The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 1 November 2011

Session 4

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HEALTH AND SPORT COMMITTEE
9th 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:

Bill Alexander (Highland Council)
Theresa Fyffe (Royal College of Nursing Scotland)
Rhoda Grant (Highlands and Islands) (Lab) (Committee Substitute)
Melanie Hornett (NHS Lothian)
John Howie (NHS Health Scotland)
Matt McLaughlin (Unison)
Rachel Ormston (Scottish Centre for Social Research)
Gail Trotter (Scottish Government)
Joan Wilson (NHS Tayside)
Martin Woodrow (British Medical Association Scotland)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 1 November 2011

[The Convener *opened the meeting at 09:32*]

Interests

The Convener (Duncan McNeil): Good morning and welcome to the ninth meeting of the Health and Sport Committee in the fourth session of the Scottish Parliament. I remind everyone present, including members, that mobile phones and BlackBerrys should be turned off completely.

We have received apologies from Mary Fee, who is unable to attend this morning. I invite Rhoda Grant, who is here as her committee substitute, to declare any relevant interests.

Rhoda Grant (Highlands and Islands) (Lab): I do not think that I have any relevant interests, but it might be appropriate to draw the committee's attention to my membership of Unison.

Draft Budget 2012-13 and Spending Review 2011

09:33

The Convener: Item 2 is our second oral evidence session on the draft budget 2012-13 and spending review 2011, which will be a round-table discussion. I welcome our witnesses: Bill Alexander is director of social work at Highland Council; Melanie Hornett is nurse director at NHS Lothian; John Howie is health improvement programme manager for the keep well programme in NHS Health Scotland; Gail Trotter, from the Scottish Government's child and maternal health division, is family-nurse partnership national implementation lead; Joan Wilson is head of nursing and vulnerable children and families at NHS Tayside; and Rachel Ormston is research director at the Scottish centre for social research. Thank you all for coming. I look forward to an interesting session.

I remind members that, although they will have an opportunity to ask questions and follow up issues that are raised in the discussion, the main purpose of the round-table format is to encourage dialogue among the witnesses, with members doing more listening than asking questions—a challenge for all politicians, indeed.

I will kick off with an issue that was raised in last week's meeting. What is preventative spend?

Bill Alexander (Highland Council): I suggest that preventative spend is doing something quickly, effectively and timeously, to prevent situations from escalating in a way that will need greater intervention and greater spend later. For example, if a child displays difficulties early in their school career, a quick and effective response—perhaps in a multi-agency way—can prevent difficulties from escalating and requiring much more significant intervention at a later stage.

The Convener: Does anyone else want a stab at defining preventative spend?

John Howie (NHS Health Scotland): From the perspective of the keep well programme, it is about recognising that certain communities and individuals are at risk of early onset of disease and premature death and ensuring that investment is made to tackle the risks that are associated with such difficulties in later life. As Bill Alexander said, such an approach reduces spend later on. Early intervention spend reduces expensive treatment spend later and improves life quality.

The Convener: Excuse me. Is anyone else having problems hearing, or is it just me? Can the broadcasting staff help, please? Thank you, that is better. I think that I am too loud now—as usual.

I will not ask everyone to give a broad definition of preventative spend, but do the witnesses think that there should be a clear definition, to enable us to understand and measure preventative spend?

Rachel Ormston (Scottish Centre for Social Research): We certainly need a clear definition of what we are trying to achieve through preventative spend so that we can measure whether the spend is having the desired impact. Bill Alexander's definition, which was about the need to prevent problems from arising later on, is probably the right way to go. It is about defining the problems that we want to prevent and focusing spending in that regard.

Bill Alexander: I understand that, in the discussions about the proposed children's services bill, consideration is being given to whether it would help if authorities and health boards reported on how much preventative spend they are committed to. If we are to be required to measure and report on preventative spend, we will need a definition that is tangible.

Gail Trotter (Scottish Government): From the perspective of the family-nurse partnership, we know from the evidence that we have on the development of foetuses and the evidence from neuroscience on the development of a baby's brain that investing in the mother during the antenatal period can have a significant effect on the life-course outcomes for the baby and the mother. Any definition of preventative spend should be linked to the evidence that we have to substantiate the approach.

The Convener: How do we work out what has the biggest and best impact? We could spread the money thinly or we could focus on certain areas.

Rachel Ormston: The evidence from the United States, where the family-nurse partnership has been developed and evaluated over about 30 years, is that the project has the greatest impact when it works with the most vulnerable mothers and children. I am talking about impact not just in the short term, through reductions in injuries in infancy and better child language and emotional development, but in the longer term, through reduced involvement in antisocial behaviour, crime and promiscuous sexual activity when the child reaches their teens.

The evidence is also that the programme has a bigger impact on young single mothers on low incomes than it has on older mothers who are perhaps married and more financially secure. It is important to ask where the preventative spend will have the most effect. That is why the decision has been made to focus the FNP on teenage mothers in Scotland and England, because age is such a risk factor in bringing up a child.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We are getting into the important initial debate, which is about universal versus targeted preventative spend.

Traditionally, health visitors screened everybody regularly and repetitively, and the feeling was that many people were seen too frequently and that we were looking at what was normal. Now, we are almost going in the other direction. The family-nurse partnership project in Edinburgh involves 180 families. I am sure that targeting 180 out of 58,000 births last year will produce a result for the families involved, but the cost is £1.2 million and our discussion today is budgetary. Is that the right way forward? Should we look again at "Health for All Children 4" and the whole system of health visitor screening, which identifies slow speech and language development and other developmental abnormalities as they appear, rather than target the families that the witnesses talk about?

One conundrum for the committee is how we ask health boards and local authorities to tell us how they are directing their spend between universal and targeted services. What constitutes a reasonable level of targeting and a reasonable frequency of universal screening? I do not know whether any panel member wishes to respond.

Melanie Hornett (NHS Lothian): I do not know whether I can answer your question about what a reasonable screening level is.

We are fortunate to have universal health visiting services, which provide an excellent service to the majority of our children and families. However, having had health visiting for many years, we know that it is not engaging with some of the most challenging families or the most vulnerable people, to whom Rachel Ormston referred. We are talking about a different approach—not an either/or. As Dr Simpson said, the issue is achieving the right mixture.

Further work has still to be done to continue to strengthen and improve the universal health visiting service for everyone. However, there is a place for targeting for some of our most challenged families.

John Howie: Keep well has been a targeted prevention programme since 2006. It uses evidence to identify the target populations, and it focuses on the top 15 per cent most deprived communities in the Scottish index of multiple deprivation. Some additional populations are also recognised to be at risk of the early onset of cardiovascular disease and to require a range of support on social circumstances and lifestyle. That is the evidence that has been used to allow the targeting to happen.

In the past five years, we have developed several engagement strategies. The programme is

challenging, but almost 140,000 health checks have been delivered and we have identified high levels of need. We have the figures on referrals and on some clinical outcomes.

Dr Simpson: Are the relevant budgets fixed? Are such programmes well or adequately funded? Today's session is about budgets. Do you have to make bids every year? Initially, the projects were pilots. Have they moved from being pilots to the main stream?

The Convener: Before we move on to those questions, Richard, Mr Alexander and perhaps others want to respond to your first point.

Bill Alexander: Dr Simpson talked about Hall 4, which provides welcome, reassuring and evidence-based clarity about targeting.

Some children will be ably supported through the core programme, which will continue through school in the core curriculum. However, there will always be children who need additional support at some particular time in their lives, and if they get that support at the right time, it can be effective. It does not need to be expensive, and it can be delivered by the universal service—the health service in the early years and the education service during school years.

09:45

There are also some children whose needs are more acute and who might need the involvement of another agency. The challenge is to bring in that additional support from the additional agency quickly and without hassle, bureaucracy or delay. It can be directed by the universal service without additional gate keeping, for example by social work doing further assessment activity.

If a health visitor has done an assessment and says that a child needs some additional support from social work, that support should come in quickly. If it is low-level intervention, social workers should not need to do a lot of further assessment. It is the same through the school years: if a school identifies that a child needs additional support, that support should come in quickly.

The intervention does not need to be expensive. If we can front load our services and resources to the points of early intervention, we will prevent more expensive interventions at a later stage. We can spend as much as we want on children with high-level needs today—and we have to—but continuing to spend that money today will never reduce the number of children with high-level needs. The only way to do that is to get effective support in quickly, either through the universal agency or from an additional agency, at the time when additional needs are first identified.

The Convener: That implies that we need the integration and co-ordination of agencies but that that is not happening. We may come back to that point.

Gail Trotter: I want to emphasise Bill Alexander's point. Lord Laming reminds us, in his Victoria Climbié report, that families have a right to expect that any intervention delivered in the home or to support families should be based on clear evidence. We have to start with that as a premise for good spending. We need evidence for what we are doing in supporting families; they have the right to expect that.

Dr Simpson: I keep being stimulated into asking questions. Mainstreaming is a central issue. We have been piloting projects with the Paisley midspan studies from the 1980s onwards. We have been fantastic at pilots, but if we are serious about preventive spending and we are to talk to the health boards in the spring about their actual expenditure, we need to know whether your projects are being mainstream funded. The family-nurse partnership is not at the moment—I think that it is still a pilot. Are any bits of the keep well programme now mainstreamed? Have we learned enough in five years to say to every health board what they should be doing and what outcomes they should expect?

John Howie: The five years have generated a lot of knowledge. The plan is for another three years of investment for keep well—£11 million per year spread across all the boards, with the dominant investment being in Glasgow at nearly 40 per cent.

I will continue to evaluate where we are at the moment, and decisions will be taken at the end of the three years as to whether there will be continued investment. The general consensus is that the programme has generated a lot of momentum. Staff are extremely skilled in engaging and delivering the checks, and follow-on services are far more able to respond to a range of acute and complicated support needs. We are in a position where we would expect to see the programme as a mainstay of the national health service contribution to a reduction in health inequalities, but at the moment it is still a three-year investment.

Dr Simpson: So, in effect, it is still secondary prevention.

John Howie: Keep well is primary prevention.

Bob Doris (Glasgow) (SNP): I am glad that we are saying that targeted and universal services are not an either/or. That is a false polarisation: we do both and have done both for a long time.

I am interested in how we move a targeted pilot scheme into getting mainstream funding; maybe

we can return to that. However, I want to ask about the evidence base. There are two things that we do in budget scrutiny: one is to look at the cash pumped into initiatives—be they mainstream, pilot or targeted projects—and the second, which is what I am looking at, is to identify the outcomes from preventative spending.

I wonder whether there are two strands to the outcomes of preventative spend: can we identify short-term health and social benefits and separate them from the long-term cash savings? Harry Burns was here last week, and he talked about early intervention with young children. Some things, such as the effect on birth weights and mortality levels, can be measured quickly with a control group. Can we get quick, sharp, focused and identifiable health outcomes in the short term, and how long is it before we see cash savings? What should the committee be considering? We will know the cash input, and then—whether it is this time next year or whenever—we can look for the evidence that measures have been successful.

Rachel Ormston: It is perhaps worth saying a little about the evidence base for FNP in the United Kingdom. FNP has been evaluated for quite a while in the US, and a number of randomised control trials have shown positive short-term outcomes for the child, as well as longer-term outcomes as the child grows up. There have also been positive outcomes for mothers, such as improved employment rates and less dependency on benefits. A randomised control trial is being conducted in England. It involves 18 FNP test sites and it is due to report in 2013. The trial will test how replicable the US outcomes are in a different context with universal health services and health visiting.

I suppose that the question is how much evidence you need, and when, in order to make decisions. There is good evidence of impacts from the US. Early evaluation in England of the implementation of test sites suggests the potential for a lot of good impacts—for example, on mothers' knowledge of health behaviours during pregnancy, early bonding and attachment, and ways of looking after their children; and on breast-feeding rates. There have been similar findings in Lothian, but the work is at an early stage. I should add that the trial in Scotland is not a randomised control trial, so we are not able to say definitively that, if we had not had FNP, we would not have had the outcomes. However, we can consider the potential impacts.

FNP collects a huge amount of data—which Gail Trotter can talk about—on birth weights, the take-up of vaccinations, post-natal depression, and a range of other things.

Gail Trotter: Bob Doris raises an important point about the evidence required before any intervention is made. A benefit of FNP is that data is collected for every single intervention—every telephone call, every home visit and every contact with the young clients—so we will have evidence on whether what we do does or does not make a difference.

The early signs in Lothian are promising. Two particular things stand out. We are engaging young people who have traditionally been called "hard to reach" or "hard to engage", and they are staying with the programme and the nurse. We are seeing early signs of self-efficacy: people are becoming more confident as parents, are attending antenatal classes, and are reducing smoking.

It is early days. I guess that a lot of us want to see quick evidence to justify the investment, but some of the evidence will not emerge until much further into the future, when the children attend school. We will then see how ready they are, how their language development has been, and whether their mums are less likely—like mums in America—to go to prison. We have to err on the side of caution. Some of the benefits that we anticipate will take longer than most of us round the table would want.

Joan Wilson (NHS Tayside): I reinforce what Gail Trotter has said. Tayside is the second site in Scotland for the family-nurse partnership, and we started properly only in July. Already we are working with more than 100 young women and—even in these very early stages—we are beginning to see the effects that Gail described. Young mothers are engaging with the programme, are really interested in working with the family nurses, and are starting to think about what kind of mothers they want to be. They are hard-to-reach girls in some cases, and it can take considerable time and effort to engage them with universal services—if they engage at all. However, although we are at an early stage in Tayside, we are beginning to see some differences.

Bill Alexander: Outcome measures are absolutely fascinating. They are very important for the early years, but the effectiveness of early intervention can be seen at all stages and ages. The family-nurse partnership is an obvious model in the early years, but we have worked consistently in Highland to focus on early intervention for eight or nine years now. I believe that that is why, right across the age ranges, we have continuing lower and declining levels of substance misuse in teenagers and continuing lower levels of youth offending at a time when other authorities' numbers of looked-after children are going up but ours are not. That is demonstrably because of early intervention.

We have posts for children service workers that are social work posts in schools. Those workers

respond immediately to difficulties that children have in schools. Last year, because of the budget pressures, we allowed some early intervention posts not to be filled in a part of Inverness with significant difficulties, which Mrs Scanlon will know very well. Within six months the numbers of looked-after children were going up—the effect was that quick. When we now talk to our social work managers about budget difficulties and challenges, they say, "Please do not reduce the number of children service worker posts. If you have to reduce the number of social worker posts or managers, okay, but don't take away the early intervention posts."

We can say the same for other ages and stages—for example, older people. The things that keep older people at home are the things that make them healthy and happy to live in their communities, such as lunch clubs and social networks. Again, we need to spend a lot of money on older people who are in care and in hospital, but if a fraction of that money was spent in communities on non-social work services that just keep people happy and healthy in communities, it would prevent a lot of older people from going into care or hospital.

Bob Doris: I want to let the discussion flow, but I have a brief observation. I am hearing from what has been said that there is positive evidence that we can quantify some benefits quickly but we should keep the faith and be patient in order to achieve real, long-term benefits. That brings us back to the issue that Richard Simpson talked about, which is how quickly we can have enough evidence about pilot projects in order to start to mainstream them and roll them out. However, I am thankful for the evidence that we have had so far in the discussion.

Mary Scanlon (Highlands and Islands) (Con): For obvious voice reasons, I will not say much this morning. However, I am struggling to understand some points. I am with Richard Simpson on the issue of the health visitor versus the family-nurse partnership, but pretty much everyone round the table this morning is for the family-nurse partnership.

The evidence from the Royal College of Psychiatrists focuses on vulnerable families. We all agree with that focus, but we should not just leave out everyone else. The RCP recommends some of the work that Phil Wilson has done on screening approaches. We may have an evidence base for family-nurse partnerships, but we have an enormous evidence base for health visiting.

I have a question for Bill Alexander. I live in Inverness, and I know that in my own family my granddaughter got her MMR at 15 months but her next health check was when she was five. If a family does not see anyone for a health check for three and three quarter years, how can anything be picked up? That is what I do not understand.

I will make another point at this stage if I may, convener, because I am not sure that I will speak again this morning.

Highland Council is integrated with NHS Highland, with the council the lead authority for the care of children and NHS Highland looking after the elderly. At the moment, children do not get a health check for three and three quarter years when they are under five. Given the evidence that we heard on child and adolescent mental health services, how can we have a universal health care service when the profession of health visitor is basically withering on the vine? How much better can that be? What improvements will be made to health checks for children between 15 months and five years of age?

10:00

Bill Alexander: I think that some of that question was directed at me—there are a number of issues in it.

I am keen to talk about the integration of health and social care in children's and adult services. We are still working towards doing that from April next year. We are doing it for many of the reasons that people around the table have talked about, and I am happy to talk about it further.

Earlier, Mr Lyle whispered in my ear, "More resources. People want more resources." The issue with resources is getting them into the right place. If we are to prioritise resources, health visiting is one service that we should prioritise. That is another reason why I am passionate about the integration of health and social care.

We need to shift the balance of care in children's services as much as we do in services for older people and adults. We spend at the entirely wrong age in children's services: we spend on teenagers. If a fraction of the money that we spend on teenagers were spent in the early years, it would pay off for us all. As has been said, it may take some years for the results to come through. It does not win votes in a council chamber—or probably at Holyrood—to say that we will do something this year in order to spend less in five or 10 years' time, but that is what it means.

Health visitors must be the foundation of our children's services, not only our early years services. We should have more health visiting and spend more on it. I am not an expert on family-nurse partnership, so it is for other people to talk about that approach.

We need clarity about when we do the checks in the early years and what they mean. It is not possible to provide additional support for the entire

population. We have to identify the children who need the additional support—often, not a lot—and the ones who need multi-agency support. When a child goes into early education or is in a care setting, it is the job of not only the health visitor but the other agencies that are involved, using the health visitor as a named person, to combine all the information that we have about the child.

In the early stages of "Health for All Children 4", some health visitors were anxious that some children who had additional needs were not being identified early. The additional check that has been introduced is a helpful safeguard and has reassured many health visitors.

We must use the checks at the key stages—which include the checks that happen at nursery when children go into education as three-year-olds and the checks for children who are in care settings—in a focused way to identify the children who are appropriately supported by the core programme and those who need additional support.

Melanie Hornett: I will try to distinguish between health visiting as a universal service and the family-nurse partnership. The family nurses see young women from very early in the pregnancy until the child is two. The child then goes into the care of health visiting and universal services. As we have said, the family nurses target the most vulnerable young women and families at that crucial stage.

Health visiting is an important universal service. I disagree with Mary Scanlon that it is withering on the vine. I would be sad to think that that was the case.

Mary Scanlon: Those are health visitors' words, not mine.

Melanie Hornett: They would not be my words at all. However, the profession has a number of difficulties. It has an ageing workforce, and in NHS Lothian we have an increasing population—it is one of the few areas in Scotland to have that. We therefore have an increasing future workload for health visitors.

Health visiting is a universal service but, within that, we need the additional scope to target services, whether through the family-nurse partnership or other means, depending on the needs of the child and the family. I do not for a moment think that we do not need universal services. I agree that we need to strengthen those services to respond to the challenges that we face with children and young people. I also agree that it is not only about children and young people and that we need to consider all age ranges.

There are a number of challenges ahead of us. We are lucky to have health visiting as the foundation in universal services, as Bill Alexander said, but we need to be open to new ways of working that are evidence based—such as the family-nurse partnership—and which can help us to move forward.

Mary Scanlon: Most of us around table know what the family-nurse partnership is about. Our predecessor committee did a report on child and adolescent mental health services. As a result, the Government introduced an additional health check between 24 and 30 months, which we welcomed. However, I have never been clear about what is included in that health check. It has been a bit vague. I ask Bill Alexander what is included in it, given the information that I have provided.

Bill Alexander: I am afraid that, as a director of social work, I will pass on giving you a response to that question, but other colleagues might be able to give you a more specific answer. As a social worker, I would not want to comment on that health visitor check.

Mary Scanlon: Who is responsible for the check?

Joan Wilson: The check at 24 to 30 months will involve a full development check for the child to ensure that they are reaching age-appropriate milestones. If they are not, the health visitor will look at what other services need to be involved. The check also involves checking that the child is up to date on immunisations, checking their height and weight and addressing any other concerns that the parent or carer has about the child.

Rhoda Grant: I hear what everyone is saying about preventative spend and the importance of investing in the early years, but there needs to be a period of what could be described as joint spending, to deal with the problems that preventative spend was not in place to prevent. As Bill Alexander said, we must deal with the current problems in teenagers, but we also know that if we spend early we can prevent such problems from happening in future. How is it possible to do that when budgets are being cut, especially in local government?

In Highland, children's services come under local government, which has had its funding cut even further than health has. Is the money following those services from health? How do we spend in a way that does not give up on people just because they did not have the opportunity to benefit from such investment in their younger years but ensures that the same does not happen to another generation?

Bill Alexander: There was additional funding for children's services in the early 2000s, and there is no doubt that the authorities and health boards that put that funding into early intervention and early years services are now benefiting from

that. We had more money at that time for integrated children's services and that allowed us to cope with that double spend.

You are right that we cannot ignore and walk away from teenagers who have high-level needs. Without additional money, levering funding into preventative spend is a challenge, but I believe that that is what the various change funds that we are now looking at will involve. That is certainly what the change fund for reshaping the care of older people is about. The money cannot be used to plug the gap in existing services; it must be used as a catalyst to lever money from higher spending services, in particular acute hospital care, into preventative areas such as community-based care and intermediate services.

I expect that to be the case with the early years change fund, but that is a greater challenge because the pay-off is not as quick. If you close an acute hospital bed today, you can spend that money in the community tomorrow. If you intervene effectively with a young family, it takes a bit longer for the pay-off to come back and the cash savings to be realised. We have to use the change funds as a catalyst to lever funding into preventative spending areas.

Gail Trotter: I want to reassure Mary Scanlon and other members that family nursing complements and supports the role of the public health nurse, as she or he is known in Scotland. New learning is emerging from the new way of working and we are starting to share that through the modernising nursing in the community board and the chief nursing officer for Scotland.

For example, the education and training of those nurses is seen by nurses and health visitors as new, supportive and innovative. The model of supervision for the nurses—the high level of supervision through a psychologist—is seen as a model that we might need to emulate in health visiting, and how the clients are engaging with and being retained in the programme is innovative. Finally, having nurses collect data, collate it and make sense of it to look at proof of what they do is something that we are keen to share through the modernising nursing in the community board.

Across the UK, 60 per cent of family nurses have a health-visiting background, so it is a natural career progression to work in that way. We have an ethical duty to work with our public health nurses and health visitor colleagues to share learning for the development of the health visiting profession. It is early days, but Ros Moore, the chief nurse, is working closely with us on sharing the learning from family nursing.

The Convener: Can people around the table comment on their knowledge of the change funds and indicate their involvement in access to them or whether they have been involved in any way to lever money from them and take advantage of the innovation?

Bill Alexander: The only change fund money sitting in budgets is for older people's services, so anyone in children's services will not currently be involved with the change funds. We know, however, that there is a change fund for early years. I understand that local government still has to commit its share to that and that an early years task force is working with local authorities on how the spend will be used.

Just to give people an idea, we have about £3.5 million from the change fund this year and next year in Highland. With that figure, we seek to achieve a return three times the size, so we seek to create £10.5 million. That sum will, first, continue the services that we are putting in just now; secondly, it will meet the demographic challenge of more older people in the future; and, thirdly, it will close our budget gap. We are using the money as a catalyst to save money down the line and to grow services. My understanding is that the same is envisaged for the early years change fund.

The Convener: Would you say that that was £10 million of savings coming out of acute care?

Bill Alexander: It will be both out of acute care and changing long-term residential care accommodation into intermediate services.

The Convener: How do you involve in your model the third or voluntary sector, which is very important in delivering change?

Bill Alexander: The guidance for the change fund for older people emphasised that there had to be a three-way partnership. The chief executives of the health board and the local authority had to sign up to it, along with a representative from the third sector. That is not easy, because the third sector is not one person but a group of agencies of different sizes and with different interests representing a range of different stakeholders. However, the third sector has been built into the process from the outset.

The Convener: You have spoken very much about your experience regarding the model for the change fund, but how have you overcome the barriers to ensure that the third sector plays a significant role in influencing the use of the change fund in your area?

Bill Alexander: I would not say that we have overcome the barriers; I would say that we are still wrestling with them. This week, I will speak with about 100 representatives of third-sector organisations who will all want different things to happen with the £3.5 million I referred to earlier. As part of that, we must seek to achieve

consensus alongside what we wish to do across NHS Highland and Highland Council. I would not say that that is easy. As Gail Trotter said earlier, part of it is about having an evidence-based approach. We cannot use the change funds as part of a bidding process as we used to do. We used to ask, "Who's got a good idea and wants to bid into this?" Now there must be a commissioning process that is evidence based and there must be consensus about the approach. I believe that it will be easier when we move towards a more integrated service and have one decision-making structure, one budget and one set of management. Whether it is children's services or adult services, when there are decision makers in both the council and the health authority, alongside the third sector, decision making takes a lot longer than it needs to.

The Convener: The third sector is a bit worried that there is a higher test on them to provide evidence on outcomes than there is for health boards or local authorities. There is a big issue regarding who gets access to change funds because at this point a lot of the evidence shows that they are held by health boards and local authorities, so the third sector is fearful that they will not get the use of them.

Bill Alexander: You are absolutely right. Third sector agencies are anxious about that. The reality is that those agencies can use that funding more effectively and quickly and often with better outcomes. Local authorities and health boards are sometimes slow to respond, whereas third sector agencies can act much more quickly.

10:15

Richard Lyle (Central Scotland) (SNP): Every organisation has its priorities. The reason why I whispered in Bill Alexander's ear earlier is that everyone says, "We need to do this and that, so we need more resources." Richard Simpson raised the issue of ring fencing, pilot schemes and more resources. Should your organisations have a budget heading for preventative spend, with funds that can be bid for? We can talk about preventative spend as much as we like, but we cannot do it if we do not have resources. Should there be a separate budget heading?

Bill Alexander: This is probably not fashionable for somebody from a local authority to say, but if we had not had ring fenced funds for much of the past 10 years, a lot of money would not have gone into preventative spend. The reality is that the money would have gone to other priorities. Ring-fenced funding is not easy to use or manage and it involves doing a lot of work to join various strands. It has many challenges, but if some of the money had not been ring fenced, it would not have gone to the right places. That might not be the fashionable thing to say, but I speak as a manager who had to deploy the funding.

Melanie Hornett: Significant amounts of money are already spent on prevention on a range of issues. I am sorry, but I cannot give you a figure for NHS Lothian off the top of my head. Having ring-fenced funding to set up pilot programmes such as keep well or family-nurse partnerships allows us to establish and develop the work. The hard task is then to mainstream it. That is the bit that we struggle with. We need to decide what we will stop doing so that we can instead do that other thing, because it is a better approach. People have their favourite things to do that have worked well for them and which they are often reluctant to let go. As we become more able to consider programmes across the age ranges with different evidence bases, the challenge is deciding which of them will be the most effective for the population that we serve and how we focus the money on that.

Significant amounts are already spent on prevention. I am not sure that a discrete budget heading would result in more being spent. In NHS Lothian, there is a huge drive towards prevention and reducing inequalities across all our objectives and agenda, so we do not particularly need a budget heading. That might help some organisations, but not others.

John Howie: My colleagues in all 14 NHS boards welcome the ring fencing for the keep well programme, as it provides a degree of protection. As I said, the funding will be protected for the next three years, which helps with planning. Although keep well has been with us for the past five years, it is still being introduced to a lot of new areas in our communities, such as Inverness and parts of Glasgow. As we spread the programme more widely across Scotland, there is still a need for the ring fencing. It is welcomed by colleagues across the board.

The Convener: The committee is considering whether the approach would assist with the focus on preventative spend. The focus on waiting time targets drives how money is spent. Richard Lyle talked about having budget headings and an explanation of what the money is expected to be spent on. Would that approach distort things or would it allow you to identify the shift, identify and evaluate the programmes and examine the outcomes? Does that method allow us to encourage, and push and pull through, a shift in spending in the health service? That approach has helped with other problem areas, and money followed that directive. Does anyone have a comment on that? No? Okay.

Dr Simpson: It is an important issue, though, because the health improvement, efficiency, access and treatment targets have driven health

service managers and the health service. As many will be aware, managers have to meet waiting time targets and they will go to extraordinary lengths to meet them—sometimes even gaming, unfortunately. There is no doubt that waiting lists and waiting times have been driven down since 1997 under both Administrations.

The question to Bill Alexander is whether we should be doing the same with the early years. You say that the number of looked-after children had dropped and has now risen again because a couple of posts have been abolished, and I think that you are absolutely right. I used to have social workers in my general practice and in years when they were removed—every new director of social work took the social worker away from my practice—our problems with children rose because the health visitor-social work interaction failed. That goes back to the Mitchell report in 1979, which suggested that such interaction should be happening.

Could we and should we set specific targets? Should we say, "If your looked-after children levels are rising, you're not doing the right job"? The number of looked-after children has risen from 11,000 to 15,000. Generally, we are moving towards having more looked-after children across the country, but in Highland, where spending is being used on earlier intervention, the figures are going in the opposite direction. That would seem to me to provide an opportunity to have something harder in the single outcome agreement that says, "As a local authority, you have to demonstrate that your levels of looked-after children are dropping" or whatever targets the clinicians—the people at the front line—think are the appropriate ones to ensure that the local authorities direct the money appropriately.

Bill Alexander: The challenge is the balance between a broad outcome and a particular indicator or target. We do not want people to be delayed in hospital, but is six weeks the right target? We are now re-evaluating that. We want looked-after children to have good educational attainment, but are maths and English standard grades the right target, or is it about a range of vocational qualifications?

The problem with specific targets is that everything becomes focused on that particular area. If we did an exercise to measure the number of people who are delayed in hospital by five weeks and six days, it might be revealing.

Dr Simpson: We have done that and we have got median targets.

Bill Alexander: And it is revealing.

Dr Simpson: I have a family member involved in this at the moment and it took three weeks for a social worker to be allocated to do the assessment. The nurses, doctors and general practitioner had already done nine tenths of the assessment, but there was no joint recording system and no single shared assessment. It is a very poor system in which silos are not working together.

Bill Alexander: Exactly. There are silos. There is not a system; there are two systems. We have front-line practitioners whose only motivation when they get out of bed and go to work every day is to do a good job. They seek to be as joined-up as possible and to deliver an integrated service, but there are organisational silos that inevitably prevent that by delaying decision making, having separate budgets and all the rest of it. I believe, and I know that there is cross-party support for this, that we should be moving away from organisational silos into truly integrated working, not only at the front line—whether it is getting it right for every child or older people's services—but in the back-office functions.

Dr Simpson: We did that with Perth and Kinross in 2001, when there was a pilot for the joint futures programme. There is still a unit in the Scottish Executive called the joint futures unit. I do not know what it does, but it has been there since 2000 to do this. The Perth and Kinross system collapsed. I am sorry for interrupting, convener, but we have been there and we have been saying this for 10 years.

The Convener: Your apology is accepted, Richard. No one here can answer that question on behalf of the Scottish Executive, but it comes back to the issue that has been identified. Mr Alexander has already placed on the record his enthusiasm about joint co-operation and joint delivery. That point has been made.

Bill Alexander: Should we really have a single budget or just an aligned budget that people can still make different decisions about? Should we really have single management? Should we really have only one committee that makes decisions? When we have tried to do this before, in various parts of Scotland, there has not been a common understanding of singularity. People sometimes come up with an integrated arrangement, but they have different understandings of where the decisions get made.

Dr Simpson: And such arrangements are not permanent.

Bill Alexander: Exactly, and you have to move towards singularity.

Dr Simpson: Absolutely.

Bill Alexander: As for incentivising targets, which you mentioned earlier, that can be very difficult because of the very challenges that you highlighted. If you incentivise a six-week target,

what about those who are delayed by five weeks and six days? That said, the general outcomes must be incentivised.

The problem with ring fencing in the past was that it just went crazy and there were too many separate ring-fenced streams. We could not deliver on a common objective because, as has already been pointed out, the two separate ring-fenced streams could not be joined up with the mainstream budgets. However, it is only sensible to have some protection for priority budgets.

Dr Simpson: That was very interesting.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): The discussion in the past five or 10 minutes takes me back to the comments that we heard last week from Professor Deacon and other witnesses about the evidence that you need before you just go ahead and do this. We all seem to agree on the need for a preventative, targeted, integrated approach to the health service and all the age ranges it covers, which suggests that we should move towards reconfiguring the provision of health services to ensure that they are not in silos. Indeed, Mr Alexander might well have been suggesting as much. Do we need to consider some sort of formula in which we start with ring fencing, which leads to pilots, which in turn lead to mainstreaming? That brings us back to the issue of evidence. When do we finally accept that we have the evidence to mainstream all this, end the ring fencing and tell everyone, "This is the way we're delivering the service"? Could the committee come up with such a formula?

I am not getting at the keep well project, but I am struck by John Howie's comment that he has had five years' funding and that he is getting another three years' funding. How long do you have to ring fence money and have pilots before you mainstream anything? Let us come up with a formula in which, once we have decided that we have the evidence—whether it is from RCTs, case studies or whatever—and have reached a consensus on the approach to take, we mainstream it. Would that not get us around many of these problems?

John Howie: When keep well began in 2006, it had a 10-year range of outcomes. The initial short-term outcomes related to successfully engaging with the target population, inviting individuals to health checks, identifying their needs and successfully referring them to a range of different services that were agreed between the practitioner and the individual. All those things have happened. We have also collected data on individuals; in West Dunbartonshire, for example, 30 per cent of the individuals who have had a health check have a one in five risk of coronary heart disease in the next 10 years. Those needs have been identified. Moreover, referrals to appropriate services have ranged from 15 per cent in the Borders to more than 50 per cent, again in West Dunbartonshire. In short, the first part of the short-term outcomes has been achieved.

Medium-term outcomes include a reduction in risk factors through lifestyle changes, the successful administration of statin medications to reduce cholesterol and support for weight management, smoking cessation and other such issues. Although our data in that respect is more limited, a number of small-level studies have been carried out—for example, in Tayside—comparing people who have had a keep well health check with those who have not. Those who had the check showed reductions in cholesterol and blood pressure and reduced weight gain. The medium-term outcomes are beginning to be realised.

As for the impact on long-term morbidity and mortality, we have general statistics that show a reduction in coronary heart disease and have been encouraged by a slight narrowing of the gap between our most deprived and most affluent communities. That said, we are still some distance away from being able to conclude whether keep well has had any impact on those figures.

10:30

One of the big challenges with any primary prevention programme is that so many factors dictate why an individual's life circumstance or health circumstance changes, especially when we are rechecking every five years—a lot can happen in that period. Unless you carry out a randomised controlled trial, it is difficult to know whether keep well has had a direct impact on an individual's wellbeing.

We have to trust our logic. If we agree that smoking cessation services, weight management support and so on are effective, and that we are successfully getting people into those services, keep well is having a positive impact.

That is a lot of evidence, but only parts of Scotland have taken on the programme and we have still to introduce it more widely in a range of areas. While we would want to move to mainstreaming, we have a ring fenced budget of £11 million. The ambition for us all is to see keep well as part and parcel of a normal NHS delivery system. At this stage, though, boards have the protection of that money, which, as I mentioned earlier, they welcome.

The Convener: Can comparisons be drawn between those areas that have not got keep well and those, such as West Dunbartonshire, that have it? What is the difference in outcomes?

John Howie: I will probably bring in a research colleague in a minute to describe the flaws—or not—of various research methodologies.

One example is Tayside, where they compared individuals who had not been for a keep well health check with those who had, and recorded their status two years later. Comparing the two groups it was found that statin uptake was twice as high in the keep well population, that blood pressure had dropped more quickly in that group and that those who had been for their keep well health check had experienced less weight gain than those who had not.

The Convener: But within that, people who engaged would have got decent advice and so on and harder-to-reach people who did not engage would have carried on their lifestyles. Keep well gives people the opportunity to identify a worry that they already had.

Has any work been done to compare areas that do not have keep well with areas that have the programme in place?

John Howie: We have not made those comparisons within the programme. We have made a commitment to ensure that all the most deprived communities are targeted, hence the focus on the Castlemilk and Drumchapel areas of Glasgow. Areas in Inverness will also be considered. The ambition is to spread the programme across as many of those communities as possible.

Direct comparisons between those who did not receive a keep well health check and those who did tend to be small scale. Tayside is one example of that.

The Convener: So despite the lack of evidence, we are going to roll the programme out anyway.

John Howie: As I mentioned, the evidence is there in terms of short and medium-term outcomes. We are engaging and identifying and people are being successfully referred on to services. We are also seeing some returns in terms of clinical change. The evidence is there that the pathway is working successfully.

In the next three years we will embed further evaluation into the programme. The main focus of that approach is under discussion.

Gil Paterson (Clydebank and Milngavie) (SNP): I apologise for being late. I should not take a phone call before a meeting but it was quite important.

I go back to the family-nurse partnership programme. It is early days for NHS Lothian and NHS Tayside to come to conclusive thoughts on it but, with hindsight, and given the knowledge that you have, would you have proceeded with the programme from your normal budget or would that have been impossible? Do you have the flexibility in your budgets to promote a programme such as FNP on your own volition, without prompting from the Government? We will be taking evidence from the minister.

Melanie Hornett: Knowing what I know now, it would certainly have been a significant challenge, but it is always easier with hindsight.

There is compelling information on the family-nurse partnership, its research base and its outcomes from the work that has been done in the United States over 30 years. The issue for us is whether it fits the context of universal services, which we have touched on, the culture in Scotland, and the way in which we live our lives and want to interact with services.

I would have been convinced that the family-nurse partnership was worth supporting and taking forward. We might not have been able to do it on such a grand scale as we have been able to with Scottish Government funding, but the evidence that was there, the outcomes that had been achieved and the work that had been done in England would have convinced me that it was well worth doing. If we had not had the funding, it would have been a much bigger challenge, and it will be a challenge in the future, as we seek to mainstream it and integrate it in the longer term.

Gil Paterson: I suppose that my follow-up question to that—

The Convener: I think that some of the other witnesses might want to respond.

Joan Wilson: From NHS Tayside's perspective, our interest was such that we really wanted to be involved in the family-nurse partnership. When we first made approaches, we were not aware that any funding would be available. At that point, we were keen to try it on a very small scale in one postcode area in Dundee. We made a contribution to that from our existing budgets. As we got more involved, we moved on to get the Government funding, but we have made our own contribution.

We would have wanted to test it anyway because of everything that has been mentioned, including the strong evidence base on how it has worked elsewhere. It brings something different and something new, and outcomes that we are not seeing from the universal services.

Gail Trotter: We know that it works out at approximately £3,000 per year for a client to complete the programme, so it costs about £8,000 in total to deliver it to a family. That is strong and useful evidence. We do not have comparable information for health visiting and the outcomes from health visiting. That is not to say that outcomes are not achieved, but we do not have

the evidence. That information on the present cost of the programme is useful for health boards' future planning and the programme's sustainability.

Gil Paterson: You pre-empted my supplementary. That is excellent—thanks very much.

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Jim Eadie (Edinburgh Southern) (SNP): I have been very interested in what a number of the witnesses have said. I would like us to nail down some specifics on the family-nurse partnership. I invite Gail Trotter from the Scottish Government to give us a sense of when we can have sight of the evaluation that has been undertaken and what the cost of rolling out the programme nationally would be.

Gail Trotter: The evaluation is in three parts. The first part is in the public domain through the Scottish centre for social research, which looked specifically at engagement in the pregnancy part of the programme. The final report is due in 2013.

Rachel Ormston: There will be another two reports next year, as well.

Gail Trotter: We need to remember that the evaluation is looking just at the transferability of the model to the Scottish context. It is not looking at cause and outcome, although we are seeing some early positive gains.

A planned roll-out of the family-nurse partnership programme will involve an expansion in NHS Lothian and NHS Tayside in the next four years, and possibly the involvement of five other health boards over the next few years, at a potential cost of just under £14 million.

Jim Eadie: Over what timescale is that?

Gail Trotter: It is between now and 2015.

Jim Eadie: Did you want to come in, Rachel?

Rachel Ormston: I was just going to say briefly that the results of the English RCT, which I think are likely to be of interest to the committee, will also be available in 2013.

Jim Eadie: Why did the Scottish Government decide not to go down the RCT route, which has been followed in the States and in England?

Gail Trotter: There are probably several reasons. One is that the Department of Health is doing it for us, at a cost of £5.3 million across 18 primary care trusts. We anticipate that the results will be transferable into the Scottish context. Secondly, the results will be out in the next two to three years and will be useful in shaping how we extend the family-nurse partnership programme in Scotland. There is probably no need for us to spend that money when somebody else is doing it.

Jim Eadie: Okay. That was helpful clarification. I want to ask Mr Howie about the keep well project—this goes back to something that Bill Alexander said at the outset about preventative spend. Appropriate early interventions can prevent much more significant expenditure later. However, in the evidence that we have taken this morning, I have not heard anything that suggests that we have captured what the cash savings would be or how we would free up time for the health professionals who provide care in the NHS. Mr Howie rightly identified 145,000 health checks and the fact that more people who are at risk of cardiovascular disease receive appropriate and timely interventions. Could that be looked at as part of the evaluation of the keep well project?

John Howie: The evaluation that is being considered for the next three years has four components: one is around clinical outcomes, one is around patient experience and a third deals with the financial gain from the sort of activity in the keep well project. It is a very complex financial modelling exercise, given that we are looking at the impact that interventions will have decades down the line. The University of Glasgow is putting that together just now. We have had initial discussions—I do not think that Dr Walker is involved in them. It is part of the evaluation that the keep well extension board in the Government is considering. We expect a decision in the last quarter of this financial year.

Jim Eadie: Will you share with the committee the methodology that is being used in that evaluation? When will we see the outcomes?

John Howie: The methodology is being worked on just now, so it would be unfair for me to go into the detail—I would not present it very well. We will certainly share it with the committee as soon as it is available.

The Convener: Bob Doris has a specific point to make on that.

Bob Doris: My point is with a nod to our next witness panel. What you said was interesting. You talked about savings further down the line and we are talking about workforce planning further down the line. What consideration have you given to workforce planning? Perhaps you are not involved in that, but are you talking to people who would be involved in it? We are going to see shifts from acute care into the community and so forth. Does that go hand in hand with what you are doing? Have you given that any thought?

John Howie: We have not had any such discussions. There are significant staff movements and resource savings in moving from acute care to community-based care. We all face that challenge.

Until a building actually closes down, it is not possible to realise the savings.

We are seeing changes in practice. NHS Lanarkshire will over the next six months test the use of treatment-room nurses for delivery of keep well health checks. We are building up the skills and we are sharing the skills across a range of settings. A couple of areas are looking at the pre-surgical assessment period as an opportunity to engage with individuals. There are short-term efficiencies to be gained by using new opportunistic methods of introducing the keep well health check, but we are very much at the modelling stage in relation to what the bigger savings could look like.

Translating modelling into the reality of changes in spend is a significant challenge, especially when there are new and inventive ways of delivering community-based and primary care models and new and expensive approaches are being developed for the secondary care side of the NHS. At this stage, we cannot say exactly where the savings will come from. They are decades down the line, but we are putting in place modelling arrangements and looking at more efficient ways of delivering the programme.

10:45

Jim Eadie: You mentioned short-term gains. To help us to move from considering an abstract concept to something that makes a difference to people's lives, can you tell us what the short-term gains have been?

John Howie: As I highlighted earlier, about 145,000 individuals have received a health check who would not necessarily have come forward to the NHS to learn about their current health status. In some cases—I used the example of West Dunbartonshire—30 per cent of the individuals who came for their health check were assessed as having a one in five risk of getting coronary heart disease within the next 10 years. I highlighted the fact that, in response, approximately half of that same population have been referred on to a range of services, including weight management, smoking cessation and stress counselling services. If we accept that those services are effective and that positive outcomes are being delivered for those individuals, the early evidence that we have suggests that people's health and wellbeing are improving as a consequence of the contribution of keep well.

On mainstreaming spend, we must remember that the keep well investment is very much at the front end of activity, up to the point of referral, and that the mainstream spend is focused on the follow-on services. Therefore, there is a mainstream contribution to the overall programme.

The Convener: Screening and raising awareness are all very well and smaller numbers of people are referred on, but how confident are you that the services further down the line have the capacity to make a difference?

John Howie: The capacity question was initially a concern. We are talking about a fairly large programme. Anything between 30,000 and 40,000 individuals are coming through with a range of new needs being identified. Services are required to refer people on to. As part of the development process, the keep well programmes have to engage with follow-on services to ensure that they have the capacity to deal with the new range of needs that will be introduced to them. There have not been any capacity issues so far. There has not been a bottleneck effect, which is reassuring.

The Convener: How many of people with weight, smoking or alcohol problems for whom a risk has been identified and who have been referred and passed on have stuck with the programme for a month, two months, three months, six months or a year? How many successful outcomes have there been?

John Howie: Evaluation of the outcomes, including the patient outcomes, that the services have delivered has been limited. I gave the example of NHS Tayside. Gains have been achieved in cholesterol, weight and blood pressure management. We have small-scale examples.

Generating data from follow-on services not only in the NHS, but within local government and the third sector, has been a significant challenge. Data management has been a significant challenge, and getting consistent data so that we can make firm comments on the effectiveness or otherwise of services has been a challenge. In many ways, we need to trust the logic in primary prevention. If we accept that the services are effective—they have shown that they have been—we would expect the same of level of care and support for the individuals who are coming through the keep well programme. In the next three years, we will again look at where we can introduce more detailed scrutiny of follow-on services, but we must remember that the keep well investment is up to the point of referral, and that the mainstream investment follows thereafter.

The Convener: Remind me what the investment was.

John Howie: It was £11 million.

Dr Simpson: This was my question earlier, convener.

The Convener: Allow me to finish my line of questioning, Richard. The issue takes me back to my original question about what prevention is. Can identifying people, making contact, identifying a

problem and referring some of them on be considered prevention, given that it does not necessarily lead to other outcomes? If we do not follow through and create life-changing opportunities, the work does not feed into prevention.

John Howie: It contributes to those changes after the keep well health check. There is investment of £11 million in the health check, up to the point of the referral on. The responsibility thereafter to support individuals to make the necessary changes and to sustain services comes from a mainstream allocation. We must remember that there are many other factors that determine whether an individual sustains the change. The tobacco legislation, for example, has been an extremely helpful mechanism for supporting people who are going through the smoking cessation programme.

The Convener: In seeking to identify preventative projects, we can clearly see how the early intervention that we have discussed today is intensive support. It will make a difference in the early years and it will be picked up at the nursery and in mainstream support. We can see a line there, but when that line is broken, it is like getting the big fish out of the water that falls back in—when people say, "I nearly caught one that size." I am open to persuasion, but can that truly be considered preventative spending?

Dr Simpson: Professor Barber, who was a professor of general practice at the University of Glasgow, ran a programme on hypertensive screening in 1979, and the results that were published in the *British Medical Journal* showed that, over a three-year period, 90 per cent of patients who were registered with general practitioners would be seen at their general practice and could be screened. Will the targeted expenditure on the keep well programme and the new programmes that are emerging be sustainable if we do not address the 100 most deprived practices, which are part of what is now known as the deep-end group? They see patients from deprived areas day in, day out, and they will see 90 per cent of them over a three-year period.

I have always questioned why we need new programmes and why we are not funding those primary care practices adequately with integrated care that involves social work and voluntary organisations, as well as funding primary care practitioners to have the time to see those people. That seems to me to be a sustainable way forward, compared with what we are doing. You have demonstrated today that, five years on, we simply do not know whether outcomes have improved. We know that we are engaging, and that is great, but we do not know whether things are improving.

In Scotland, we have equity of provision. Citizens throughout Scotland have a GP whom they can see for 10 minutes. The trouble is that, if I live in Drumchapel, comorbidity and my multiple problems will mean that 10 minutes for me does not mean the same as does 10 minutes for someone in, say, Bridge of Allan or Stirling. People in those places do not have the same problems or the same comorbidity, but everyone gets the same access. The Labour Government, the SNP Government and the UK Government have clearly all failed to deal with health inequalities because we do not have equality in provision. We have equity of provision.

I am sorry. That was a long speech, but there is a fundamental problem that nobody has succeeded in tackling. I do not think that we will tackle it unless we use the primary care system, which is the best system that we have. It is the best system in the world, with its registrations, its database and the information that is held. That is where the funding should be going if we are to mainstream the keep well programme.

Gail Trotter: I am sorry to talk about the family-nurse partnership programme again, but I reassure you that 75 per cent of clients in the programme are from deprivation categories 4 or 5, so by default we pick up people from the general practices to which Dr Simpson refers.

The Convener: We do not want to pick out anything, but we are struggling. We have asked other evidence panels what preventative spend is and we have a long list of evidence from retailers and pharmacists as well as from any other group you like that works hard in this field. That evidence states that they are involved in the preventative health agenda. There are many claims for it and we take it seriously, but we are struggling to identify what it really is so that we can ensure that we can support initiatives that meet given criteria.

I have mentioned the wider roles and we have received evidence on that subject. Many of you sitting around this table, including members of the committee, are professionals and have had a long-standing interest in such matters. I mentioned third sector involvement and we have had evidence from the chief medical officer that many preventative interventions do not necessarily need to be carried out by professionals. Getting people who are in difficulties through their day, making them feel better and helping them to cope can have a preventative input. I would like to give you a brief opportunity to deal with that.

I met the poverty truth commission this week in Glasgow, along with kinship carers who provide vital support in the early years. They do not feel that they are included in any of the agendas. Some feel that some of the programmes that are designed for kinship care are patronising and they

do not feel supported and involved. I am sure that that is not the case in the areas that you are working in, where you deal with people directly, but do we agree that there is a non-professional role and that we must empower carers and develop their skills? Do you have any comments on that rant?

Melanie Hornett: I agree with you on the role of carers. They already offer us massive support and help through what they do daily, which is often unseen. I also agree about the third sector. There is an issue about the professions because not only do we need to work better with the third sector and carers, but there needs to be some significant change in professional boundaries across the professions to enable the workforce to move forward to deliver on the challenges we face.

Joan Wilson: I agree. There is a care role for the third sector, particularly with children and families. It can do a lot to provide some of the lower-threshold support that does not need the professional involvement of health visitors or nurses, and it can and does complement the work that is done by professionals. It does many practical things for families: for example, third sector involvement can ensure that children get to school in the morning and it can support families in getting the right food on the table for the children. I have been involved in progressing a Big Lottery bid locally with the third sector and as we have worked through how it can complement the work of professionals, the work has been quite amazing. We need to work on third sector involvement and to consider it seriously, because this is not just about highly paid professionals delivering care.

Bill Alexander: That is absolutely right. A little bit of money spent on carers goes a long way; kinship care must be one of the most demonstrable examples of that. A child who is supported in kinship care is likely to have much better outcomes than a child who is supported in residential care—and it is cheaper, so it makes good professional sense and good financial sense. Good financial sense and good professional sense often go hand in hand—they are not exclusive. The same applies to other ages and stages. A little more money spent to support communities will mean that those communities can support people for longer and that they will not require formal services.

In the Highlands, as Rhoda Grant and Mary Scanlon know, we were in almost permanent conflict with the Lochinver community about the provision of formal social care services in Lochinver and we now allow that community to run its own services. We provide the formal social work support and it provides a wellbeing hub. Older people feel a lot more supported across Assynt and it is also cheaper.

The Convener: I thank you all for the valuable time you have given us this morning. I am sure that the evidence and insights that have been given will help our scrutiny of the budget.

11:00

Meeting suspended.

11:07

On resuming—

The Convener: I welcome our second witness panel, which comprises Martin Woodrow, who is Scottish secretary to the British Medical Association Scotland; Theresa Fyffe, who is director of the Royal College of Nursing Scotland; and Matt McLaughlin, who is a regional organiser at Unison's NHS Greater Glasgow and Clyde branch.

In the interests of time, we will move to our first question.

Bob Doris: I thank the witnesses for joining us. Your submissions highlight two themes—the relatively strong budget settlement for health services, which all the submissions note, and significant challenges that remain, which the submissions quantify. I have no doubt that we will discuss that.

We talked with the previous panel about preventative spend, spending to save and perhaps changing structures in the system. I am keen to know how you feel that the Scottish Government has worked in partnership with you as equal partners in driving forward any change, particularly on preventative spend. You see projects in action and your workforce planning could be affected. I am interested in knowing what dialogue you have had with the Scottish Government on preventative spend.

Theresa Fyffe (Royal College of Nursing Scotland): I will separate the two issues that you raise. Our workforce planning dialogue is with boards. I will be straight with you and say that I do not see good evidence of workforce planning in relation to preventative spend. When the Scottish Government pulls together the workforce plans, it would be expected to consider whether those plans support what might be required for preventative spend.

There is no doubt that we have been one of the organisations that have lobbied hard for preventative spending. I give the Government full credit for taking a step on preventative spending. The programmes that have been outlined are positive for where we need to go.

I will pick up on evidence that has been given previously and this morning. If we are not to have the same debate five years from now, we must avoid having what could be viewed as ring-fenced funding that does not turn into something that is sustainable.

I am concerned about how the change funds—to which I am happy to return—will turn into sustainable developments and about how to ensure that workforce planning delivers what is needed when professionals are required. I return to an earlier point. I see a place for the engagement of the voluntary sector and others, but we need a balance of both aspects—not just one or the other. We are not getting workforce planning right for the preventative spending culture that the Government has stepped up to say that it needs.

Martin Woodrow (British Medical Association Scotland): The dialogue on the medical workforce is more at a national level, where there are structures that ensure appropriate discussion of workforce planning. As Theresa Fyffe said, much of that discussion has not explicitly covered preventative spend—there is a disconnect between the two. More broadly, there is discussion about how the workforce needs to move from acute settings into the community. That is part of the preventative spend agenda, but not explicitly so.

Bob Doris asked about discussions on structures. As we have heard, that is linked to preventative spend through the discussion on integrating health and social care. However, it is fairly early days for that discussion, as the Government has to come up with its preferred model for integrating health and social care, as you know. Local dialogue has also taken place—planning is fairly advanced in the Highland area, for example—but it has not necessarily always been good dialogue.

Matt McLaughlin (Unison): First, I do not think that Unison has accepted that the settlement for health spending is strong. NHS Greater Glasgow and Clyde will receive an uplift of less than 1 per cent of what it spends, so there are challenges. That leads into the debate about efficiencies and cash-releasing efficiency savings. For health boards to deliver a service, to deliver preventative intervention and to make workforce planning changes, there has to be investment in change and change needs to run in parallel with the delivery of acute care in hospitals for our aged and ailing population now. The evidence does not stack up to show that we are getting that balance right.

Bob Doris: I take from your responses two themes. First, health boards need to do more on any change in workforce planning. We can ask the Government how it is working with health boards to ensure that they raise their game, so that information is useful.

Secondly, we heard from the first panel about different ideas for preventative spend and I asked you about that to find out your ideas for preventative spend. It is all very well to tell you that you must deal with the challenges of stringent budgets and so on, but you have ideas about how we can take forward preventative spend. This is your opportunity to put some of that on the record. I am keen to hear a little more about that.

Theresa Fyffe: To be honest, we expected more to be provided for the tobacco and alcohol interventions that are required, which flatline in the budget.

As for all the evidence that we have heard about the keep well programme and all that, we support that and see it as a positive way forward. On the family-nurse partnership, I agree with what the CMO said to the committee the other day. We must try to manage universal services, which are important, as well as having targeted interventions. I have picked up from listening to the previous panel the question of where we will make the shift if we continue with targeted interventions, which depend on change fund leverage money, as I said. That is what I meant when I said that the programmes are all very well in themselves but, as the committee has noted, if they do not turn into sustained ways of working beyond a period of time, we will not see the necessary change.

11:15

The other thing that concerned me is that, as the Government said, the way in which the change fund money was used in the last round was pretty weak. I am concerned about how the change fund money—which is quite a significant sum—will be deployed. It should be used in a way that gets close to those interventions and programmes and makes them work for clinicians.

On the issue of the workforce, we have reached a stage where the cuts to the number of nurses have brought us back to the levels of 2006. The family-nurse partnership requires experienced nurses. To get the approach right, we need to provide the appropriate workforce to ensure that the programmes are sustainable and can be delivered. If we do not do that, we put the programmes at risk. The workforce represents an intensive resource that must be provided in a targeted way, while ensuring that there are the necessary numbers of health visitors and others to maintain that service for others.

We think that most of what was put in the programme represents a good way to go forward.

We are supportive of that. The issue is to do with how we ensure that that gets embedded and that the change fund is used as leverage to ensure that that happens. My worry is that the programmes do not become sustainable and end up like the many partnerships and alliances that we have had before, such as that involving Macmillan Cancer Support, where posts are funded but disappear when the funding ends instead of becoming true posts.

Martin Woodrow: Reflecting again on your previous discussion, I think that the issue is what we mean when we talk about preventative spend. As you have heard, there are different views on what it means. Talking in the broadest national policy sense, the BMA has been supportive of preventative spending and has had ideas about the smoking cessation agenda, alcohol policy and so on. To be honest, we have had relatively little involvement in things like the family-nurse partnership model, because it does not directly involve our members. There is an indirect involvement, but we have not been directly involved in discussions on those kinds of things at a local level.

Matt McLaughlin: The big challenge is mainstreaming. There are lots of worthwhile projects across health and social care and all the other facets of public service delivery. As we see it, the challenge is that there comes a point at which they become either unsexy or unvalued and something new comes along, and we do not transform something that works well on the ground into something that can work in the main stream. Certainly, that transition can be very difficult.

The convener made a good point when he asked what preventative spend is. That would be a good debate for us to have across Scotland. We see preventative spend as involving much more than health and social work. It encompasses housing and education and the communities in which people live. Linkage across those areas is essential if we are to make preventative spending work effectively in the long term.

Bob Doris: So, to be clear, there is a welcome for preventative spend, there is a request for more clarification of what the outcome of that spend would be and, more important, there is a call for an effective transition from pilot projects to enduring schemes once we have the evidence base to prove that something works. We have picked up on that last point before. I welcome the support for the direction of policy, but I note that there are challenges around implementation. The organisations that are represented on this panel are vital in helping us to solve those problems, and I thank our witnesses for their time.

The Convener: On broader co-operation and integration, a recurring theme is that the only way that we will be able to deliver some of the preventative interventions is by having broader approaches and getting out of silos. I note that the RCN's written evidence draws our attention to the Scottish Government's overview of first-year proposals, which identifies a clear weakness:

> "In most cases it is not clear to what extent partnerships have associated planned activities with tangible targeted reductions in institutional care, and associated budgets (hospital and long-term residential care) in favour of community based services."

That has been recognised by the Scottish Government and professionals in the field.

There is a lot of rhetoric about preventative spend, planned services and early intervention, and budgets have been identified, but there is little clarity about where they will come from, who will lose and so on. I think that we are all agreed that the principle of preventative spend is correct. Have you any views on how we can address the problems in that regard? What should the committee say to the Scottish Government on the problem of overcoming barriers to better planning, co-ordination and integrated care and, most of all, better outcomes for people in difficult circumstances?

Theresa Fyffe: There is a risk that, as we look at previous innovations that we have tried but not implemented as a way of working, such as joint futures work, we say that the only way in which we can do something is by having massive structural change. I am concerned that we could go in that direction because of the feeling that, if we move everybody into one place, we will achieve change. However, silo working can happen in one organisation just as much as it can happen in two organisations. I have seen a lot of evidence of that in my experience of the health system.

I believe that what is needed is more transparency. We have never been able to track exactly where funding goes so that we can say, "Well, actually, this is what we funded." Our view is that efficiencies are sometimes, sadly, just cuts by another name. We do not have the transparency to say where an efficiency was found and what the savings from it were put into.

If we are to make the shift to a new way of working, we must have the transparency to be able to say, "Well, actually, this is what the project is going to cost." We need evidence that will give us a cost analysis as well as show what works. However, we cannot do that in the current system. We cannot find a way of saying, "This is how the funding is being allocated," because it is in programmes with broad headings that could mean many different things.

We do not believe that restructuring is needed. As I think the CMO said, restructuring can be an

unfortunate distraction from what people are trying to achieve. There is interesting evidence from Australia, which has been through massive change in that regard, that the impact of restructuring on the health and wellbeing of staff is so detrimental that that important resource does not stay on top of what is being attempted. The top-down approach does not bring clinicians and others to deliver in the way that is wanted. There must be a mechanism that values the role of staff in change.

The Convener: I suppose that the challenge to organisations such as yours, which may have vested interests, is to nevertheless bring your significant resources and your minds to bear on the problems. I do not think that it is sufficient for the committee just to hear your criticisms. Perhaps you can advise the committee on alternative ideas.

Theresa Fyffe: We have submitted evidence to the cabinet secretary, which we would be happy to make available to the committee, about possible solutions—that is the kind of organisation we are. We do not believe that what is happening is the right way of working, so we have put in significant evidence to say, "We think that these are the solutions." We did research on a number of different areas across Scotland and found really good examples of practice that is working very well. We are saying, "Let us build on that and get the energy of those ways of working, which will involve the voluntary sector, professionals and other sectors." That is definitely the way forward. If the committee would like to see that evidence, we are happy to provide it. I agree with you that it is not enough to say that we do not agree with something; we need to offer solutions as well.

The Convener: I am sure that the committee would appreciate that information.

Martin Woodrow: Like Theresa Fyffe, I do not think that the answer to this problem is to throw everything up in the air and rearrange all the structures. That would simply cause chaos and would not solve the problems. Never mind Australia—one need look only at England to see the problems that are caused by significant reorganisation.

Although the BMA does not see community health partnerships, as currently structured, as the answer, we still believe that they form part of the solution and should be the focus of activity in health structures. They need to re-establish themselves with healthcare professionals as something that should be at the heart of decision making because, at the moment, there is a feeling, certainly among doctors, that that is not what they are doing.

This is not just about integration of health and social care; other public services and the third sector also need to be integrated. Of course there are problems within the health service itself and we need to break down certain boundaries between and silos in primary and secondary care. We agree that things should not simply be thrown up into the air and that professionals should be put at the heart of the structures. Like the RCN, we are engaging with the cabinet secretary. In fact, we will meet her later this month to talk through what we think are the solutions to this issue.

Matt McLaughlin: As someone who, as a young regional organiser, was involved with the joint futures project in Perth and Kinross, I am struck by the impression that, many years on, we are still having the same circular debate on these issues. That is frustrating not only for our organisation but for the professionals on the ground who are delivering the service. Everyone accepts the principle that greater integration and closer working together are good things, but the models that have been proposed have been a bit top-down and handed down to people. Indeed, some of the CHP models are weak on transparency of decision making and, in particular, democratic accountability at local level, and we need to come to grips with those things if we are to challenge the current situation and bolt on the Christie commission's recommendations. The big worry for people and communities on the ground is that these changes will be cash driven, not quality driven. If we are serious about preventative care, we need to focus on putting quality at the centre of the system, irrespective of the cost.

Mary Scanlon: I have a supplementary to Bob Doris's question. As spend to save has been on the agenda for more than four years now, I would like to know more about your close working with the Government.

I was surprised to find that, in 21 months, NHS staff have been reduced by 3,900, 1,100 of whom are administrators and more than 1,700 of whom are nurses. Given the emphasis on spend to save over the past four years, why have nurses fallen foul of these reductions? Why have so many nursing posts been lost? Surely nurses contribute enormously to preventative spending approaches. Were we overstaffed with nurses in the first place?

Theresa Fyffe: As was highlighted in a previous evidence session, when you are faced with fiscal problems, you look first of all at your workforce and find out whether you can make any savings on your fixed costs. It is reasonable to point out that nurses seem to have come off the worst in this respect, but the history of nursing suggests that it has been ever thus. As I pointed out earlier, when the funding ended, the Macmillan nurses were whipped out, even though they were there to deliver. I should say, though, that some of those savings were planned in partnership with us.

We have given appropriate consideration to the kind of team that we might need, such as healthcare support workers and registered workers and others. The escalation of the savings in the last quarter meant that we are heading back to 2006 nursing workforce figures. That is worrying at a time when we are trying to shift from the acute model, some of which has been because of closures in the acute systems. You are taking wards out, so naturally you are going to take out some staff. We understand that, but what we are not seeing is a corresponding shift over to the community and to the primary care service, which is where we are trying to get to. We are concerned. We are asking the boards, "At what point do you say that you have done what you can do in fixed staff costs? You cannot keep going."

11:30

I was a little concerned when I picked up on the evidence that the next target might have been the incremental shift of nurses—I say nurses, although it is not just nurses. I will be honest here. Nurses took the pay freeze on the chin. They did not complain a lot about it, because they understood what was going on. They believed that they were all in it together.

The way it is working now, I am afraid that nursing has lost a sense of all being in it together. Nurses think that they are very much on their own and that they are being targeted for savings. The concept of less is more is laudable, but when you are on the front line and less is more means that you have more work to do and fewer staff, it does not feel laudable. There is grave concern at the moment about quality of patient care.

We cannot continue in this way, which is what I meant when I said that the workforce plans do not seem to capture the need for the shift of work to primary care and the particular agenda of preventative spend.

Matt McLaughlin: That is a valid point. As my colleague pointed out, nursing numbers have been significantly reduced. It would be a mistake to gloss over the fact that 1,100 admin workers have been taken out of the service as well. They do a valuable job, quite often facilitating registered professionals to deliver the front-line service.

I will give you an example. NHS Greater Glasgow and Clyde is in the process of carrying out a survey of health visitors' work on childcare and child health. My understanding is that that survey will conclude that between 12 and 17 per cent of health visitors' time is spent dealing with patients on a one-to-one basis. The rest of their time is spent filling out forms and doing paperwork. Many registered nurses and other professionals in the NHS will empathise with that.

The crude numbers workforce planning game helps you to demonstrate that you are making budgets balance, but it does not deliver and, in its current format, it does not drive you towards the delivery of a proper service for people on the ground. Health visitor numbers underline that spectacularly.

Mary Scanlon: Given that the spend-to-save focus has been with us for a few years, what I am really asking is why spend to save had such a dramatic effect on nurse numbers. Most of the witnesses have been talking about efficiency savings or cuts. There are no explicit efficiency targets for next year. Will that help the workforce? Will it change the focus? Over the past 21 months, why has the spend-to-save focus led to a loss of 1,700 nurses as well as the admin staff? We are looking at that same focus for the next five years.

Matt McLaughlin: The reason is pretty simple. By and large, across the board, health boards have centralised services. As my colleague pointed out, with centralised services you take a number of beds out of the acute side, and the biggest group that is affected by that at the front line is nursing staff. Because of the way in which boards do their workforce planning, there is a direct correlation between the number of beds and the number of staff on a ward-by-ward basis.

I will take what the member says under advisement, but my understanding is that boards are still being asked for 3 per cent cash-releasing efficiency savings for next year, so it is not the case that there is no pressure on boards in that way next year. Given how the financial settlement stacks up, there will be even more pressure.

Mary Scanlon: I am reading from a briefing from the Parliament's information centre.

The Convener: The other panellists want to respond to the question, Mary.

Theresa Fyffe: There has not yet been an agreement on efficiency savings, actually. It is not clear that the figure will be 3 per cent—we expect something, but we have not heard yet. That takes me back to the point that workforce measures have become the best way in which to try to balance the books. As I said, that is understandable. It is where you start, and any organisation will do that. We have just been through the latest round of workforce planning. I believe that boards are working with a financial envelope, rather than on the basis of what services they need to provide. We have workforce plans with very little lift in the numbers of advanced nurse practitioners, who are essential to the delivery of the service. I could count on the fingers of one hand the number that one board thought it would need. That tells me that boards

are thinking, "This is the money we've got, and this is what we do."

The issue comes back to the point that we are trying to continue to provide everything and spread everything more thinly on the ground. The boards are caught in the middle. The political challenge for them is to set out what they can afford with the funding that they have and say what has to go. Until now, the workforce has been affected, because that has been easier. My concern is that we have reached a point at which it is not safe to continue with that. Some boards are starting to see that, although I am concerned that some are not.

It is not easy to talk about disinvesting, but we must consider where we need to do that, as one of the previous witnesses said. The boards will continue to try to balance the books. They will use any fixed cost to do that, because they cannot touch particular services. That is the challenge that we face. As I said, if preventative spending is to become sustainable and part of core services, there must be a plan that enables boards to build that spending into their budget, rather than trying to couple it up with what they already provide. That is the challenge that we face in Scotland. We need to consider how we can achieve that, rather than asking the boards to make savings and saying that they must live with what they have.

The Convener: Mr Woodrow, do you wish to comment?

Martin Woodrow: I have nothing to say on the specific question about nurse numbers, but I echo Theresa Fyffe's comments about what is happening to services. It is obvious that boards are planning their workforce on the basis of what they can afford. As we said in our written evidence, we need a country-wide discussion about what health services we can and cannot afford to provide. That discussion cannot exclude things such as reconfiguration of services, as many such discussions do at present.

Mary Scanlon: There are 1,700 fewer nurses and 40 fewer doctors than there were 21 months ago. The changes seem to have fallen disproportionately on the nursing profession.

The Convener: We have mentioned the effect on morale of making savings through wages and conditions, and we take the point on that. We heard in evidence last week that the level 4 information in the budget shows £24 million for merit awards. Can we have a debate about the future of the health service when people are having their pay frozen and we are openly discussing holding back increments, yet there is £24 million in the budget for merit awards?

Martin Woodrow: I suppose that that is a question for me more than anybody else, as you would expect me to defend the pay of doctors, and consultants in particular. Distinction awards are a significant, although relatively small, part of the pay bill for consultancy. They have been part of the consultant remuneration package since 1948 and are an important part of rewarding doctors who do the most for the health service.

As the committee is probably aware, distinction awards are currently the subject of a UK-wide review. The Doctors and Dentists Review Body has produced a report that is currently with ministers, including the Cabinet Secretary for Health, Wellbeing and Cities Strategy. We expect an announcement on that imminently, and that will lead to a review of the system.

Until that announcement, I do not have much more to say on the matter. Obviously, we will contribute to the subsequent consultation. We will see what happens with the awards in future.

The Convener: What about fairness and all being in it together? We need a debate about what is important in the health service and how we spend our money. Irrespective of the consultation, there is £24 million in the budget for merit awards when the lowest paid, who deliver the services, are expected to take a pay freeze. Is that justifiable?

I do not want an answer from Mary Scanlon, who has her hand up. However, it looks like I am not going to get further answers from anyone.

Fiona McLeod: I will follow up on some of the things that Mary Scanlon said. It is interesting that she provided numbers for staff changes and I provided percentages. It is interesting that Matt McLaughlin talked about the 4 per cent drop in administrative staff. I used to be a health librarian, so I would probably have fallen into that.

The figures that I have show that there has been a 1.7 per cent fall in nursing staff and a 9.5 per cent fall in management staff. Given that the SNP Government's commitment was to a 25 per cent drop in management staff, it is significant that we have already achieved a 9.5 per cent drop.

When will we accept the evidence that preventative spend works and that, therefore, we will have to reconfigure services—not reorganise them from the top—to enable the preventative spend that we need to make? If we accept the evidence and mainstream the pilot projects, do we accept that the corollary is staffing changes? We heard from previous witnesses that services do not always have to be delivered by professional staff and that we will use a lot more third sector staff and volunteers—non-professional staff. Do the professions accept that, if we follow the evidence chain in relation to preventative spend, we will have to consider the reconfiguration of staffing as well as service delivery?

Theresa Fyffe: You are absolutely right. That is what I meant by balance. To be honest with you, nurses have had no problem accepting the evidence for change. Changes to the skill mix in nursing teams have already been happening for a number of years. Matt McLaughlin's point was very well made: without administration staff behind them, registered nurses will end up doing things that are inappropriate and that they should not be doing.

It is good to move towards working with the voluntary sector and having other alliances. In any examples that I have seen of people on the front line working together, they are good at doing so if they are allowed to do it. The cuts do not come from the people on the front line saying that they do not want to do something any more; they come from the project being over and the funding not being available. That is what happens.

We need to move towards embedding changes in the main stream when we have evidence that they work. That brings us back to transparency. Given the way in which the finances are presented, I challenge anyone to be clear about them. We have struggled with that and are aware that other organisations also do. We need to get better at saying how we will sustain and provide for a service.

I am not suggesting that there will not always be some people who are challenged by change, but the majority are up for it and want it. Nurses are renowned for going out to areas where others do not go. Nurses already work in front-line out-of-hours services and homelessness services with different models. Different models will not be a problem, but there will be a problem if there is no funding to sustain them.

11:45

Matt McLaughlin: There is no dispute within Unison nor among Unison members that preventative intervention is the way to go; the issue is how we get there. However, the reality is that irrespective of how much money is put into it today, the benefit of that model of provision will not necessarily flow tomorrow; its real impact has a longer tail. Therefore, we need to have a discussion about how we run things properly in parallel.

As Theresa Fyffe has said, our members right across the public sector work openly and effectively with other organisations. Our big concern at the moment is that if we set up that direction of travel on the basis of a race to the bottom to save money, we will not get the benefits that we should get. We need to have a system in which there is a proper social baseline—for wages and terms and conditions—for working with other organisations. It seems a bit ironic to me that some of the most vulnerable people in our community are looked after by some of the most poorly paid in our community, who rely on benefits. That feeds into poverty and health; and it comes in through the back end in the form of poor health among those individuals and their families.

I agree that it is not about ripping up what we have and starting again, but we need to build significantly on what we have and put at the core of the agenda tackling poverty, rather than just managing budgets, the number of beds and the people who deliver care.

Martin Woodrow: As I said earlier, we support the need to look at the configuration of health and social care services. Doctors very much want to be part of that discussion.

It comes back to what sort of health service we want and can afford. There is an assumption that if we build in additional preventative services we will see an immediate gain, as we will be able to lose some of the more reactive services, but that is a brave assumption to make, because, given our ageing population, we will continue to need what we have. The bigger debate is about what we can afford to provide.

The Convener: In some of the evidence last week, we heard the argument that we should just get on with it. It is strange to hear that we need to wait for all the evidence to assess any gain, yet we identify the loss quite quickly. We heard this morning that some intervention posts for young people in schools have been taken away. We know from evidence that more elderly people are taken into hospital over weekends because of the absence of a home help three times a day. We recognise such loss immediately, so why do people continually put forward the argument that we really have to wait years to see benefits from any initiatives? If you take away the Macmillan nurse, the loss is seen immediately.

Theresa Fyffe: It goes back to the fact that a number of years ago boards struggled with what they called creeping developments. Notably, one board ran itself into serious funding difficulties—in fact it was called to answer for what happened. It let things happen but could not manage the budget. Boards have gone back to being concerned about being clear about funding for their core services.

Often, projects and new ways of working sit alongside the core service. A problem—more in big board areas than small ones—is that it can be easy to identify a saving if only one or two people are involved, when in fact the big saving might come through reconfiguring a service that involves much more money.

Political will comes into this. If politicians are up for using preventative spend—and this Government has been brave and taken on the legacy from the start—the results may not be tangible only five years from now. Things will take a lot longer than that, so it may not be easy to say now what we have done. I feel that now is the time for politicians to have the courage to say what the core service is and where they will find the funding for it. They should stop the present game.

We recently made a freedom of information request on prescribing. Boards already face a 4 per cent rise in prescribing costs, and there is a big programme of work—well supported by the quality alliance board—to tackle prescribing costs. However, that will take a long time to deliver and, right now, boards know that they will have to meet those rising prescribing costs. That is why small projects are being identified as ones that can be lost and why core services are not being tackled. We have to have a debate on those issues.

RCN Scotland believes—and I think that Martin Woodrow of BMA Scotland would agree—that that is the present situation. Having that debate would be better than having people continuing to believe that we can keep going when things are being made so thin on the ground. I worry about quality and safety when nurses feel stretched and when, sadly, they end up in media coverage or press releases about poor care. As a professional, I cannot accept such coverage. We have to work together to ensure that the present situation does not continue.

Dr Simpson: What you have said leads into my questions quite well. I will start by assuring Theresa Fyffe that my question on increments was intended simply to identify the fact that, even with a wage freeze, there will be incremental drift, which will probably be greater because fewer people are leaving post and fewer new people—who are cheaper—are coming in at the bottom.

Integrated resource framework pilots indicate massive variations in total costs for particular populations—I think that the pilots have mainly been on elderly people. We should be addressing those huge variations. If we can bring the least well performing groups up to the average—not the best, but the average—savings will be made. Theresa Fyffe mentioned prescribing. Some general practitioner prescribing may be perfectly genuine and appropriate, but the variation in the levels of prescribing can be massive—20 or 25 per cent. We should surely be considering that to a far greater extent.

Territorial boards spend about £8.5 billion out of the £11.5 billion, so the non-territorial boards—including Government spend on the department and the national boards—are spending a huge amount of money. Surely the cuts or efficiency savings for the non-clinical boards—those that are not dealing with clinical areas, as the State Hospitals Board or the Golden Jubilee board do—should be far more like the Government levels of 10 per cent than the 3 per cent.

Martin Woodrow: On the first point, I agree that unexplained variation is an area that we should look at. Richard Simpson has highlighted prescribing, which I am aware that a number of boards are looking at with practices and the local medical committees that represent GPs locally. They are supportive of those initiatives. Such variation can often be explained by differences in practice populations but, where it cannot be explained, GPs are working locally with boards and are going along with that agenda.

On your second point, it is easy to say that the non-clinical boards should be hit harder, but it is important to remember what some of those boards are doing. For example, NHS Education for Scotland provides very important education and training services. A large proportion of its budget relates to trainee medical staff, so it has a direct impact on patient care. Other non-clinical boards have important roles on the very agenda that the committee is focusing on—preventative spend. Public health is a big agenda for them, so we need to be a bit careful about saying that they should be hit particularly hard.

Theresa Fyffe: I draw your attention to the work of the efficiency and productivity strategic oversight group. EPSOG was run as a committee, but it has now gone into the Government's quality alliance board work stream, in which there is a clear move towards removing variations. It has been decided that the chief executives should now run that programme. The question will be whether they use it to demonstrate the changes in variation that they need to make. We keep a close eye on that, because the point is: if evidence has been found on a more efficient and productive way of doing things, why are we not following it through? We have not been doing so. The committee might want to pay attention to those attempts to make changes.

I would be concerned about what I would refer to as salami-style cuts to the non-clinical boards. If we do not have funding for development or the quality agenda, the boards will not get the benefit of that. In nursing, cuts have started to be made to the very teams that provide continuing professional development to nurses in the wards. If funding to the non-clinical boards were to be cut, I would feel that we were choking off any support for the development of the service.

It would be interesting to look at the agenda of the non-clinical boards and what they are doing to support different ways of working. If they are not providing such support, they need to be

challenged, because they must work towards ensuring that they are ahead of the game when it comes to where we need to be five years from now. They need to come up with the measures and the development that will help us to get there. I urge that we do not cut the funding of the non-clinical boards because I do not think that it will provide the answer.

It comes back to challenging variation and boards having to be accountable. I am sorry for sounding like a cracked record, but transparency is the issue. How do we know which boards are following through on efficiency and productivity as well as prescribing? Which boards are tackling that seriously? We made an FOI request on that because we could not get the information. We should not have to do that to find out what is happening on prescribing and how we are tackling those costs.

Dr Simpson: I would like to come back on that. I am glad that you have put on record the point that the main boards have considerable value, provided that they focus their work.

Let me give just one example of what I am concerned about. Specialist nurses have been a major development over the past 15 or 20 years, not so much in taking over the role of the consultant or the doctor, although that is part of it, but by providing, in areas such as heart failure, the necessary support to keep people in the community. However, we are hearing that specialist nurses are being pulled back, not just into specialist cardiac wards—which is not totally inappropriate—but into general medical wards, and are being taken away from such specialist roles. How do we ensure that boards do not do something that must be massively counterproductive from the point of view of preventative spend? Admittedly, that is secondary or tertiary prevention, but it is still about supporting people and preventing them from coming back into hospital.

12:00

Theresa Fyffe: I agree entirely. That is what I meant. It is very easy to target individual posts when you are trying to make your saving. When savings are dropped down a very big system and you are told that you have to find your percentage of the overall figure, if your only saving can be in fixed costs, as in staffing, you go for your staffing. I have been pleased lately to hear senior people in some boards say, "We cannot do any more of that." This is the first time that I have started to hear that being said. I was becoming increasingly concerned when we were not hearing it—Matt McLaughlin and I shared that point earlier on.

If we do not get to where we want to be, that is exactly what will happen: we will target individual posts, because at the moment managers require to meet the savings targets. They will have to go to the only place where they can find the savings, because they are not allowed not to meet the savings targets. The job of a manager is not to go back into the room and say, "Sorry guys, I can't make my savings"—you cannot do that, although obviously you have to demonstrate that there has been a risk assessment and that you have done what you need to around quality and safety. To an extent, that is what we keep asking for, because we are not seeing evidence of what happens to services when a post is taken away. That is never challenged enough and the impact is seen only in the lives of the patients and their families, if people go and talk to them about the loss of the nurse. It takes time for the impact to filter down but, believe me, individual patients and families know the difference when a post is taken away from a service that is provided to them. As long as we do what we are doing and make cuts to the workforce, that is what will happen.

Matt McLaughlin: Theresa Fyffe's description of the reality of the situation is dead on. Across the NHS in Scotland, people today are having to make cuts to balance their books. They do not necessarily have the opportunity to implement a proper spend-to-save agenda or make some of the other investment that they might want to make in preventative care; it is about balancing the books today.

We are in year 5 of having to balance the books today and in some areas we are at the hard end of successive change processes. Some boards are trying to get on the front foot; it is not all bad. However, when you have to balance the accounts at the end of a given period, the reality is that you look first and foremost to your biggest cost—I know that a number of the people in the room will be employers in their own right. In the NHS, the biggest cost is people, so that is where the impact comes.

The Convener: If you are committed to changing the culture and bringing about early intervention, prevention and all of that, that should be at the heart of your decision-making process. The hard thing is that we have just heard in evidence that it is not. Decisions that have been made will prevent us from moving in that direction. We have heard some evidence about elderly care and the education, training and development of the care workforce—not only the professional workforce but, for example, training home helps to recognise dehydration, a urine infection or whatever it is that causes people to be taken into hospital, who sometimes, and at great expense, will never come back to their home. Such basic stuff must be done. If none of that education,

training and development is being done and that budget has been sacrificed, how do we develop the workforce so that our approach is truly preventative?

Theresa Fyffe: That is a challenge. Matt McLaughlin is right that some boards are trying to turn that around.

It goes back to Mary Scanlon's point. Nursing accounts for 42 per cent of the workforce, so if you choose to reduce staff costs, nursing is an obvious target—you start there and then look at administrative posts and other posts where you think that you can make savings. Our dilemma in nursing is that we have workforce tools and workforce planning, but we do not have fixed figures indicating that you need to have this number of nurses versus that number. For that reason, nursing posts are a much easier target.

That is what I meant when I referred to what would happen if we continue with the current approach. The workforce plans that are coming in now reveal that they have not planned for more nursing; in fact, quite the opposite is the case, at a time when we are talking about a significant change in how we will provide care.

Many of the workforce panels will say that they are working within a financial envelope and on the basis of what they can afford. We cannot continue with that. If we do, we will end up without the skilled people to do what we need to do. We are talking about our legacy for five years from now. It is about not what is happening right now but what we will have in five years.

The Convener: With all due respect, they might be planning for more care workers or registered nurses. Are they not doing that either?

Theresa Fyffe: That is an interesting point. When a ward was closed and a team taken out, healthcare support workers, registered nurses and others were also taken out. The move to giving teams healthcare support workers and others was a good one, but we are still targeting a workforce figure because that is the only way the books can be balanced in the end.

Many health board managers are waking up to the fact that that is not working and is not sustainable. I come back to the point about how boards are going to balance their books with rising cost pressures. The work programmes that are in place will take time to deliver the changes, so how are managers going to balance their books if they do not do it through their fixed costs?

Gil Paterson: I want to speak about a similar area. The problem for us all—in industry, government, health boards, councils and so on—is that when we have a fixed budget, we have to work within it. Perhaps the difference between a health board and, for example, my business, is that I can borrow so that I can achieve my priorities for the financial year. The Government and health boards do not have that ability to borrow. On top of that, we are facing a budget cut.

Most health professionals and, I think, all the members of the panel have acknowledged that the Government has decided to use the Barnett consequentials to assist the health budget. I do not think that that is enough to sustain the health service as it is. As in the real world, health spending is subject to rampant inflation. What are the panel's views of that? If we could cut away at that, we might be able to square the circle.

Matt McLaughlin: I think that everyone recognises that NHS inflation is rampant. It would be more helpful if we had a sense that the Scottish Government also understands that and factors it in when it is talking about settlements for boards.

As I understand it, the two key areas of health inflation are the price of medicines, which we have spoken about briefly, and fuel, such as electricity, gas and fuel for vehicles. We all face those pressures every day but it was recently suggested to me that, in a health board the size of Glasgow, a 0.5 per cent increase equates to about an extra £4 million, which is a big number on top of an already big number for health boards.

Whether we can use spend-to-save initiatives to make buildings more efficient and cheaper to run, and whether colleagues in some of the centralised boards who negotiate contracts could do a better job of that, I do not know. Perhaps the committee could take a view on that.

The big challenge is that the real inflationary costs for health boards are outwith their control. It would need serious political intervention to get on top of that.

Martin Woodrow: I echo much of what Matt McLaughlin said. The prescribing budget is big and, as we have already suggested, work is on-going to control it. However, it is difficult to do so with all the new treatments that are coming online and being approved. I believe that in its evidence NHS Lothian drew particular attention to the consequences of new and particularly expensive drugs being approved. All that is outwith a board's initial control, and the fact is that it will have to provide medication that advances in medicine have made expensive. As I have said, although everyone is aware of the issues and is convinced that the matter needs to be addressed, it will be incredibly difficult to do that.

Gil Paterson: If there are no answers to that and if the Government is already using all its resources—after all, we must remember that everyone else in the public sector is being squeezed significantly—I believe that the current

spend-to-save approach will, in the medium to long term, be the salvation. When I said that there might not be enough funding, I was not blaming the Government, as it is constrained. From the evidence that we have taken so far, I feel that the only way that we can make long-term savings is to spend now to save for the future. Of course it is painful just now, but we have to find some way of making savings.

Matt McLaughlin: You are absolutely right. As colleagues have pointed out, social Scotland needs to have a debate about core NHS services. I am sure that people have already said as much in evidence—certainly, the chief executive of NHS Greater Glasgow and Clyde has been vocal about the impact of free prescriptions on his board. Although the measures are having a real impact, I believe that there are opportunities to grasp. The same health board put significant amounts of money into examining patient food production and has now invested significantly in a new cook-freeze system that serves all NHS Greater Glasgow and Clyde—and, one might argue, beyond. It took an up-front investment of millions of pounds but, in the long run, it has delivered long-term sustainable jobs for people, particularly in the Royal Alexandra and Inverclyde hospitals, and has led to local and affordable production of quality food.

Things can be done, but they require real transitional funding and cutting people a bit of slack—if that is the right expression. If your day and daily job is to cut your coat to suit your cloth, you will find it difficult to go into a completely different set of discussions and focus on blue-sky thinking and innovation. We need time to encourage and build on innovation, but any such moves must be made on the basis of providing quality care, key to which will be prevention.

Jim Eadie: Each of the witnesses has rightly highlighted not only the need to invest in preventative spending but the fact that the financial settlement has been tough and tight and that there is a fixed envelope of funding for health boards. If I understood her correctly, Theresa Fyffe said that what is considered to be preventative spending often sits outwith mainstream budgets and is therefore vulnerable in tight financial times. Can you shed more light on that issue?

Theresa Fyffe also said that she was in discussions with the cabinet secretary, and at least two of the witnesses have said that they have submitted written evidence to her to set out solutions for spending resources in one area to save money in another. Where is your thinking taking you in that regard?

12:15

Theresa Fyffe: When there is funding for a separate project, the leverage model that the CMO spelled out to the committee is a good one, particularly when the funding is given to people who are working in teams and actually delivering. It would be good if those who account for such funding could build it into the continuing budget, but because it is separate funding they do not do so. Instead, they keep the project separate and it is funded for a period of time.

It is often intended that the funding will be embedded in the budget, but it becomes vulnerable because most of the funding that goes into such projects is used to pay for people in some form, whether it is direct funding for staff posts or funding for the voluntary sector to provide a critical service. It is easier to cut the workforce than it is to say that a service cannot be provided in the same way, because that requires much more public engagement.

As projects involve only small numbers of members of the public, reductions can be dealt with in a different way, through new ways of delivering services. It is much more difficult to say that we do not need as many services, because people view that as if something that they have is being taken away from them. Delivering services differently is a challenge, but some health boards have demonstrated ways of doing it by moving to day surgery and to different ways of providing treatment, or by working with primary care and providing treatment there.

We need to step back and say, “This is the service that we want, but these are the barriers.” That is what I mean when I say that a debate needs to happen. There are barriers to that change, which are usually public or political—although they are sometimes professional, because people believe that they do not need to change—but we have to get into that debate to find the solutions.

Jim Eadie: Where is your thinking taking you on how we can reconfigure spending priorities?

Theresa Fyffe: I am always interested in how boundaries work. It might be cheaper for a patient to use a service in another area, but they have to stay within the boundary of their area, even though that might cost more, given that some of our areas are big. We need to think differently about where patients are and where they can travel to. We have done significant work on that already. I used to work in Tayside, and I remember when we decided that certain types of surgery would be provided in Angus and certain types in Perth. At the time, the public did not travel beyond Ninewells in Dundee, but they do now.

I was surprised recently because my father-in-law, who is a very elderly gentleman, needed treatment and, when he was offered a bed somewhere else, he took it. Years ago, he would not have done that; he would have said, "No, I need to go to my local hospital." An Ipsos MORI survey just before the election showed that the public are much more open to changing where they go for a service. If it means that they are treated more quickly and efficiently and the service is of high quality, they are prepared to do that.

We need to debate how we provide services. We might find that we have too many of some things because we have been looking at boundaries rather than at what boards provide.

Jim Eadie: I address my questions to Mr Woodrow and Mr McLaughlin. To recap, how do we embed preventative spending and do you have any ideas on how we can reconfigure services more effectively?

Martin Woodrow: To clarify an earlier point, I think that Jim Eadie suggested that we had engaged with the cabinet secretary on reconfiguration. I was actually talking specifically about how we can re-engineer the structures of health boards and CHPs to ensure that decisions are made by appropriate people, that they are not so manager led and that there is more clinical input.

On reconfiguration of services more specifically, the difficulty is that the work needs to be done at an extremely local level. Again, the same principles apply and you need to engage clinicians in that decision-making process. Often, there will be financial issues at stake, but there need to be sound clinical reasons for any changes to services. Although, at the moment, we have a presumption against centralisation of services, that is making life difficult for health boards. The classic example that everyone gives is the difficulty that NHS Lanarkshire is having trying to close an accident and emergency service that it thinks it does not need. Obviously, there is a huge political agenda around that issue, but we think that it is a nettle that needs to be grasped. If we are going to have an efficient health service, a decision needs to be made on that, and the public and clinicians must be involved in that discussion.

Matt McLaughlin: If we want a faster transition to preventative spending, we need to work out how we can get an adequate funding formula for that, which allows us to run in parallel and deal with the training issues and development issues as well as taking the communities along with us as we go. We also need to have a clearer understanding of how we evaluate and determine the quality of interventions, and we need to come to an understanding of what an improvement is, why it is an improvement and why it needs to be mainstreamed.

As the convener said, it is easy to quantify a loss, but it is apparently difficult to quantify something that is working in a positive way. The classic example of that is the home help who squeezes in another three visits every day because it makes the budget work, although that has an impact on the quality of care that they deliver, because they have less time to spend in people's homes.

Unison would not necessarily support a full-scale reconfiguration for the sake of it. There are discussions to be had around some of the special health boards, with regard to what they do and how they support the front-line services. Any change of that nature needs to come from the bottom up. We have had enough top-down reconfigurations of public services. We need to find a mechanism that puts communities and professionals in charge so that we get the right fit at a local level.

The Convener: Rhoda, as a substitute member, you have sat patiently while others have asked questions. Would you like to ask a question?

Rhoda Grant: Yes. We are talking about changing the balance of care from care that is delivered in the hospital to care that is delivered in the community, and about preventative spend. We have also talked about the numbers of nurses that are leaving the service. It occurs to me that that could be because we are asking people to work in a different way. Given the age profile of some of the professions, being asked to work differently—for example, working in the community instead of in a hospital—might be challenging, and it might be that people would rather leave than change their way of working. What work has been done to equip the workforce—some of whom have huge amounts of experience—for a change in the way of working? Is that being carried out? If not, could the scenario that I have outlined be behind the figures that we are seeing?

Theresa Fyffe: There is no doubt that, among the older workforce, there has been a move towards taking opportunities for voluntary redundancy. I do not think that that is to do with an inability to move to the new model; I think that it is more to do with being tired and thinking that they do not want to deal with another change.

Nurses now come out of training able to work in communities, primary care settings and acute settings. We have had that for some time, so we have a body of nurses who can make that transition. We have staff nurse roles in the community so that they can go between acute and community care and work elsewhere. That has been a really good move, because it has opened

up career opportunities and has stopped the silo thinking that says that someone can be only an acute or a primary care person.

You are right that where we need to make the transition to change we need development to enable people to know where they need to work differently. It probably comes back to the issue that Fiona McLeod raised: when there are different ways of working with voluntary sector professionals, we need to do some work to enable the true balance to be struck. We could do more to support those teams as they work differently. When they have achieved that balance, it is brilliant. Where they have not—our research, which we will submit to you, contains some examples—it often comes down to the person who is leading not enabling people to work differently and blocking it. That definitely requires development. Not everybody is as signed up to the idea as we would wish: where they are, there has not been a problem. That is where I would identify a development opportunity.

Mary Scanlon: My question is in addition to Jim Eadie's. Will each of you give an example of where you would invest additional money for preventative spend to save, and where you would take that money from? A ballpark figure might be £5 million to £10 million. We have heard plenty of reasons and the evidence has been interesting, but we have not got to the specifics. I hoped that Jim Eadie's question would bring that out, but it did not.

The Convener: You are being very helpful and I am sure that Jim Eadie appreciates your taking his question on. Whether the panel appreciates the question or not, I am sure that they will attempt to give us an answer.

Theresa Fyffe: To be honest, as a professional leader of a group of nurses, it would be very arrogant of me to think that I could make such a suggestion without a proper working model that suggests a change you could make at a local level, and that takes me back to what Martin Woodrow said. We need to be partners in that process and, as an organisation, we are happy to be partners in it. I have done such work in the past. We sat down and proposed a change and we worked with the public and everybody who was interested to come up with a plan. It would feel very wrong if I were to say what I think we should do, because that work has not been done. I am not saying that the boards have not tried to do it, but it has not been done with us in partnership. We would be prepared to be at that table, but we need to cover the local context and we need both public and patient engagement. That is the way forward. If we do that, we will come up with something that will definitely identify such specifics.

Martin Woodrow: Like Theresa Fyffe, I find it very difficult to say what we would stop doing. The decision-making process needs to be a local one. We can talk about the preventative activity we would support at a national policy level to deal with alcohol, tobacco and obesity, but I cannot say that an individual health board should do this, that or the other and should take out money from something else. That is not a question that I am in a position to answer.

Matt McLaughlin: I would struggle to get it into a £5 million envelope. That is a difficult question to answer. Theresa is right: it would be terribly arrogant of us to sit here and say, "This is what you should do."

A major irritation among our members who deliver services is the lack of integrated IT. The lack of integrated IT costs a lot of man and woman hours on a daily basis. Health visitors in Glasgow are spending more time filling in forms at a time when, from a high-level Scottish Government perspective, we should be reducing the number of admin workers because they are not front-line staff. People's perception of the reality on the ground is that it is disjointed. You could do a heck of a lot by investing in that grade of staff to release registered professionals and others to do more front-line work with the most disadvantaged in their community. That would be a significant step in the right direction.

12:30

Bob Doris: I am hoping to get some perspective on some of the numbers that we have looked at today. Although there is £1.3 billion less in the Scottish budget from the UK Government this year—the previous UK Government took another £0.5 billion out of that budget—there is a 0.5 per cent real-terms increase in the NHS board funding allocation. I fully accept what Mr McLaughlin said about inflation in the health services. The stats show £800 million Barnett consequentials coming to health over the next three years.

It is important to look at head count. In Scotland there are 2.2 medical and dental staff per 1,000 population and in England there are 1.9 per 1,000 population. In nursing and midwifery, the figure is eight per 1,000 population in Scotland and 5.9 per 1,000 population in England. I appreciate that the head count is falling. My wife, who works in high-dependency nursing, would not allow me to make light of that, but I did hear some glimmers of encouragement from Mr McLaughlin and Ms Fyffe. Do not let me down now that I have said that. I think that Mr McLaughlin said that some health boards were on the front foot and that although there is not best practice as standard, occasionally they get it right. I think Ms Fyffe said that they

sometimes buy into a partnership model—still not good enough—and get it right.

When we carry out budget scrutiny, it might help us to look at some examples of where health boards get it right, so that we can say to the cabinet secretary next week, "If some can get it right somewhere down the line, why can't others?" Such examples might help inform our budget scrutiny.

Theresa Fyffe: We can certainly give you some examples. You are right about the figures, but that is why media coverage in England is the way it is. Are we heading in that direction? I have been around the health service all my career and I could not bear to be in a place with such figures. That is why they are where they are in England. Scotland has an opportunity to step back from going in that direction. When people see the figures they say, "England has that number, so why can't you go to that number?" They do not make the corresponding link with quality, safety and public opinion of the service, which in some parts of England is at an all-time low.

We can certainly give you some examples of where boards are starting to do that work, but the problem for us is that there is not always transparency in that. I cannot match finance to workforce. We have tried. We have done everything we can, but we cannot do that. We submitted a document, which we called, "Taking the pulse of NHS Scotland", but we could not match finance to workforce. That is the challenge. We can give you examples of what we believe is good practice, but we cannot match finance to workforce. Until we can do that—we have been lobbying for it—we will always be left wondering where the money has gone because we do not know.

Bob Doris: That information would be helpful. Thank you.

The Convener: Mr McLaughlin, are you going to disappoint Bob Doris?

Matt McLaughlin: As Theresa Fyffe said, we would be really concerned if we were to start following the English model of healthcare.

Gil Paterson: So would we.

Matt McLaughlin: Excellent. You asked for good examples. A lot of good work was done initially around crisis teams and drug and alcohol action teams in trying to deal with bed-blocking issues. To be fair, in the past 12 months some of that has foundered a wee bit. Audit Scotland recently produced a report that said that things had stalled. However, that is the kind of engagement from which the public, our members and the service all benefit. People quite like working in that kind of intensive area, where they can make a real difference to somebody's life and where their intervention helps somebody come out of hospital, get back into their home and be properly supported in their home. That is the key balance. Those are the kinds of area where there is good practice.

In the past four or five years health visitors have taken on a mountain of extra work around running breastfeeding clinics, running positive parenting programmes and looking at how they interact with youngsters around the 30-month check-up. From a Glasgow perspective, there are challenges in relation to how the people involved have implemented what should be a positive initiative. I do not think that we should say that, just because there is a problem with how something is being done in a particular area, the initiative is wrong. The initiative is right; it is some of the people and some of the attitudes that are the challenge.

Those are examples of where there is good practice, albeit that perhaps it could be better.

Bob Doris: That is helpful. Thank you.

The Convener: There are no other questions, so it remains for me to thank you on behalf of the committee for your valuable time and interesting insights. I am sure that the evidence that you have provided will be useful in our budget scrutiny.

We previously agreed that we would take item 3 in private.

12:36

Meeting continued in private until 13:08.

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