is important to consider smoking, nutrition, mental health wellbeing, the avoidance of drugs, tackling alcohol problems and ensuring that people have reasonable parenting skills. This is not rocket science, yet we have a huge variation in the number of midwives. Dumfries and Galloway has double the number of midwives that Lothian has. I think the social problems in Lothian are substantially greater, but there are twice as many midwives per birth in Dumfries and Galloway. My real interest in this budget is the variation. If we put funnel plots on almost everything and tackle the outliers, we could achieve a lot, but although I hear what you are saying about the third sector we are not joining those things up. Those are just some examples.

Sir Harry Burns: One reason why these variations occur is that we do not have a consistent, timely way of measuring the impact. Variation is essential—but variation based on need, not local decisions that are made about where money can be saved most easily.

The patient safety programme has shown clearly that, if you get focused information around a series of evidence-based interventions, they will change. It has also shown that health boards, hospitals and individual units can be held to account—I do not like to use that phrase in this context, but that is the reality—for variations and that the system will respond to evidence that they are not performing.

The real failure—I hold my hand up in this regard—is that we are only beginning to realise that it is possible to have a timely information system. It will take quite a significant change in behaviour across the system to get a timely information system around population health improvement, as that does not lend itself naturally to the kind of information system that is used in relation to long-line infections in intensive care units. However, we have to achieve that change, and I have some ideas about how we might do so. I am not aware of any other place that has that kind of information system, but other places might be able to help us with bits of it.

We are having to generate some new thinking around this area. However, as you know, my view is that this is the biggest show in town. It is the most important thing that we can do in our society, and it is really important that we get ahead and come up with something that makes explicit failures in local systems to tackle problems.

Dr Simpson: I entirely agree with you. If clinicians are given the information that they are underperforming or are taking risks with patients' safety, they will change their behaviour. That is true of almost all of them—the ones that do not change need to be held to account. Most clinicians would want to change if they were given information that suggested that they should.

For example, smoking is of critical importance with regard to low birth weight. Dundee had the worst figures in Scotland for smoking, so it introduced an innovative system with vouchers and now it has the best figures. However, as far as we can see, we are not going to have that system across the rest of Scotland.

On one hand, there is variation. On the other, there is the need to ensure that good, innovative practice is transmitted to other areas and that people do not simply say, "It wouldn't work here", or, "I'm not really interested". How do we drive that through the system? What incentives should a budget provide to ensure that a change or innovation is spread in order to reduce inappropriate variation?

Sir Harry Burns: To go back to the experience with cancer, there was variation in the way patients were treated across Scotland. In the west of Scotland, we introduced a managed clinical network for breast cancer and the 10-year follow-up study that we conducted showed that its introduction had a substantial impact on long-term survival rates. However, at the time, lots of clinicians said, "Oh, we don't do it that way." My response in Glasgow was, "If you don't do it that way, you don't do it at all." We were very firm with them. Through having people who took an interest in the issue and were prepared to respond to evidence, audit themselves and discuss cases in real time, we created the multidisciplinary team approach and improvement occurred. We have to create the same kind of thing around population health improvement. If people are not prepared to adopt what appears, according to the evidence, to be the best practice, we have to move on and get in other folk who will do it. We cannot have people

ignoring the fact that the evidence says that they should change.

We should be looking at having five or six strongly evidenced interventions across Scotland that we can compare for consistency, and we should design them to allow people to discuss why their area is inconsistent, if that is the case. If it transpires that there is inconsistency because, for example, the service is better delivered by a voluntary sector organisation than by a health board, that is what needs to be done, and people have to take that on board. My hope is that people would see sense and support the voluntary sector where that is the best way to deliver the service.

Dr Simpson: I do not want to hog the questions but I have another example: day surgery, on which we have had targets for 10 years for 17 procedures. Fife NHS Board achieves the targets whereas, next door, Tayside NHS Board has 20 per cent achievement. That is 10 years on from the targets being set. There must be institutional barriers that need to be overcome to achieve what you want to achieve.

Sir Harry Burns: Part of that will be to do with case mix, I think.

Dr Simpson: Yes, but the figures go from 20 per cent to 70 per cent.

Sir Harry Burns: I would need to think hard about what the differences are.

Dr Simpson: That was in an Audit Scotland report from two or three years ago, so it might be slightly out of date. However, there was huge variation.

The Convener: To return to Richard Simpson's point, which we raised with the other panel, how do we use the budget process, through the questions that we ask and the issues that we focus on, to assist in achieving your and our ambition to have a life-changing influence on deprived people? Is it about having a greater focus on priorities and certain groups? Should the change fund be spread thinly across Scotland or should it be focused in certain areas? Should there be a focus on early intervention, rather than having a big list of desirable things that we can claim credit for here, there and everywhere? How do we use the budget process to focus on that activity and overcome the barriers?

Sir Harry Burns: Ultimately, there is a need to adopt a life-course approach. Intervention needs to occur at different points in the life cycle. Health inequalities in Scotland are widest in the 35 to 55 age group. The biggest inequalities are among people of working age, and the origins of much of those are in the early years. My priority would be to focus as much as possible on the early years. In five to 10 years, we will begin to see significant benefits and can begin to let investment flow through the age range.

In relation to the other end of life and the health and social care change fund, we absolutely need to focus on whether people are cared for in an appropriate setting, but I would invest some money in preventing 50 and 60-year-olds from becoming dependent elderly people. Let us get weight management, physical exercise and other measures out there to prevent people from developing chronic ill health. We can do that throughout the life course, but the evidence on the impact of chaotic early years in creating adversity throughout life is stark. We are a long way off getting it right. I will advocate strongly that we should focus on children.

There is an issue about universalism versus targeting, but services need to be available to all. Just because somebody lives in a rich area, that does not mean that they do not have domestic violence or alcohol abuse in the family, so that help needs to be available. However, the reality is that we would tend to spend more in more deprived areas. We should be content about that.

The Convener: How do we ensure that the health boards, which are under all sorts of pressures, will ensure that the money is spent on those areas? How do we drive that money to follow that ambition?

12:30

Sir Harry Burns: We must identify the children and families who need it. That means a different approach to data. There is no question in my mind but that the right thing to do with data is to use it relentlessly to benefit the people whose data it is. Too often, the system out there is nervous about linking up data. If not linking up data means a dead baby, that is a system failure. We need to be much more innovative in the way in which we link up data while preserving confidentiality and so on. There are ways in which we can do that, but we need information systems that surround individuals. We need data systems that can pick out children who will be in trouble. We need information systems about their social circumstances—specifically their family—and their locality or local social capital. We need information about all those aspects and we need to be able to find ways of using it to target.

EDI was invented in Canada, where the score is allocated not to the child but to the area that the child comes from. That allows them to say, "Here are three or four streets where there is particular evidence of poor socialisation and educational development, so we need to focus on that area. Within that area, we've got other evidence that says that, in these families, there's drug abuse

and criminality. That allows us to focus even more. In those families, there's a new baby on the way, so we need to focus even more strongly on these individuals." Tiering information in that way allows us to begin to hold not just statutory agencies but the third sector—the whole system—to account for the benefits that we might see.

The Convener: Does that prevent people from just getting on and doing things?

Sir Harry Burns: No—we just do it.

The Convener: But we know the areas in Inverclyde, for example, that are most deprived, do we not? It is where people do not live as long, young women get pregnant early and smoking is prevalent. Even I, as an old boilermaker, know that.

Sir Harry Burns: You know the areas, but you probably do not know the families. You will have a good guess with some of them—

The Convener: I know too many of them, but that is beside the point. We know the areas geographically and en masse. If we targeted them, we could get to many of the families—not 10 out of 10 of them, but eight or nine out of 10.

Sir Harry Burns: But the aspiration is to get to 10 out of 10 through the data. We can describe localities in great detail and have been doing so for about 10 years. However, we need to get in and target the individuals—I do not like the word targeting, because it involves the language of doing things to people rather than doing things with them, but I am not sure whether there is a better word. Who is it that we support in developing a nurturing approach to babies? We need to get 10 out of 10 because to fail one is a disaster. We need to do the best we can for every single child born in Scotland. That must be the aspiration.

Patient safety was a kind of cottage industry that junior doctors did. They reviewed, for example, five years' worth of gastric cancer cases, and it was more about their career than about improving health. What made the difference was when Don Berwick stood up and said, "If we get this right we will save 100,000 lives in America." He did it in a year and a half. We need a big aspirational goal for what we are trying to do. We need to set ourselves that kind of goal. We need to tell health boards, local authorities and so on that they are part of the package and that it is their goal that we are setting. The goal needs to be 10 out of 10.

Jim Eadie: If I understand you correctly, you are saying that it is not enough just to identify where the deprived communities are in Scotland. As the convener said, I think that we all know that. You are saying that we need to drill below that to find out the streets where the people who are most in need live and find more specifically than by postcode area the families who have problems. I understand that there is neighbourhood survey data that would allow us to do that now. Why are we not using that to target funding? If we cannot use it, do you have a specific proposal that might move us to where we want to be?

Sir Harry Burns: We need a much more sensitive indicator of the individuals and individual families who need this funding. You cannot simply assume that people who are poor and live in a bad house are bad parents and that people who live in a £2 million house in a good area are good parents. On average, you might be right but, if you are to target your resources most effectively at the right people, you will have to be much more specific.

Of course, you will also want to know whether you are achieving things. We have the capacity to do that in Scotland through our record linkage system, but the fact is that you need to be able to follow these children up. For example, with the debate on sectarianism in football, I got a phone call from a neurosurgeon, who told me that he and his colleagues had been collecting information on head injury admissions in their patch and had found that such admissions increased whenever there was a particular football match. When I went to talk to them about it, the psychologist present said, "One of the really sad things is the number of babies and children admitted with head injuries." I thought to myself, "What?" "Not only that," the psychologist went on, "Some of them were admitted more than once." If that is happening out there, I want to know that social work, the police, the education system and so on are all involved in dealing with it. However, we have no way of linking up all that activity and we need to be very person-specific to ensure that we are managing the system appropriately. That can be done.

Nanette Milne: Are you not advocating what might almost be described as back-to-the-future practice-based health visitors who would follow families closely? I know that, when my husband was in practice, doctors would have informal conferences with health visitors, who would say, "I'd like you to go and see so-and-so. There's a problem with the baby." That strikes me as a good approach.

Sir Harry Burns: You will know about the current controversy over community and practice-based nursing. The critical point is that the two sides need to talk. For example, I know of a system in Rotterdam that ensures that professionals who deal with children can share concerns without having to hold anyone's information on a central computer. A teacher might say, "I'm a bit worried about that kid"; put the name and community health index number—or

whatever the Dutch equivalent of the CHI number might be—into the system; and then be linked up with anyone else who might have expressed concerns about the child. They would get a phone call from a social worker, policeman, general practitioner or whatever and a conversation could take place just on the basis of concerns. There are ways of doing this but you are absolutely right: information sharing is fundamental to identifying who needs most support.

The Convener: I am sorry to go back to this, but the question is whether the budget aids your ambitions in that respect. Does the budget support the development of that kind of information exchange? Will it help to make such exchanges easier? Will it allow investment in the information technology that could lead to record sharing and so on?

Sir Harry Burns: Absolutely. If we could change the pattern of cancer care in Scotland with £20 million 10 years ago, £500 million will certainly help us to leverage change into this system now. If you are asking me whether we could do more with £1 billion, my answer is that I do not know.

The Convener: Perhaps I was communicating poorly. I was trying to ask whether there is enough focus to ensure that the £500 million will go to dedicated areas and be spent wisely. Will the £500 million be retained by health boards, which are under pressure, instead of being invested for the future? Is there enough significant investment in information technology, given that the IT budget has been cut, to build a records system that will meet your ambition on exchanging information?

I am not making a political point about the budget. All members with an interest in health accept that health has been given a larger share of the budget than any other sector has been given. I am asking whether the budget, as it is set out, will enable you to meet your ambition, which we share.

Sir Harry Burns: A sum of £500 million is enough to get the attention of health boards, voluntary agencies and councils. How we then use it will be down to the ingenuity of the early years change fund, the health and social care change fund and the system out there. The answer is yes, we can do what we want to do with £500 million, but we need to be very clever in how we use the money. Next year we can have another talk about the matter and see whether we have been clever enough. My aspiration is to be very clever and very focused.

Richard Lyle: I am getting very concerned. I worked with the Convention of Scottish Local Authorities, and when we took away ring fencing and gave councils money they still went and did what they wanted to do. I think that you would be chasing the £500 million.

Information gathering is good. We have district nurses, health visitors, doctors, the housing department, social workers, councillors and politicians—we have the best information we can get. With the greatest respect, if you collect more and more information, with all the IT costs, you will get bogged down in information.

I agree that we want to make people's health better and share information, but do we honestly allow health boards to do their own thing? That is what we seem to be doing. Do health boards not share good practice, as some councils do by going along to a national organisation? We heard this morning that one board has just woken up to something that another board did 10 years ago.

I am coming on to a hobby horse of mine, which you likely heard me mention earlier. Do you honestly think that we should consider reducing the number of health boards in Scotland, even though that will involve a transitional period? I am just setting down a marker; I am not suggesting that we conduct root-and-branch change tomorrow.

I am concerned about what you said about the £500 million. Given all the pressures that we have talked about, to go and spend it on information gathering would be a waste of money.

Sir Harry Burns: No, no. We are not going to spend £500 million on information. The fundamental thing that will drive change is knowing what is happening to children, and the fundamental problem with the existing system is that the individuals that you listed do not talk to one another—some of them do, but most do not. We do not handle information about children well, and we need a better approach.

We are talking about targeting the families who need support and monitoring what has happened to the £500 million. The £500 million should be spent on the services that the families get. You misunderstood what I said. I am not sure what the IT budget is for the Scottish system, but it will not be a hell of a lot more than £500 million. That is not what I was talking about. The system that I was talking about could probably be set up for about £10,000. I point out that when the World Health Organization ranks countries on how they look after children, the Dutch are perennially at the top of the rankings, so borrowing some Dutch thinking and technology would probably not be a bad start.

As far as health boards are concerned, I am with Susan Deacon. The change fund is a distraction. At the moment, the pressure to get the system right is huge. I do not think that we have time for me to give the committee an anecdote

about system change, but it is a distraction. England is going through its reorganisation just now and the eye is completely off the ball. The English have to save a lot of money and they will not achieve that, because managers are worried about their jobs. In the longer term, we need to get the show on the road and fix the population's health.

12:45

The Convener: You have stunned them all into silence.

Graeme Dickson: I hate to interrupt the chief medical officer when he is on a roll, because he is very entertaining as well as being informative.

About half of the change fund is going to the older people side, which already has good information systems in place. We know that there is massive unexplained variation across health boards and local authorities. Work that was done by the Social Work Inspection Agency showed that, depending on where someone lives, they are twice as likely to go into a care home as they are to get care at home. That is completely unrelated to spend or to services. Addressing that issue through joint working between the health board and the council is one of the main aims of the change fund. Everyone knows that they must rejig their services, but they have been too busy running up a down escalator to take the time out to do it.

Seventy million pounds is a small amount when compared with the total budget, but when people across the system are asked about the first year of the change fund, they have welcomed it as an opportunity to do something different to make the service better and to stop doing what they have always done. To support them, we have put assistance from the joint improvement team into all 32 partnerships. We bring people together—we are holding another session this Friday—to share best practice and we ensure that people learn from that best practice.

If members want to come back to talk about telehealth, I can talk about that too.

Richard Lyle: Why is there variation across the country? Why can we not have a standard that everyone must follow to ensure that everyone in every part of the country gets the same health provision as everyone else? I am sorry that I annoyed you earlier, but are we not telling health boards what they should be doing and ensuring that they are doing it? Is that a factor? I do not want to be dictatorial, but we should be advising health boards on what they should do and ensuring that everyone in the country receives the same provision.

Sir Harry Burns: You are right; I agree. We need to wring that variation out of the system. However, one of the reasons for the variation relates to the earlier discussion about evidence. In matters such as health improvement, it is difficult to do randomised controlled trials as we do when a new drug comes out. When a new drug comes out, we do such a trial and what needs to be done with that drug is as plain as the nose on your face, so that we can say, "In these circumstances, we will use that drug."

If we put 20 public health folk into a room to look at a series of health improvement interventions, I am not saying that we would get 20 different answers, but there would be a number of different interpretations of complex information. I return to the point about just doing it—if something looks as though it will work, we need to have the courage of our convictions to move ahead with it.

This week's *The New England Journal of Medicine* describes an interesting randomised controlled trial in America, which shows how difficult such trials are to do. In a randomised controlled trial of housing benefit, a third of single mothers received no housing benefit, a third received a voucher to give them housing benefit, and the final third received a voucher to give them housing benefit on the condition that they moved to a better neighbourhood. Try doing that in this country! After a five or six-year period, the third group—the group that got the housing benefit and moved to the better neighbourhood—had a lower body mass index and lower indicators of diabetes risk. If the women moved to a better neighbourhood, they were healthier than the folk who received the same amount of money but stayed in their old neighbourhood.

That is the kind of study that the Americans can do. We cannot do that, and it would be grossly unethical by our standards. However, unless we have that kind of data, we often struggle to get consensus. Part of my role is to get the best possible consensus and then—you are absolutely right, Mr Lyle—to say to health boards, "If you do this, you will get X percentage benefit in the children that we have identified, so get on with it and do it." I therefore agree with you.

Graeme Dickson: At the other end of the age spectrum, we track the provision with health boards. It is a slightly different issue with local government, as it has democratic accountability in its area and historical patterns of service. However, the NHS also has historical patterns of service. You heard from both Professor Deacon and Roger Gibbins about the time that it takes to shift from fixed provision into community services, to get new places up and running in the community and to convince the local population that it is good to disinvest from the beloved local

hospital. Boards are being forced in that direction, but it will not be an easy or rapid journey.

Mary Fee: I raised the commissioning and procurement process with the previous panel, and I will ask you both the same question. What, if anything, can we do to strengthen that process? I am thinking in particular of the way that procurement can disadvantage third sector organisations, which have suffered disproportionately through cuts. Private sector provision of care and services across areas can vary dramatically from a higher to a lower percentage, and the third sector fits in somewhere in between. The third sector is well known for providing the highest level of care. Can we use the commissioning and procurement process to level out care provision? What can we do to support the third sector to get a bigger share of the pie?

Graeme Dickson: I will give you the same answer as Roger Gibbins gave, which is that we need to get people better at strategic commissioning, which is joining up and deciding the services that they want to deliver. The particular issue at present is around local government procurement of services, and I know from hearing directly from community care providers that they are concerned that they are being targeted disproportionately. However, locally elected members take the decision on how to conduct their procurement. We have provided some guidance on good practice in procurement as part of our help for joint working, but in the end it is up to a local authority to decide how it procures its services.

Sir Harry Burns: I think that it comes back to the issue of measurement. You have to know what you are commissioning and what the outcome will be. The problem has been that third sector organisations have done extraordinary things but they are never counted.

One of my favourite third sector organisations is a theatre group called Theatre Nemo, which works in prisons with young men, usually with a violent history. The first time that I went to see its work, the deputy governor of Barlinnie was there and said, "I'm here to tell you to listen to this lady. She changes lives." The question in my mind is: can we demonstrate the change in life brought about by such an organisation? The theatre project gets the young men to tell their stories in ways that they have been unable to do. It enhances their self-esteem, and it appears that they are therefore far less likely to reoffend. Who is counting that? It will be important in aiding the commissioning process to return to the point about measuring in some way what individuals experience as a result of investment in the system. If the theatre project was having a bigger impact than a standard social work appointment, I know where I would put my money.

Dr Simpson: I have a brief question on e-health. The new proposals have effectively fragmented the budget. The money is now being handed to the health boards, which will be allowed to do what they want, presumably within certain guidelines—they are required to go on to clinical portals, for example.

I have always understood that we should not go for a £12 billion central records system, so I entirely approve of what you have said about that. However, I am concerned that we are now fragmenting the budget. We seem to have given up on any possibility of the centre holding the reins to the extent that will produce the information that you want.

That is perhaps exaggerated, but I am concerned that we are moving in the wrong direction. We have not been very successful with our central organisation—the group expertise has been very poor in the central department, and there are real problems in that regard—but to fragment the budget among individual health boards seems to be courting disaster.

Sir Harry Burns: I am not familiar with the budgetary arrangements for that particular programme, but members can rest assured that I will be trying to claw back much of that to ensure that we are collecting the right data to allow that type of change to take place.

Infant mortality in Scotland currently stands at 4.1 deaths per 1,000 live births in the first year of life. In three years' time, I would want that figure to be reduced to 3.5 deaths. What will health boards do to deliver that? I can tell them about six or seven things that they can do. How will they measure the progress? They must get the systems in place to do it. That is the type of approach that we need, and we say that to all health boards, although the smaller health boards always have big statistical variations.

Richard Lyle: They do not listen to you.

Sir Harry Burns: I can shout loud.

The Convener: Ignore the heckling from the side, Sir Harry.

Nanette Milne: Perhaps Mr Dickson might come back to telehealth, as I wondered what he was going to say. I was particularly taken with Susan Deacon's response to my earlier question.

Graeme Dickson: I was going to say that 18 months ago, we moved the Scottish centre for telehealth into NHS 24. I have now amalgamated with the telecare people in my directorate, and in NHS 24 we now have the only core focus in Europe—if not the world—on telehealth and

telecare. Those people are rolling out a number of national programmes, one of which involves high-definition videoconferencing.

I did not hear this conversation in person, but I am aware that when the Cabinet Secretary for Health, Wellbeing and Cities Strategy was doing the annual review in Orkney last week, one of the patients told her that in the past he had to travel down to Aberdeen to see a consultant, where he was told within about two minutes that he was fine and he could go back to Orkney. This year, he had been able to do everything by videoconference, and his entire clinical team was able to join in. We are getting there in rolling out the system nationally.

There are a number of projects around stroke and chronic obstructive pulmonary disease. I saw a great demonstration of the telestroke project in Lanarkshire, which links up consultants in the area's three acute hospitals so that they can make a diagnosis—even at night, from their own homes—by interviewing patients, doing a computerised tomography scan and deciding whether thrombolysis is appropriate. The system is less fragmented than it was in the past and is now being rolled out nationally.

Nanette Milne: That is encouraging. There is still a long way to go, but there is tremendous potential.

The Convener: I see that members have no further questions for the panel. I thank Sir Harry Burns and Graeme Dickson. That was an interesting and entertaining session—you brought us back to life.

As was previously agreed, the committee will now move into private session.

12:59

Meeting continued in private until 13:37.

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e-format first available
ISBN 978-0-85758-864-7

Revised e-format available
ISBN 978-0-85758-881-4

Printed in Scotland by APS Group Scotland