The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 23 October 2012

Session 4

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HEALTH AND SPORT COMMITTEE
28th Meeting 2012, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Kim Atkinson (Scottish Sports Association)
Rachel Cackett (Royal College of Nursing Scotland)
John Downie (Scottish Council for Voluntary Organisations)
Jim Eadie (Edinburgh Southern) (SNP) (Committee Substitute)
John Gallacher (Unison)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Stewart Harris (sportscotland)
Ian Hooper (VOCAL/Glasgow Life)
Dr Kristi Long (NHS Education for Scotland)
Alex MacKinnon (Royal Pharmaceutical Society)
Dr Andrew Walker (Adviser)
Martin Woodrow (British Medical Association)
Paul Zealey (Glasgow 2014)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Tuesday 23 October 2012

[The Convener *opened the meeting at 09:36*]

European Union Engagement 2011-12

The Convener (Duncan McNeil): Good morning and welcome to the 28th meeting in 2012 of the Health and Sport Committee. As usual, I remind everyone present that mobile phones and BlackBerrys should be switched off, as they can interfere with the sound system.

We have received apologies from Gil Paterson. It gives me pleasure to welcome back to the committee as substitute our former member Jim Eadie. Welcome, Jim.

The first item on our agenda is to approve a report to the European and External Relations Committee that sets out our European engagement over the past year. Under the changes to the Parliament's European scrutiny arrangements, all subject committees are required to submit such a report annually. The report simply lists what the committee has undertaken on European matters. Do members agree the report?

Members *indicated agreement.*

European Union Reporter (Appointment)

09:37

The Convener: The second item on our agenda is the appointment of a committee European Union reporter. Members will recall that the post was previously held by Richard Lyle, who has now left the committee. I understand that Aileen McLeod has indicated that she is very interested in holding it, so I nominate her for the appointment.

The question is, that Aileen McLeod be appointed as the committee's European reporter. Are we agreed?

Members *indicated agreement.*

The Convener: Aileen McLeod is duly appointed to serve as the committee's European reporter. Thank you all for that.

I suspend the meeting for a minute while our panellists take their places.

09:37

Meeting suspended.

09:38

On resuming—

Draft Budget Scrutiny 2013-14

The Convener: We move on to agenda item 3, which is continuing scrutiny of the Scottish Government's draft budget 2013-14. Our first evidence session this morning is a round-table discussion of the health aspects of the budget. At this point, I invite everyone to introduce themselves, even though we know many of the people who are here, as it is a useful way of starting proceedings.

Mark McDonald (North East Scotland) (SNP): I am an MSP for North East Scotland.

Alex MacKinnon (Royal Pharmaceutical Society): I am director for the Royal Pharmaceutical Society in Scotland.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife.

John Gallacher (Unison): I am the Scottish organiser of Unison.

Dr Kristi Long (NHS Education for Scotland): I am the equality and diversity adviser for NHS Education for Scotland.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Rachel Cackett (Royal College of Nursing Scotland): I am a policy adviser for the RCN in Scotland.

David Torrance (Kirkcaldy) (SNP): I am the MSP for the Kirkcaldy constituency.

Jim Eadie (Edinburgh Southern) (SNP): I am the MSP for Edinburgh Southern.

John Downie (Scottish Council for Voluntary Organisations): I am from the SCVO.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

Martin Woodrow (British Medical Association): I am the Scottish secretary of the British Medical Association.

Drew Smith (Glasgow) (Lab): I am a Glasgow MSP.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): I am from the Coalition of Care and Support Providers in Scotland.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow and deputy convener of the committee.

Dr Andrew Walker (Adviser): I am an adviser to the committee.

The Convener: I am Duncan McNeil, the MSP for Greenock and Inverclyde and convener of the committee. I welcome everyone.

As usual, we will do our best in this round-table discussion to do more listening than speaking.

I ask the deputy convener, Bob Doris, to kick off proceedings. I hope that we will make some progress thereafter.

Bob Doris: Thanks, convener.

In scrutinising the budget, we have already heard David Bell and John McLaren say that they believe that health has been prioritised and that, indeed, it is a budget for health. In cash terms, there is a £290 million increase to health boards, or a 0.5 per cent real-terms uplift. If we look at individual budget lines, we will see that the health inequalities budget is up 33 per cent and that the money for the early detection of cancer is up almost 15 per cent. In the round, that means that there will be winners and losers in the health budget. How has health been prioritised in general in the budget and what do the witnesses feel about the priorities that the Scottish Government has set out? If you do not agree with them, where would you take money from internally within those priorities?

Rachel Cackett: The health portfolio has come off better than many of the other portfolios in the way in which the budget has been structured and the way in which the committee is looking at how money has been spent. There is no doubt about that. That is not to say that everything in the garden looks rosy for health spending. We know that demand is increasing, that we have an ageing population and that drugs are ever more expensive, and those pressures are continuing. The front-line recurring money that is going directly to national health service boards is going up, but we are looking at a flat-line or perhaps slightly reduced in real terms overall picture for health, although that portfolio remains in a much better position than the position that many other portfolios are in.

On individual budget lines and where there are winners and losers, as we said in our written evidence, there are some areas—one of which is health inequalities, for example—in which the uplift is perhaps not quite what we expected from the comprehensive spending review. We understand from the Scottish Parliament information centre briefing and discussions with Government that some savings seem to have been found. It is interesting that, although those savings are comparatively small in cash terms, they have not been reinvested back into priority areas such as health inequalities. That was a little bit of a surprise to us, given that so much of the budget

narrative is focused on improving inequalities in health and generally across Scotland.

There is an issue that we face. On its own, the health budget is in a relatively sound position in not facing significant real-terms decreases, but as we move ever further towards an integrated way of delivering care, what happens in other budget lines, particularly those that relate to delivery of the outcomes that the Government has set for us, really matters. If there are decreases in what social care can provide, in the funding that goes to the third sector and in how we join up to deliver outcomes, we will have a much bigger question than a question that is about only what is in the health part of the draft budget. I know that, in the past, committees have called for a much more joined-up way of looking at how we will spend money in the future if our ultimate aim is to ensure that public sector funding as a whole is able to deliver better on the outcomes that we are all looking for. We have certainly called for that. The national health service cannot deliver those outcomes on its own, however well protected its budget is.

John Gallacher: The Barnett consequentials from the Department of Health spend have been passed on to NHS Scotland, and obviously we all welcome that. That has been sustained for the three years of the comprehensive spending review. However, NHS Scotland has been required to make 3 per cent efficiency savings for the past couple of years, and that is continuing. Members will see from Unison's submission that the targets have been exceeded by some £80 million over the past three years. Some £596 million has been taken out through efficiency savings over the past three years. Health still gets a very good report card on outcomes for patients and the quality of service in terms of satisfaction, but the pressure on the health service—particularly the workforce—to deliver is intense and intensifying.

Bob Doris asked about winners and losers, and the workforce has been one of the big losers in the past few years in relation to how NHS Scotland's budget has been managed. We have seen a significant reduction in jobs. Unison's submission includes figures from the Information Services Division of the NHS in Scotland for last year, which show that more than 700 jobs have gone. Prior to that, 4,000 jobs went. On top of that, significant vacancies are being managed and no jobs are being advertised in the health service, so there are fewer people trying to deliver against increased demand. In addition, health service workers are suffering the third year of a pay freeze and they are being asked to pay more for their pension contributions and to make registration payments that were previously paid for by employers.

09:45

The health service is doing well in managing the quality of services and its budgets. There was a revenue budget underspend this year, but that is being paid for largely out of the workforce budget cuts. The goodwill of the workforce cannot be sustained indefinitely and some of the efficiency savings need to be sown back into workforce measures to sustain what is going on now.

John Downie: I agree with Rachel Cackett: a bigger, more strategic discussion needs to be had. A lot of the discussion is about how to ensure a systematic shift in the balance of health spending.

It can always be argued that we should be spending more on health, but the real questions are whether we need to and where we should spend that money. The bigger issue is about shifting resources to deliver better outcomes. As Rachel Cackett said, health delivery impacts across a range of key policy areas and the same thing happens in reverse. What we are missing in part are cross-portfolio outcomes. People bandy about terms such as "whole-system approaches" and "total place" in relation to pooling budgets, but we need to look more clearly at the outcomes that we want. For example, the third sector's role in health needs to be better recognised and supported. If we are trying to deliver and drive change in the system we need to move more urgently towards community-based services, which need to be more clearly defined.

We cannot continue in the same way. We are all aware of the ageing population factor and the potential impact of welfare reform in the next couple of years. We need to accelerate away from institutional and acute care and towards community care. The question is how we get rapid growth to support and enable people to live well at home in their communities. That is about a shift in health resources—perhaps that does not mean less money in the top-line budget; rather, it is about where we are spending it.

The Convener: Are you arguing that the health budget should be protected? Is ring-fenced funding a barrier?

John Downie: We spend around £11 billion on health. We could debate all day the state of individual and community health in Scotland. We have the worst health outcomes in Europe, so it could be easily argued that that money is not being spent effectively to deliver better outcomes for people.

Spending the budget more effectively is about using a preventative and community-based approach. One per cent of the budget is spent on the third sector, which traditionally delivers significantly better outcomes and provides

services that are much closer to people, so we need to shift the balance.

The Convener: I am interested in the issue because we know that the Welsh Government has not protected its health budget. Before the October recess we had evidence from the previous panel about protecting the budget. Would that act as a barrier to shifting money?

John Downie: I need to think about that; I will come back to you on that point.

The Convener: Okay. I think that that is the real test, though.

Alex MacKinnon: Good morning, committee. My first concern centres on what looked like a £4.5 million reduction in the pharmacy services budget. We have subsequently discovered through conversations that we have had and submissions to the committee that that amount is a permanent transfer of a portion of funding from the e-pharmacy budget to NHS National Services Scotland.

That is a concern with regard to the whole e-agenda. The NHS National Services Scotland budget is experiencing a cut of £1.4 million, and the e-health budget is down for a reduction of £1.6 million. The challenge is to try to get some transparency around what is happening with e-health.

As we all know, one of our biggest challenges is an ageing population with people living longer with more chronic disease. We can overcome and cope with that challenge only if all health professionals work together, so we need to start breaking down some of the intra-professional and inter-professional barriers that exist.

The most important thing that we can do to help in that regard is to ensure that there is proper and appropriate electronic communication between healthcare professionals and between primary and secondary care. I am, therefore, a bit worried about the general information technology plans, as there is not complete visibility around them.

Proper resourcing for e-health is fundamental to the effective development of therapeutic partnerships between patients and everyone who is involved in their care. We urge the committee to seek further clarity and transparency around some of the intentions—and the subsequent budgetary provision—in the e-health strategy. Proper communication and a shared information system across the NHS are vital if we want to improve person-centred and preventative care.

Martin Woodrow: I do not want simply to echo my colleagues' comments, but I agree with much of what Rachel Cackett and John Gallacher have said. I will make a couple of points to follow up on those comments.

The British Medical Association said in its manifesto for the parliamentary elections last year that, rather than concentrating on organisations—such as those that are here today—talking about whether we are spending in the right areas, it is time for a much bigger debate on the issue and for us to broaden it out to the public for them to determine.

On health, the situation that we are in is such that we cannot go on as we are. We need a clear debate, and we need the public to understand that we are in constrained times despite the fact that the health budget is protected.

My second point is that the issue is wider than the health budget as far as the health impact is concerned. The BMA has said over the years that it is important for any policy decisions that are made across Government to be subject to a health impact assessment. We need to think cross-departmentally and across the public sector when we make decisions.

Annie Gunner Logan: I was interested to hear in the committee's previous evidence session the description of the budget as a budget for health. It struck us that, although that was a reasonably accurate description, the budget is not a budget for health and social care.

The complexities of current resource transfer arrangements may not surpass all understanding, but they certainly surpass mine. Most social care funding still comes through the local government budget, which is a completely different chapter of the budget and has been cut quite significantly.

Although we support—as I believe the committee does—the Government's proposals for health and social care integration and for a move to integrated budgets locally, we ain't there yet. Our concern is that, in the intervening period between what we have now and local integrated budgets, social care funding will go down at a rate of knots.

We want to bring that to the committee's attention. Bearing in mind what Rachel Cackett and John Gallacher have said about the contribution that social care makes and the impact that it has on overall health spend, that is an area of significant concern.

Dr Long: I agree about the importance of the larger, cross-public sector view. A good example of that comes from work that was done on gender-based violence—the cross-portfolio work that involved health services and a wide range of public sector organisations.

Inequalities are often easier to miss if we look at single programmes, single portfolios or single organisations. As we look across different portfolios and aggregate the impact, it becomes

easier to see more systematic issues. As we look across health and social care, that is likely to become more obvious, particularly in relation to potential risks of welfare reform.

Bob Doris: I will tease out some points from what has been said. I mentioned health inequalities because much of the money to deal with them should be spent in the community. That theme has come up in relation to the integration of health and social care or overlapping budgets. In the most recent year for which we have figures—2010-11—£341 million was transferred from health boards to local authority budgets. That has not been scrutinised effectively enough, and the committee is keen to scrutinise how that money is spent once it is transferred and how the third sector and other organisations are engaged in the best use of it.

I hope to know whether the witnesses have in mind targets—I know that we are looking at inputs again and that we need to look at outcomes. The strong view has been asserted that the third sector can often deliver more effectively in the community and do so at a lower cost. Given that, do you have an aspiration for the percentage of the resource transfer, of local authority budgets or of the NHS budget that should be spent in the community with the third sector? In moving towards the integration of health and social care, the committee would like to look at those things, to be sure about how money is spent, where it is spent and whether it is spent effectively.

Rachel Cackett: We do not have a percentage figure, and I am not sure whether that feels like the best way of taking us along the path towards better integrated care. It feels important that we all look at who the best provider is for a service that has been deemed to meet a need that has been identified locally. That is where we need to start. Another issue is that people need to be aware of the consequences of decisions about what is commissioned where and of the impact on wider services.

To pull out those things into a contained space might well lead us up a garden path that will not be very fruitful in the long run. However, that is not to say that we should not have a much broader debate about how services are delivered, about how the local needs analysis is best met by services that are available locally and about where new investment needs to go.

I am sure that we will discuss later where the change fund sits, alongside resource transfer. In relation to that, we would have the same issues as Bob Doris raises about the transparency of some shifts of resources. If we cannot get that right with the scale of resource transfer at this stage, we have a lot of work to do to ensure that, when we have a properly and fully integrated budget—that is what we are aiming towards—the problems are sorted out. That will ensure that, when we return to arenas such as the committee to scrutinise budgets, we are 100 per cent clear that we are investing in the right areas for the best outcomes for local people. We are some way off that yet.

I will pick up on the use of the word “protection”. We need to be clear that we are talking about protected budgets for health services. In the light of increased demand, that does not necessarily mean protected services. That distinction is important.

The budget has in a way been protected, which is great in the current circumstances. However, to pick up on many of John Gallacher’s points, given the pressures that the NHS is under, that absolutely does not mean that front-line services—the services that we can provide, given increased costs and increased demand—are protected in a way that means that everyone will get the same service next year as they are receiving this year. We must be absolutely up front that we are in that situation—what is protected is the budget, not services.

The Convener: Bob Doris asked about a percentage. In relation to where that money would come from, one of the submissions—I do not know whether it was yours—said that 10 health boards have already overspent their revenue budgets.

10:00

Rachel Cackett: Yes, that was in our submission. For the past three or four years, we have done a quarterly review of the performance of the territorial boards—the 14 front-line service boards—in the NHS. We have used freedom of information requests to get hold of the data that they submit to the Government on their performance.

The latest data that we have is for the first quarter of this year, so it is already a little out of date. From that data, it was clear that the majority of boards had already overspent on their revenue budgets. Some of them may be holding reserves to try to deal with that overspend over the course of the year, but pressures were clearly starting to show. Many boards were much further behind on achieving their efficiency savings than we would have expected in the first quarter of the year.

That certainly flagged up to us the fact that boards were under pressure. There have been headlines about certain boards facing significant financial pressure this year despite the fact that, as happened last year, their overall budgets were protected and many of them had an increase in their recurring revenue.

We wait with interest to see what comments Audit Scotland makes by the end of this month on the sustainability of spend in our NHS boards, because we have been trying to disentangle that from the end-of-year accounting decisions that are made to break even and achieve efficiency targets. There is a varied picture, but many boards seem to be relying on using their earmarked, non-recurring funding—their health inequalities money, for example—to make up shortfalls in their core spending on front-line services through their revenue grants. Although we are not talking about enormous figures at the moment, we are talking about a number of boards and we should examine the impact on long-term sustainability more closely.

John Downie: The change fund is designed to stimulate a shift in the balance of care and blaze a trail for health and care integration. Many good projects and services have been funded through that mechanism, but it is not clear to us whether that has prompted a real change in the system. We do not see a more general approach to planning, a management focus or public spending from acute care being embedded in community care. We do not see the projects being embedded.

We do not like the percentages in the budget. For 2013-14, a minimum of 25 per cent—which is only £20 million—of the change fund money must be directed at the third sector. That should be built into the guidance so that it helps to drive the change that we want. It could be monitored by the third sector interfaces and the team that the Government has around the Health and Social Care Alliance Scotland.

However, there is a bigger picture in relation to the shift in resources. We have said to the Scottish Government that, starting in the financial year 2013-14, it needs to create a more direct funding stream for the development of third sector capacity and roll it out pathfinder fashion. Four or five health boards should be identified to begin a programme with an initial budget of £10 million to examine collaborative and co-production approaches that are focused on shifting the way that we deliver health towards community care.

We also need to ensure full engagement with health and social care partnerships, so we need a strategic commissioning process. That would involve a shift from 1 per cent to 5 per cent of the budget being spent on the third sector. That is quite a small shift, but it could be quite a significant change in how we spend the budget. At the moment, the emphasis is still on acute and medical services. The decision makers in the NHS do not see the medical impact of prevention. They need to get with that agenda.

John Gallacher: It is true to say that resource transfer from health to local government and from acute care into the community has been a dark art in the past. In many places, the calculations around that were abandoned and a line was drawn in the sand.

The change fund is a ring-fenced pot of money. It is not a significant amount, but it has led to services that were previously in the acute sector being delivered in the community. In Lanarkshire, the age-specialised services emergency team—ASSET—project provides intense acute services for older people in their homes.

On the wider question, Unison's view is certainly that health and local government services are much better provided by directly employed staff of health boards and local authorities. Health boards have not outsourced many services in the past to the third and private sectors, but local government has done so to a significant degree over the past decade. Unison would have significant concerns if policy levers were used to force health boards to outsource and privatise significant tranches of community-based health services. The simple reason for that comes from Unison's experience of local government outsourcing, which is that it is a drive to the bottom for pay and conditions.

It is no exaggeration to say that over the past three years, a whirlwind has passed through the community and voluntary sector, which delivers services to the most vulnerable in the community, because the workforce's wages were cut by more than 17 per cent overnight and people's conditions of service were cut so that they operate on a basic hourly rate of £6-odd. I mean no disrespect to domestics in the health service, but people get £7.49 an hour for starting as a cleaner in a hospital.

Is it seriously the committee's intention to start a market for the provision of care services in the community in which carers are paid less than £7 an hour when they cater for the personal care and health needs of older people in society? I do not think that Scotland wants to go in that direction.

The Convener: In defence of the committee, I think that we have made some strong comments on commissioning, procurement and how we treat, and what we expect from, the care workforce.

Annie Gunner Logan: I will make a couple of points and then comment briefly on John Gallacher's points. I think that Bob Doris's first question was about resource transfer. I think that that has been and is a dark art. Many years ago we tried to track what was happening to a specific chunk of resource transfer, which was the money coming into local authorities from the NHS in respect of the closure of psychiatric hospitals and long-stay hospitals for people with learning disabilities—this was in the late 1980s and all through the 1990s. It is fair to say that the majority

of people who left long-stay hospitals were supported in the community by third sector organisations. It dawned on us about six or seven years into the process that the resource transfer money coming across from the NHS was being regularly updated for inflation, whereas the third sector providers who were supporting the people who came out of hospital had had six or seven years of standstill budgets, with no inflationary increases applied.

We tried to chase down why that resource transfer was not being transferred to the organisations that were doing the work, but we largely failed to do so. We were obviously quite curious about where the rest of the money was going, because it was clearly not going to the organisations that were supporting the people who had left hospital. We did quite a lot of FOI-ing about that back in the day, but we were reassured by colleagues in the public sector that it would all be okay once the joint future group had done its work. The committee will know that that is 10 years old already and that we are largely still in the same position now. That story perhaps illustrates to the committee how hard it is to chase down where resource transfer money goes and what it is used for.

On the question about targets and whether there ought to be an allocation of a fixed percentage to the third sector, I am probably with Rachel Cackett in that I think that it is about what the money goes for rather than who it goes to. Some of the discussion around this is the same discussion that the committee will have on quotas in any field, whether it is women on boards or whatever. The question is whether quotas are the best way to achieve change. The converse of the argument is that if change is clearly not happening by any other route, quotas might be worth trying in order to light a bonfire under the process.

On John Gallacher's comments about public services being best delivered by in-house services, in quality terms there is little evidence to support that, certainly in social care. I agree with him absolutely about the whirlwind passing through the third sector on staff terms and conditions. That is why I have appeared on panels before the Health and Sport Committee and its predecessor committees for the past 10 years banging on about the issue. The committee has been supportive on that, yet we are still no further forward. When I was before your colleagues on the Local Government and Regeneration Committee before last Christmas, I talked about developing the living wage through procurement, but I told them that, in many third sector and private sector organisations, the issue is now not the living wage but whether organisations are compliant even with the minimum wage. There are all kinds of arguments, which I have rehearsed before this committee many a time and oft, about the pressures that third sector organisations are placed under that lead to that situation.

Alex MacKinnon: Never mind what is going to happen with the shifting of resource under the plans for the integration of health and social care, it is extremely difficult to get a handle on what is happening with budgets at a territorial board level. The draft budget gives high-level detail but, from the professional bodies' point of view—I represent pharmacists, for example—it is difficult to get a handle on what is happening. What are the efficiency savings? Where is the cost cutting? What does it mean for the delivery of services at the front line?

From the professional bodies' point of view, those things are concerning, because we have a professional duty to ensure that we can inform workforce planning so that the workforce that will be required to deliver services in the future is put in place. We also have responsibilities for career development and for upholding the morale of our professions in what is increasingly becoming a challenging and difficult economic climate. To assure ourselves and to understand how resources are shifting, especially under the new health and social care integration agenda, we need much more transparency in budgets at a territorial board level.

Nanette Milne: I have a question about the cost effectiveness of NHS spending in general. As you know, the committee has been doing some work on access to medicines via the Scottish Medicines Consortium, the area drug and therapeutics committees and so on. It is clear to me that medicines are under close scrutiny and that we know exactly what value we get from them, but spending on medicines represents only 15 per cent of the NHS budget. It cropped up at one of our committee sessions that there is not the same level of scrutiny of many other services that are provided in the NHS. What are the panel's views on that? What further work needs to be done to get down to the nitty-gritty of getting value for money from the services that the NHS delivers?

Alex MacKinnon: The health professions, social care and the third sector need to work together more closely on getting value for money. We need to try to avoid duplication in the system. We need to iron out better who is responsible for what, with an understanding that what we do needs to be transparent and obvious, and that our responsibility does not stop with our own area.

We have responsibility for the patient journey all the way through. We have a shared responsibility as healthcare professionals, as carers and as third sector workers. I make a plea that, when we revise contracts, we consider how the different contracts—for healthcare professionals, for

example—link together. We are working closely with the Royal College of General Practitioners to do just that. We want to get clarity and a better understanding of what we are all doing in order to avoid duplication. That will produce efficiencies in itself.

The Convener: Can I stir up the discussion on that point a wee bit? I do not mean to single out Alex MacKinnon in particular. The various organisations, professions and interests have been coming along to see us for some time, and Bob Doris and I have heard similar things at the Local Government and Regeneration Committee as well. Given that everyone agrees that what Alex MacKinnon described needs to happen and that we need to get a grip on this, why has it not happened?

10:15

Rachel Cackett: There are times when I ask exactly the same question.

Alex MacKinnon mentioned duplication, but there is also an issue to do with joined-upness and how we become more efficient as a joined-up workforce. One issue that we have been banging on about—to use Annie Gunner Logan's words—for some time is the lack of joined-upness in workforce planning. We have a workforce planning system that compartmentalises the professions and does not look at, for example, the implications that changes to junior doctors will have for succession planning for advanced practitioners in the nursing profession. To us, that does not seem like a good use of resource or a good way to forward plan. Such changes will certainly have an impact on the number of students that we might want to take forward in looking at succession planning for the nursing workforce over, say, the next 10 years.

If we cannot even manage to get the Government departments to sit down and look at those things together, we will constantly end up with gaps that not only people but money will keep falling into. Despite asking for that as a professional body for some time, we still have an issue with that not happening as a joined-up piece of planning—and I have to say that I do not know why.

John Downie: Convener, you probably hear quite a lot from people from different sectors with different vested interests. We are arguing for more direct spending on the third sector because we think that it can deliver better outcomes, but you will hear the same from the trade unions and health professionals. Everybody says, "Give us more," "We can do more," and "Don't cut us." Part of the issue relates to how we can work better by taking a co-production approach. At a discussion that I attended last week, a number of councillors around the table said, "We like the principles of self-directed support but,"—they like the principles but, frankly, they do not want to give up power and control to individual people in their communities.

Part of the issue is that we are not seeing a transfer of power. We are talking a lot about health outcomes but, frankly, as Martin Woodrow said, most of the time we do not ask ordinary people about what outcomes they want for their communities. A way to address health inequalities is by shifting power and resources so that local people can make decisions, which I think they can do. We know that these are constrained times, but we need to see a shift in the power dynamic. Most of the time, people are being told what is best for them rather than being allowed to work it out and being helped to do things for themselves. Part of the shift that is required is that we need to address some of the vested interests.

In terms of health, we also need to look at what we want to achieve and how we will achieve better outcomes for health and wellbeing. Frankly, the medical model that we have at the moment does not work. We are spending £11 billion a year and we still have the worst health outcomes in Europe, so what does that tell us? If we do not change that at the top level and recognise that, we will still be here in 10 years' time.

Martin Woodrow: In response to Nanette Milne's original question about value for money, we absolutely agree that there needs to be more scrutiny of other budget areas as well as the drugs budget. As we said in our written evidence, health boards do not provide the information to allow that scrutiny to be undertaken.

One question that occurs to me is this: what do we mean by value for money and what is it that we are trying to measure? The key thing at the moment is that we are focused very much on specific numbers and outputs—how many Xs we are getting through—rather than the impact. Obviously, we are moving towards the equality agenda, which is a big issue for the Government, but if we are to start assessing other services realistically, we need to focus on what it is that matters to us when we are undertaking that measurement. At the moment, it is all about numbers.

Following up on Rachel Cackett's point about workforce planning, I entirely agree that there is a need for clear, joined-up thinking about how we plan the workforce. We have been trying to do that for years in medicine specifically, but we have not been able to get that right on a specialty basis never mind across the workforce. I think that the will is there, but it is incredibly difficult to achieve.

John Gallacher: I am afraid that I disagree with Nanette Milne. I do not think that enough light has been shone on the drug costs in NHS Scotland, which are growing. One of the budget headings that the territorial health boards struggle to manage and maintain is drugs, because of new drugs and the existing pattern of prescribing.

There is more recent work at a Scottish and regional level. I was at a meeting of west of Scotland boards last Friday when a drug waste project was being set up. Hospitals are having to do drug reconciliations of older people admitted into hospital to gauge the impact of the various and multiple medications that they are on, some of which are counteracting each other and some of which are harming patients rather than helping them. A huge amount of work can and should be done to strip inefficiencies out of the drug budget in NHS Scotland and move to generic drugs rather than labelled drugs. Every pound spent on wasted drugs, which often end up in people's bins, could be invested in workers in the community, whichever sector they are in, and begin to address issues around a minimum-wage economy in the sector. The issue of drugs should get attention at all levels of the health service.

Annie Gunner Logan: I want to draw out something that we put in our written submission on value for money. Value for money is often interpreted as being about how we make service X more efficient, whereas the larger question, which comes back to something that John Downie said, has to be why we are doing service X at all. Rather than perennially focusing on making service X more efficient by stripping out management layers, cutting terms and conditions or whatever, we should be asking what outcomes service X is trying to achieve. What we should be interested in is the whole issue of systems efficiency.

Something that is quite positive in the budget and in the Government's approach is the emphasis on strategic commissioning, which has to be about linking investment decisions to the outcomes that we are trying to achieve. The first question is what we are trying to achieve. What needs to be put in place to bring that about? By all means, we should make things efficient, but it is pointless trying to make a particular service response efficient if that service is constantly feeding the demand. The broader point is what value for money actually means in this kind of landscape.

Alex MacKinnon: I truly believe that people should be able to get the medicines that they require. We know that there are polypharmacy issues, but those can be sorted out with proper pharmaceutical care. Pharmaceutical care is not just the remit of pharmacists; it should be part of the entire health system. This is more about who takes responsibility. How many people have really experienced person-centred care? Too often, it fails somewhere along the journey. It is about each individual who is involved in care taking responsibility and ensuring that that responsibility does not stop when the patient moves on to the next part of the journey.

I believe that the issue of medicines can be sorted—we have already done a lot to sort it. However, I must stress that budgets should still allow people to get the medicines that they require. There is a big piece of work still to be done on ensuring that people are taken off medicines that they do not require. The statistics on that, and the reasons why people are hospitalised—in my short submission I detailed some examples—show that there is a massive piece of work to be done by all of us here, not just pharmacists.

Dr Long: It strikes me that the issue of value for money links up very well with the issue of the equalities scrutiny of the budget and the equalities scrutiny of the health budget. I agree that there is a need for further information from the health boards about how that is playing out within the part of the budget that is devolved to them. Value for money is also about value for all the people who use the health service, in all their diversity. That needs to be considered within the discussion about value. That is one of the reasons why equality and diversity are so important.

It strikes me that there might be an opportunity here, particularly if the committee is going to take forward the plan previously discussed to survey the boards again this year about local-level spend on the equalities question. Boards are in the process of agreeing the equality outcomes that they want to deliver for the next four years, and there is quite a lot of engagement with and involvement from communities on that. There might be some interesting opportunities to explore how outcomes are resourced and delivered, and what kind of lessons could be learned from that in relation to value for money and the system as a whole. I have not seen all the boards' outcomes yet.

There may also be opportunities to think about how we could support that in a more joined-up way nationally, regarding how boards work together and with local authority partners, and there might be a critical role for co-production, in terms of changing how some of the work is delivered. There are quite a lot of opportunities that may be worth exploring in future.

Jim Eadie: A number of issues are emerging from our discussion. I will pick up on two of them: medicines and the change funds.

Although I would not agree with everything that John Gallacher said, his point about medicines waste was well made. Building on Alex MacKinnon's point, I wonder whether there is a role for more thorough and extensive reviews of people's medicines, particularly among the older population, by community pharmacists in primary care and general practice. I do not know the BMA's view but, frankly, general practitioners do not always have the time to do the regular review in a 10-minute consultation. It could be more effectively undertaken by a community pharmacist in general practice or primary care. There have been some good exemplars of good practice. I am reminded of one in Fife, where pharmacists were recognised for their part in doing two things: ensuring rational prescribing and proper pharmaceutical care, and reducing waste in budgets. That seems to be a very important area on which I would welcome panel members' views.

Regarding change funds, the amounts of money are significant locally but relatively small within the overall NHS spend. They have the potential to bring about the shift that John Downie referred to from services that are provided in the acute sector to services that would be more effectively and optimally provided within communities. I would like to tease out some of the things that witnesses have said and ask them to say a bit more about the lack of spend in connection with the change funds. The change fund finance thematic review identified 21 partnerships that reported an underspend in 2011-12. In all those cases the underspend was carried over to the following financial year. The reason that was attributed to that was a time delay between approval and the establishment of change fund intervention. I would welcome panellists' views on that.

As we have people from the RCN and Unison in front of us, I would like someone to raise the issue of family nurse partnerships if there is time later on. At the moment, it would be helpful if we could deal with medicines and change funds.

Martin Woodrow: I will respond to the point about medicines and pharmacies. I think that we are talking largely about general practice. Generally speaking, GPs welcome the involvement of primary care pharmacists as prescribing advisers in the way that has been described. That is certainly taken seriously in general practice. Recent changes to the quality and outcomes framework, for example, target the prescribing and use of medicines. There are a number of new indicators around internal review and the assessment of the effectiveness of drugs, and, indeed, external peer review of prescribing patterns in practices. There is certainly willingness in general practice to work with the pharmacy community on these issues.

10:30

Alex MacKinnon: I concur with Martin Woodrow's point. In a primary care setting, prescribing advisers play a vital role in achieving efficient prescribing and in making the best and most efficient use of the drugs budget for patients. Medicines play an enormous part in the health and wellbeing of the people of Scotland. The chronic medications service in community pharmacies is designed to achieve exactly what Jim Eadie described, and we need to get that rolling and working properly following the pharmaceutical care review.

We are under increasing pressure given our elderly population. People will—thankfully—be living longer, but we will probably all have more than one chronic disease that will need to be dealt with. The role of pharmacists in that regard is immense, and they also have a role in reducing the drugs budget. We need to ensure that people are on only the medicines that they need, and that they are taken off medicines that are causing them problems. It is as simple as that.

Dr Simpson: What do you feel about the fact that we have excluded those in residential care from the chronic prescribing systems that are coming in? Those systems are very effective, and people can sign up to them. I have signed up to one, and my pharmacist now advises me on what is happening.

Alex MacKinnon: My response to that is a professional body response, because—as you are probably aware—we produced a massive report earlier in the year about improving care for people in care homes. We feel that those people need a more specialised level of care. That does not mean that we are excluding community pharmacists from being able to deliver that care, but they may need to work with specialist pharmacists in primary care and the hospital sector. We and the RCGP are committed to sorting out care of the elderly in care homes, which is one of the issues in our joint working action plan. To return to the convener's question about what we are doing, we are trying to sort that out.

The Convener: Jim Eadie mentioned the change fund. Can we get a response on that?

We know from the written submissions that we have received that the issue is not simply how much there is in the fund or whether we need to increase the amount. The big complaint is that the third sector is not at the table. The change fund remains in the hands of the health boards and the local authorities. We have seen from some of the submissions that those bodies have been using a lot of that money not to introduce preventative measures but to buy up residential care places.

Can we have some comments on how that money has been used?

John Downie: I think that you are right. That has been happening, particularly in the first year, and I have given names to committees before. It has happened in Glasgow, where bodies have been buying up residential care and using their own care services to deliver services there.

However, there is a move away from that. In a number of areas the third sector is getting round the table a bit more and becoming more involved in the decision-making process. Given that we are now in the second year, it was probably to be expected that there would be a mixed picture in terms of progress.

The main point is how, in the remaining years, we place more emphasis on building the capacity of communities to support and sustain responses to people's needs. We need a multidisciplinary approach. In a sense, the third sector has to get its act together so that smaller community organisations can be part of a larger supply chain working with specialist national and social care voluntary organisations to deliver their services.

There is much room for improvement. The Long Term Conditions Alliance Scotland and the interfaces have been doing quite a lot of work on the change funds, and they are currently analysing our report on what is going to happen in that regard. I have not seen all the details—

The Convener: What do local authorities and health boards do about the increasing demand on them? Do they just forget about the demands on their budgets? The local authority budget is being cut, and the health budget is being squeezed and there is greater demand on it. What is in the budget that can help them to make that transition?

John Downie: Funnily enough, the Scottish Government positioned the budget as a budget for enterprise, yet £8 million went to enterprise while £263 million went to health. One could argue that health has the money there, notwithstanding going over budget, which is more of a management issue.

Yes, there is increasing demand, and we cannot cope with that if the medical model does not change. That is why we must downstream or upstream—depending on which terminology we use—towards more community-based solutions.

Let me give you a quick example: I am chair of a social enterprise based in the east end of Glasgow. A project that we did with Cassiltoun Housing Association to reduce social isolation among older people worked really well and had a great social return on investment report. Not only did it reduce social isolation and allow people to get more engaged in their community and with their families but, with less demand on services, fewer visits to GPs and hospitals, less smoking and drinking and so on, it had knock-on health benefits for Glasgow's NHS budget. I could also mention Food Train in Dumfries; indeed, we recently sent the Scottish Government a whole range of preventative third sector projects that are helping to reduce that kind of demand. We know what works, but the question is how we expand and build on it.

Annie Gunner Logan: The big issue with the change fund always was and still is how to stop it being spent on shoring up existing services in a time of austerity. Age Scotland's submission to the committee documents some of the more questionable choices with regard to change fund spend.

We think that the guidance on what the fund should be spent on was never really tight enough and that the scrutiny that the Scottish Government—or, indeed, anyone else—brought to bear on spend was simply not sufficient. A more fundamental point is that we still have no clear national or local picture of what success looks like. Even if the thing has been a roaring success, we might not be able to identify that because we have never really been able to pin down the current baseline and therefore what we need to spend on various things.

Sometimes I wonder whether I should know better, but I have an almost ridiculous sense of optimism about the strategic commissioning agenda, as long as it is properly taken forward. All the voices that John Downie has talked about, such as the community groups, the patients and the service users must be included, all their ideas, thoughts and proposals on what should be provided in the first place must be taken on board and investment decisions must be made on that basis.

As for the third sector's involvement in the change fund, things are, as John Downie suggested, coming on. In the beginning, we had a little bit too much of people handing us a plan and simply saying, "Sign it," but things are moving on from that.

Rachel Cackett: I agree with much of what has been said about the change fund. At the moment, it is still quite hard to track a lot of what is going on. When we looked at this year's plans and examined the variation in spending by the partnerships against the different thematic headings, we found the spend to be very variable. That might be justified, but there is nothing that tells me why that should be. For example, under the enabler theme, some partnerships are spending quite a lot on the resources that they need to enable the sorts of shifts that we are hoping for, while others are spending almost

nothing. Those partnerships might have the best reason in the world for spending so little—they might already have done a great deal of work to put them in the position to do what they need to do—but it is very hard to unpick what lies behind the figures and find out what that actually means at a partnership level. We can do more on that. I also point out that the process is very new and we must ensure that the scrutiny and guidance is right, while giving people enough time to find their way. In that respect, it is good to hear the third sector saying that it feels a bit more included.

My second point comes back to the convener's question to John Downie about what health boards and local authorities are meant to do, given the pressures that they are under. We have raised this issue on a number of occasions. Although we support what is a fairly fundamental shift in the delivery of care, the fact is that it is happening at the most difficult time possible. That might be helpful in focusing all our minds, but we are having to do all this without any pump priming, additional funding or buffer zone to deal with the fact that, while we try to get things right and change things for a generation that might have very different—and, one hopes, fewer—health needs than those in present middle and older age, whose needs are significant and often very complex, we have no additional resource to continue to give those in middle and older age who already have health needs the treatment, the care and the support that they should have the right to receive. The difficulty facing health boards and councils is how to effect a shift without reducing the service that we around the table and our parents would want to receive. It is an absolute conundrum.

I sound a note of caution about characterising what is happening in the NHS as being entirely down to the medical model, because that does a disservice to an awful lot of change that is happening. I know that Jim Eadie wants to talk about the family nurse partnership, but an awful lot that is going on in the public sector goes way beyond what has been characterised in the past as the medical model. At the same time, we should not forget that the NHS often deals with very complex clinical needs that require complex clinical interventions and sometimes we need to establish a continuum of care from very low-level early intervention support through to end-of-life situations involving people who have complex needs, who are trying to live in the community with complex conditions and who require medical, nursing, pharmaceutical and allied health professional support. I think that we can all play a part in that by understanding at which stage each of us in the professions represented around the table and those beyond this room can provide the best possible intervention and ensure that we all get the care that we need. I simply caution those who might be trying to create divisions between different parts of the sector.

John Gallacher: The health service introduced a very ambitious quality strategy just as the austerity tornado hit and, in order to achieve the two objectives of improved quality at a reduced or similar cost, it has done a great deal of innovative work on models of care that are not clinically based for a whole range of occupational groups. The reason that it has been able to do so is that, through the NHS partnership model, the health service workforce has a voice in how change could and should work.

Discussions about the change fund happen in darkened rooms between health board and local authority directors of finance, but the only way we can change, innovate and revolutionise services is by engaging the community workforce from a social care, healthcare and third sector point of view. After all, if we are to try to meet demand, we need to change models of care. That cannot be done from the top down or by imposition; instead, we need to engage the workforce across community health and social care partnerships. The people who know best how to save money, save time and improve quality are those who do the job 365 days a year and for step-by-step change to happen in what is a very difficult economic context we need to take a bottom-up approach and engage the workforce.

Dr Simpson: Does the current management structure facilitate such an approach? Is there management out there that asks its workforce how they, as individuals, can improve their efficiency? As a clinician, I found management to be a barrier, not an asset, in that respect.

John Gallacher: The committee will know about the staff governance standard, which gives every member of the NHS workforce a right to be involved in decisions that affect them and in the planning of their services. That kind of standard does not exist in most local authorities or in other third-sector providers and, in its submission, Unison promotes the introduction of a staff governance standard across all public services and for commissioned providers to achieve the goal of giving the workforce a strong voice and say in the matter.

We need to listen and talk to what those around the table have called vested interests, service users and patients. However, one of the crucial groups that needs to express a view on taking services forward better is the workforce and we need to engage those people.

10:45

The Convener: We plan to end this session at 11 o'clock, so we are coming towards the end of it.

The panellists now have the opportunity to touch on areas that they believe that the committee might not have covered, or to say something in support of their submission, or to highlight something from their submission. Are you satisfied that we have covered all the areas that are important to you?

If none of the panellists wants to take up that opportunity, I will let members ask questions. I was trying to give priority to the panellists because we are here to listen.

Jim Eadie: I want to make sure that if the panellists take up the opportunity that they seem to have declined, one or more of them addresses the issue of family nurse partnerships.

We know what input, by way of funding, has been committed in the budget to the roll-out of family nurse partnerships in Edinburgh and Tayside. I would like to hear what witnesses think the outcomes should be, what success should look like, and how we should ensure that it is measured through the evaluation process.

Rachel Cackett: The committee is probably aware that the licence agreement on the family nurse partnership is fairly tight and that there are clear expected outcomes on the long-term thriving of those children and families. Some set outcomes are being looked at.

To go back to Nanette Milne's question about value for money, the family nurse partnership is a good example of a new way of delivering services. The outcomes will be fully evaluated and we will look at whether we are achieving what we said we wanted to achieve. We are using a different way to focus high levels of resource on those who have been identified as being in most need.

We have provided specific briefings on the family nurse partnerships in the past and we would be happy to resubmit those to this process if that would help.

We have been very supportive of the roll-out, but have said two things about the family nurse partnerships. The figures that are often given for outcomes are based on the initial trials that took place in the United States, which does not have a universal health visiting system in the same way as Scotland does. It is therefore important for us to take our time to look at what is happening in the United Kingdom. England is further down the road in the roll-out of its pilots, which are also going through full evaluation.

The other point is that we should look at the impact of the targeted services. That might come back to the convener's point about how to deliver current services and make that step change. We need to look at the impact of the roll-out of the family nurse partnership on the health visitor numbers that are available for universal services, to which members of previous committees have signed up. Although it is not the case that someone who wants to become a family nurse partnership nurse has to have been a health visitor, our understanding is that that is true of many people who have gone into the role. The role is a really exciting one for a health visitor to step into. We are therefore interested in looking at the back impact on health visitor services more generally, particularly because we have not been recruiting anything like the number of health visitors that we need. The RCN is looking at that point, particularly in light of the upcoming children and young people bill. Our submission to that consultation has focused heavily on the importance of the role of the health visitor for zero to 5-year-olds, before children enter full time education. We need to be mindful of the implications of a service change on a wider system.

John Gallacher: I support the point about supporting and advancing the role of health visitors in the community. Unison has a significant interest in that membership group and proposals have been made in the past to dilute and genericise the role of community nursing, and that is to be avoided because of the specialist support that families need.

The earlier point about welfare reform should also not be forgotten because it will impact on the most vulnerable families.

Mark McDonald: When we kicked off today's discussion, the deputy convener asked panel members whether they were satisfied that we had the right priorities within the health budget and, if not, what they would shift. I think that we have not had as much focus on the second aspect of that question as we might have wanted. Obviously, when we come to write our report, if we wish to reallocate money to a specific area, we have to take it from another area of the health budget. Are panel members satisfied with how the health budget is allocated, or are there specific changes that they would wish the committee to look at within its report?

For example, if panel members want spending to be increased within their area of interest, where should the corresponding reduction come from to fund that? That is the kind of work that the committee has to do in delivering its draft budget report. We cannot simply say, "Let us increase funding to budgets X, Y and Z," without indicating from where within the health budget those moneys should come. This may be putting folk on the spot; perhaps panel members could reflect on the question and come back to us with a further submission if they are not willing to put suggestions on the record at this stage.

The Convener: We have already heard John Downie's opinion—two or three times now. [*Laughter*.] Does anyone else want to answer that?

John Downie: I was going to mention the budget line for "miscellaneous other services". Why is that money there?

The Convener: Yes, you mentioned that figure in your submission. That is fine—we picked that up in your evidence. Does any other panel member want to answer?

Martin Woodrow: The simple answer is that we do not have a fixed view that money should be shifted within the health budget from one area to another—or, indeed, that money should be shifted out of the health budget—but we need to recognise the wider impact in other areas that spending on health can have on individuals and the nation. I think that this committee has recently emphasised preventive spending, and we think that it is right to see that as a priority. Certainly, we should focus on things such as the social determinants of health and put greater emphasis on the significance of those for where we spend money. That is a focus that we would like to see without suggesting, in answer to your question, other areas where the money should come from.

Annie Gunner Logan: I will be boring about commissioning one more time, while there are still some minutes left. It is not a question of the Government saying, "Oi, you lot, we are going to take away that money for your acute hospital spend so that you can free it up for something else." That has to happen at a local level, and I think that strategic commissioning is key to that. The key question is not what comes out of one budget and goes to another, but how budgets are transferred locally, certainly in respect of health and social care.

Alex MacKinnon: In response to Mark McDonald's question, I take the committee back to my opening remarks about the e-health budget. We have been asking for it to be sorted out for a very long time. The Scottish Government is carrying out a review of improving pharmaceutical care in the community, which I am sure will eventually evolve into a new strategy for the pharmaceutical care of people in the community, but the big enabler for that is to have proper information-sharing systems, especially between secondary care and primary care. Every stakeholder at those meetings identified that—not just pharmacists but doctors, nurses, patients and everyone involved—and we need to get this right. That will be a massive enabler in terms of improving person-centred care and smoothing the journey for patients. My plea is to look at that, because we have seen how there are potentially cuts across three areas. I would certainly like to understand that.

John Gallacher: At best, the territorial health boards are getting a stand-still budget, while the special health boards are facing a significant cut. In 2013-14, an extra £214 million is being allocated out into the service—obviously, health boards are held to account in some detail for that through the review process and are required to come into balance during the financial year—but £42.9 million is being retained by the health department. The amount that is retained centrally by the health department has increased in recent years. That expenditure also needs to be scrutinised, because it is a significant proportion of the allocation to the service.

Dr Simpson: Part of my question has been answered. I wonder about the e-health agenda, because the cuts are in pharmacy, in the e-health budget and in NSS. There are three sets of cuts, yet we know that the emergency medical record system is under massive stress. It is already old and it operates on a poor platform. Access to that will not happen, so that is a major problem. Is that generally recognised?

Are people being asked what we should stop doing? Should we ask what people should stop doing? We can look at things in order. If we intervene when someone has a heart attack, we prolong people's lives. However, we can go down from that and say that other investment is producing a minimal response. Giving every patient statins might reduce their cholesterol, but will that do any good? I do not know the evidence base for a whole medical agenda that is out there. With four minutes to go in the evidence session, convener—

The Convener: We need an hour and a half for those questions.

Dr Simpson: We are doing many things for which we do not have an evidence base and which we should stop doing. Does that relate to the debate to which Martin Woodrow referred? Do we need to have a debate with the public and say, "We have to cut our cloth. We must stop doing A, B, C and D because, although they are interesting, helpful and may improve some people's quality of life, the benefit is marginal"? Given that we have lost 2,500 nurses and that heart failure nurses are being made to work in general wards instead of supporting heart failure patients, we are going backwards in the care that we are providing.

The Convener: It is Martin Woodrow's job to advocate on behalf of doctors, so he can come in.

Martin Woodrow: That is precisely the debate that I suggested in my first comments that we need to have. I do not like to pick on homoeopathy, but it is the thing that always comes

up when we discuss evidence-based medicine. We agree with Dr Simpson's point.

Jim Eadie: Some of your members practise homoeopathy.

Martin Woodrow: Yes, they do.

Rachel Cackett: The debate is about the choices that we must make now. We must be up front and honest about what some of the choices might be. A public debate is required. In evidence this year and in previous years to this committee and the Finance Committee, we have called for a significant debate on what the choices are. Healthcare is rationed in its way, whether that is through the quality-adjusted life year limits that are put on whether someone gets access to medicine or through a waiting time.

There is always a level at which choices are being made. The difficulty arises when those choices start stacking up to be no choice at all, because there are so many of them. We must start to open up, and Bob Black's recent comments were an interesting way to start us off by asking what we can afford in the current climate if we are to keep the quality of services high, on which Richard Simpson's point is well made. Chipping away at the workforce to meet an end-of-year target will never be the way forward for quality care, but that is where we are.

John Gallacher: We have salami sliced a lot of budget heads for the past three years and that cannot go on for ever. A number of boards have put forward more ambitious structural plans to centralise services, including the centralisation of accident and emergency services in Ayrshire and in Lanarkshire. Those plans would have saved significant amounts of money, but they have not been proceeded with. We are reaching a time when decisions need to be made about disinvestment from services and when a more fundamental look at the pattern of services is needed. That is where we are headed.

Annie Gunner Logan: I highlight that what has been described is already happening in social care. Local authorities are deciding no longer to support people who have low to moderate needs—that is finished; that is it. Only if people's needs are substantial and critical will they be offered any kind of service. That is a type of disinvestment, but it is not the disinvestment that any of us would necessarily support or want.

11:00

Dr Long: A linked point is that it is important to understand the impact of disinvestment on the diverse groups of people who use services. I agree completely that we do not want unplanned disinvestment; we want disinvestment to be planned such that we can understand the impacts and consider how best to take mitigating action and meet people's critical needs in other contexts.

The Convener: I believe that Bob Doris wants to correct a statistic.

Bob Doris: I am pretty worried about my eye health, because the 33 per cent increase that I referred to in my opening question was in the budget for dealing with not inequalities, but pandemic flu. I am sure that the eagle-eyed among us knew that already but, if I have given a wrong statistic, I have a responsibility to correct it at the earliest opportunity. The record will now show that.

The Convener: I thank all those who have joined us on the panel. We appreciate your evidence, your participation and your continuing support of the committee's work.

11:01

Meeting suspended.

11:09

On resuming—

The Convener: We continue with agenda item 3, which is draft budget scrutiny. I welcome Paul Zealey, head of engagement and legacy at Glasgow 2014; Stewart Harris, chief executive of sportscotland; Ian Hooper, vice-chair of VOCAL and director of sport and special projects at Glasgow Life; and Kim Atkinson, policy director of the Scottish Sports Association. We do not have the benefit of written submissions—given the short notice, that is not a criticism—so I would like to give the panel an opportunity to put some thoughts on the record if they wish. We can then proceed to questions.

Paul Zealey (Glasgow 2014): I am happy to open up. The Scottish Government is the majority funder of the Glasgow 2014 games. The package that has been established for the business plan sees support from Glasgow City Council and the Government and an earned income target from the organising committee. We are on track with that and are making good progress.

The committee will be interested in hearing how we can use the games as a driver for the Government's legacy ambitions and aspirations. The budget is sufficient to do what is in the business plan, but that is only half the story. How we procure services, work in partnership and deliver activities has the potential to create a lasting legacy from the games for people in communities throughout Scotland. We are keen to see how, in the context of the Scottish Government's budget window, the drive that the

games can provide can help to deliver on the legacy aspirations around economic development, physical activity, the regeneration of sustainable communities throughout Scotland and Scotland's international reputation.

That is my opening gambit in terms of the budget contribution that the Government makes to the organising committee.

Stewart Harris (sportscotland): I guess that it is important to talk about ambition. We would like to see a world-class system for sport in Scotland. There are two elements to that: performance, which is winning and being successful regularly on the world stage, and the system that is required to underpin that. However, as I have said previously in committees, the big ask is now how we support sport and recreation at the community level over the next few years.

It is worth reiterating that the current Government budget for 2013-14 will be £38 million. We are fortunate in having additional lottery revenues of approximately £6 million, which are coming back from the UK Government's readjusted shares. That is absolutely welcome. Also, what had been top-sliced for the Olympics from the sport lottery budget will now be returned. That gives us quite a lot of scope, and the bulk of that budget is intended to go back into community sport as we work with local partners, particularly local authorities and their agencies.

Ian Hooper (VOCAL/Glasgow Life): As I am sure that you are all aware, local government is a key provider of sports services across every local authority area in Scotland. Those services involve facilities management, the provision of facilities, the maintenance of facilities and the programmes that take place within those facilities. They also involve sports development with an increasing emphasis on capacity building in the voluntary sports sector and volunteer, coach and club development. Local government is also an active partner to agencies such as the NHS, education and social services.

The challenge for local government at the moment is to take advantage of and build on the legacy that 2014 will provide not only for Glasgow but for the whole of Scotland while meeting the challenges arising from pressures on the budget over the next two years. In addition, we must maintain the quality of the services that we provide, enhance sports development and build participation in deprived communities where participation levels are lowest. Those are the main challenges.

11:15

Kim Atkinson (Scottish Sports Association): As I am sure that members know, we are the membership body for the governing bodies for all the different sports in Scotland. We welcome and are pleased with the fact that sport's contribution seems to be recognised in the budget. There are opportunities for sport, which are mostly to do with how the resources are best spent and how giving sport additional priority can bring additional benefits.

An interesting question among our membership relates to the current budget timelines. There is a lot in the draft budget on delivery of the games but, beyond that, what are the Government's thoughts on delivering a legacy from the games, which, for our members—along with delivery of a successful games—is unquestionably one of the biggest aspects of the games?

There are budget opportunities to do with the consideration of facilities, which I know came up at the committee's first session and as part of its community sport inquiry, which we gave evidence to. We have mentioned the legacy, which I am sure we will come back to. In that context, the ask from our members is to do with physical education, people, places and performance, as I am sure that members are well aware. I am sure that we will return to those themes.

Opportunities to do with prevention—which I know is certainly not a new word to committee members—have been mentioned. There is an opportunity for the radical shift that has been requested. Sport and physical recreation can make a huge contribution to that, and I am keen to explore that opportunity. Linked to that is early intervention, which is regularly mentioned in the context of prevention, and the huge opportunity that exists for quality PE and for developing physically literate children. I think that there are a number of opportunities in that area.

The Convener: Thanks very much.

Do we know what it would cost local government to maintain the facilities that it has in place at the moment and what the bill for that is likely to be over the years? Is that reflected in any way in the budget?

Ian Hooper: I do not have the figure to hand, but the most authoritative piece of work that has been done in recent years on the physical maintenance of sports facilities in Scotland is the sportscotland report, "The Ticking Time Bomb". Although it is a few years old, it gives a pretty good indication of the level of challenge that Scotland faces with regard to the life-cycle maintenance of facilities such as swimming pools, sports centres, sports facilities and pitches. With the migration from red blaes and natural grass pitches to synthetic grass pitches, pitches might be less of an issue. The greatest challenge when it comes to the maintenance of facilities, as figures

in that report probably show, is presented by swimming pools, which are inherently difficult and expensive to maintain. They deteriorate more quickly than other facilities because of the environment that is created for the operation of pools. A number of pools, particularly those that were built in the 1950s and 1960s, and before then, require refurbishment and refreshment. Swimming pools probably present the major challenge as far as facilities are concerned.

The Convener: Is there an audit, as there is in health, of the maintenance backlog, what needs to be done and how much needs to be invested?

Ian Hooper: Each local authority will approach the issue in its own way but, increasingly, local authorities are approaching sports facilities as part of a wider estate strategy. That involves looking at the opportunities for improvement and rationalisation that exist in an authority's public estate. As part of such a strategy, one might look at the opportunities that exist to build new schools that incorporate improved sports facilities to which community access is provided and to close a swimming pool or another sports facility in the local area that is suffering from age and deterioration. Increasingly, sports facilities are being looked at not in isolation, but as part of wider physical estate strategies.

The Convener: What discussions take place with other organisations that are creating excitement and expectations and, indeed, trying to encourage participation rates that are dependent on local access and good-quality facilities? Is there a balance that is reflected in the budget?

Ian Hooper: Quality facilities are critical to participation. One should not underestimate the importance of refreshing, maintaining and improving sports facilities, whether they are stand-alone or are part of schools that are open for community access. The design and quality of changing facilities and the quality of the pitches that people play on are important. We see that all the time in terms of levels of use, attendance and participation.

In answer to your question on other organisations, we work closely with sportscotland on strategically auditing the quality of facilities across Scotland in each local authority and identifying needs—I am sure that Stewart Harris will come in on this—in each part of Scotland. That is an on-going process.

Stewart Harris: Our relationship with local government is very good. We have a good strategic relationship with all local authorities, and we bring the resources that we can, in terms of new facilities, to the party. We do not have a huge capacity and, in that respect, Ian Hooper referred to the report, "The Ticking Time Bomb". Some of the figures on maintenance for the existing stock of facilities within the timeframe are mind-boggling. However, as Ian said, each local authority will work that in its own way.

Some opportunities are coming up, though, of which the new school estate is one. We are interested in talking to every local authority that continues to receive funds to build new schools and we want them to take advantage of an early conversation with us on creating the best capacity and quality that we can in those new buildings. A huge amount of money will go into them.

There are already some great facilities out there. Increasingly, school facilities will have to become community assets for community use for a range of different things. My focus will be community sport hubs, and I am sure that there is potential for them to play a greater role across the piece. It is essential that we ensure that. We are occasionally frustrated by the lack of up-front discussion about the potential for doing that, but we certainly have a good relationship with each authority in trying to take that forward.

Dr Simpson: The Scottish Futures Trust is responsible for the school-building programme. Is it in direct communication with you and having discussions about the incorporation of community access to sports facilities as part of the development programme?

Stewart Harris: Yes, it is, but I believe that we could probably do more with it. From my perspective, the SFT has rules that it must work to on replacing schools. We will continue to talk to the SFT about how, at the design stage—at the beginning of the process—we factor in some of our expertise and resource to try to ensure that schools have the best capacity going forward.

The Convener: The other aspects that were raised in the opening remarks were how the budget reflects how we get to those parts that are difficult to reach. It was interesting to hear earlier about the University of Edinburgh study that showed that a relatively low level of physical activity can affect people's mental health, and in deprived communities participation is lower. What direction is the budget taking to ensure not only that we put money into increasing participation, but that it gets to the areas that need it and particularly to the older population and to young people? Is there evidence to show that money is being invested disproportionately in such areas to address those issues?

Ian Hooper: That is an interesting question. In Glasgow and elsewhere in Scotland, there are some good examples of partnerships between NHS boards and local authority leisure trusts or sports services whereby programmes have been designed to increase physical activity among not

only the older population but young children and the general population. In Glasgow's case, GP referral programmes have been going for 15 years. For example, programmes such as the silver deal programme, which is aimed at older people, are part of a preventative spending initiative that is aimed at improving physical activity and mental health as a means of ensuring that the problems of obesity and inactivity are mitigated.

The difficulty and the challenge is that such programmes are not necessarily replicated nationally but happen only between particular NHS boards and local authorities. It may be that we need a more national approach, with even a small shift from cure to prevention and from health care to health improvement, which is something that we often talk about. There are examples of that taking place but not at scale. If there was a small shift in spending, that could increase the scale of health improvement programmes. The collaboration between NHS boards and local authorities might then start to have a bigger impact on levels of physical activity in Scotland, which is clearly a major health issue facing this country.

Kim Atkinson: I agree very much with what Ian Hooper has said, and I know that we made a submission on that as part of the committee's consideration of preventative spending in the context of the budget last year. As I am sure we are all aware, the national physical activity strategy "Let's Make Scotland More Active" gave figures for that, saying that a 1 per cent increase in physical activity would save £85 million each year and 157 lives, and it would not cost £85 million. As you have heard me say before, if that is not preventative spend, I do not know what is, so I would very much echo those messages.

I know that a key health outcome for the Scottish Government is increased life expectancy. Sir Harry Burns has said that the key indicator of life expectancy in this country is your VO_2 max—to you and me, that means how physically fit you are—so there is no small connection between those issues at the highest level. There are practical questions about what that budget would look like, but Ian Hooper has already offered some ideas and I know that colleagues have thoughts about programmes that are showing results.

Ultimately, we are calling for an element of recognition of the issue. It is no accident that we recently provided a submission to the Finance Committee's inquiry into fiscal sustainability, demographic change and an ageing population because I do not think that sport—by which I mean being physically active—is considered in some of those circles. However, the social care issue provides a huge, new opportunity. It is difficult to estimate what financial savings would come from increased participation in sport. I do not think that we are going to close hospital wings, but we should not lose from the discussion the quality-of-life aspect that sport can contribute.

On the issue of social care, the dementia point that the convener raised this morning was absolutely fascinating. Research has shown for a while now that being physically active can make a big contribution to dealing with Alzheimer's and dementia, which we know are two of the biggest challenges that our nation will face. Although there may not be a huge amount of research into the impact that sport can have on hip fractures and balance, it is fascinating to consider whether people might be able to live in their homes a little bit longer because they do not fall as often. Given that one in two women will fall and have a hip fracture at some point in their lives, if we want people to fall a little bit less, it may be that people keep a better sense of balance if they take part in walking or netball clubs, go to the bowling club twice a week or whatever. Being physically active or taking part in sport has a huge role to play.

If you take part in bowling, your fingers may be just a bit more dexterous and your hand-eye co-ordination may be just a bit better so that you can continue to do your buttons a little bit longer. That means that you might be able to live in your home a bit longer because you can brush your teeth. There is an impact on social care. I do not think that much consideration has been given to that, but there are a lot of fascinating questions around that.

I suppose that the thought process is that an element of budget shift is required in recognition of the fact that sport and physical activity can make a difference. However, there needs to be a targeted approach, with additional new investment rather than just the programmes that currently run. We need programmes such as those that Ian Hooper mentioned and other programmes that are specifically targeted to have those outcomes. Unfortunately, those new outcomes are not going to be free, but I do not think that they will cost £85 million either and, hopefully, they will save more than 2,500 lives a year.

11:30

The Convener: Thanks for that. You bring us to the point that we debated earlier and that we have debated with various people about the difficulty in trying to apply budget scrutiny to that. In the earlier session, we identified the big role that local authorities have to play in that along with the lottery, sportscotland and education. The issue is how we even identify the inputs—how much is going into sport—never mind whether the outcomes are successful.

I call Bob Doris to be followed by Drew Smith, Nanette Milne and Mark McDonald

Bob Doris: My questions are more about the sports estates. If any other committee member wants to explore the health benefits of sport, I am happy for those questions to be taken first. I do not want to deflect the panel from that area of questioning.

Drew Smith: My question is on that area—I do not know whether others' questions are.

The panel will have heard part of our previous discussion of the health budget. I hope that they also heard me say that investment in sport is something that we should do for its own sake. However, there is a tension. We want to spend money on supporting physical activity because physical activity will lead us to better health outcomes, but sport is only one part of physical activity. How do we get to a much more robust understanding of what physical activity we are funding than just saying that some money is being spent on sport and, because we know that physical activity is good for health, that is presumably a good thing. That seems to be where the debate is at the budget level. How do we get a much more robust understanding? Investment in sport for particular groups will hit entirely the wrong people—we will be investing in people who are already active and not in people who need support to become more active. How do we get more robust about the whole process?

Ian Hooper: A number of the programmes that I have mentioned, which are long established, are not so much about sport as about regular exercise that can lead to more formal participation in sport but does not necessarily do so. They are about increasing levels of frequent and regular physical activity and involve partnership work between the NHS and local authorities that has been on-going for some time.

You asked about robustness. Because—to its credit—the NHS insists on this, many of those programmes and the impact that they have are well monitored and evaluated. There is probably a surprising amount of evidence already available, throughout Scotland, on the value and benefits of some of the physical activity and exercise programmes that are taking place as part of the health improvement programmes that the NHS is running in conjunction with local authorities. Perhaps someone needs to assess that body of evidence across Scotland and, in conjunction with Health Scotland, look at what programmes should be scaled up and replicated much more significantly to have a bigger benefit.

This is not just about sport, which was the basis of your question; it is about regular exercise, which can be taken in many different ways. Physical activity is about walking, how people get to work or school, the environment in which people live, transport and so on. The programmes are wide ranging and are about more than just sport. They are well monitored and evaluated, and they have been going on for a number of years, so we should have started to see and be able to map their benefits.

Stewart Harris: Although you are right to connect physical activity and sport, it is also right to differentiate between them. To be robust, we need a more in-depth national conversation in Government with health and to begin to reflect those partnerships locally. Ian Hooper has touched on my perception of a variation in the relationship between local authorities and health boards, which is without doubt the case. We feel that if we are looking at sport for its own sake, our relationship with local government and governing bodies, in particular, must be a key strategic driver. However, if things are going to switch, we will need to have a strategic conversation about the contribution that we make with health, local government and other agencies. If we know exactly what our contribution is going to be, we can build our capacity to deliver against it.

Therein lies the difficulty. Improving participation has always been an aspiration, but our capacity—the facilities and the people we have to meet that—is finite. Given the ambition to increase participation, I would welcome a conversation at a national and local level about how we become more robust.

In response to the point about what we do, what we do not do, what we should continue to do and what we should stop doing, I assure members that that conversation goes on every day to ensure that we get the best possible result from more efficient partnerships and relationships across the piece. However, if we want to be ambitious, it will cost money. We cannot continue to be ambitious and say that we want more participation while continuing to chop away at things. At the moment, the budget is stable—for example, we were very fortunate to get increased lottery funding—but our ambition is to have something in place beyond 2014 that makes community sport a regular and accessible activity in every community in Scotland while allowing our most talented athletes to regularly win on the world stage on behalf of Scotland, for Great Britain at the Olympics or whatever. We need to take a strategic rather than chancy approach to all that, and there will be challenges for budgets in future years because we are putting in place things that will have to be sustained in order to sustain our efforts in participation and performance.

The Convener: I call Jim Eadie to ask a supplementary.

Jim Eadie: My question is not on the last specific point, but on the more general issue of how we fulfil the ambition that Stewart Harris mentioned of creating a world-class system for sport in Scotland while recognising the contribution that physical activity can—as Kim Atkinson and, to some extent, Ian Hooper have pointed out—make to the older population. In fully accepting Stewart Harris's point about the need to work in partnership while also differentiating between the two elements, I wonder whether panel members could enlighten the committee on what the funding streams might be for each. Mr Harris has been explicit about the funding streams that are available for the Commonwealth games and, beyond that, for the games' legacy and their impact on community sport. What further resource do you require to build on the Commonwealth games and to fulfil your ambitions in relation to the roll-out of programmes that benefit community sport, and what further funding streams in health and other budgets should we be considering in order to fulfil our ambitions for physical activity?

Stewart Harris: Before we do anything about additional resources, we need first to look at how we can work together much more efficiently across various portfolios. Bodies including sportscotland then have to be clear about the challenge and ambition and what they will cost without being ridiculous. It is all about what is achievable. I have always had an issue about setting a target without costing what it will take to achieve it, which is why there has always been a huge debate about participation.

As everyone else is, we are always looking for as much certainty as possible about national and local budgets. I know that there are many pressures on both, but we need certainty to underpin the strategic direction. If any additional resources become available, they should be used for capital spend on facilities. We are spending a lot of resources on people, but I believe that the priorities should be to free up access to existing facilities, to ensure that schools and the new school estate are accessible, and to build more and more new facilities, whether they be 3G pitches or whatever. In short, we need a stable budget but, for the moment, any additional resources should be put into the built infrastructure.

Ian Hooper: Given the current climate and the stringencies on revenue and capital spending in local government, we will need to be creative in bringing resources together if we want to improve or develop facilities or, for that matter, to increase physical activity. Local government does not have the capacity or funding to do anything additional or enhanced by itself, so we need to look at various opportunities and strategic approaches that would bring resources together.

For example, with regard to physical activity, local government is, in the active schools programme—as I have mentioned—bringing together resources from the NHS through general practitioner referral funds and sportscotland. The situation is much the same with facilities. As the committee will be aware, capital spending is very constrained in local government, so any opportunities that exist are arising very much as a result of partnerships. Of course, that might bring us back to the earlier question whether we can make more of the new funding that has been made available nationally for building new schools by combining it with sportscotland funding or some other element of—albeit constrained—local government funding to ensure that we get more for our money; in other words, that we get well-designed schools that meet not only curriculum needs but communities' sports needs and need to access learning and other forms of cultural participation or development. We need to get partners to work together, to use funding creatively, to be strategic and to bring resources together in what is, for all partners, a very tight financial climate.

Kim Atkinson: I certainly recognise that, as has been pointed out, sport and physical activity are on the same continuum. I do not necessarily think that it is either one or the other; indeed, we must not forget that physical activity is often a pathway into sport for people who have not been physically active. I note that the report "Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers" refers to a "dose-response relationship"—in other words, the more physically active you are, the more benefits you get. There is a continuum within all that.

It has also been recognised that if more people participate in sport, physical activity or in whatever way they want to be active, there might well be savings to health, social care or education budgets, or there might be additional benefits gained from those budgets. Although targeting additional investment to create additional benefit will ensure that further down the line preventative spend savings will come, benefits might emerge tomorrow or the day after for, say, mental rather than physical health. Nevertheless, this is a long game. The biggest benefits might come in 10, 20, 30 or 40 years, but that is not to say that we will not get any benefits tomorrow.

As for people who are currently active becoming more active and therefore getting more benefits, there is a balance to be struck in that respect. I realise that some of the biggest challenges lie in getting those who have never been active to become active. Of course, that also raises questions about new resources; after all, such a

move will require additional people power for it to happen.

The point that colleagues have raised about partnerships is absolutely right. As we have mentioned previously, the PE issue raises questions of additional resource. I know that we are getting there with regard to having two hours and two periods of PE, but the question is how quality is being measured, whether we are really ticking the boxes, whether every young person is as physically literate as they should be and so on. As we have said before, if we want equality of opportunity, ensuring that every person is physically literate at a young age will give them a good start and a good chance. Finally, is every teacher and PE teacher skilled and confident in doing what they want to do and what we want them to do for the benefit of our nation?

11:45

On people, as we have said, employer-supported volunteering is a huge opportunity. That is not necessarily a resource issue; it is a mindset and culture issue. To achieve the aspirations that Stewart Harris talked about for community sport, which we all share absolutely, capacity issues must be addressed. More can be done in the voluntary sector, but that will not take away the requirement for additional resource to get people who have not been active into their sports gear, into gyms or into whatever they want to do to be active.

I agree absolutely with colleagues that there is a huge opportunity to use existing facilities better. A lot of small investment can make a big difference to the quality of facilities, which Ian Hooper touched on. Quality facilities can attract people to being active. The planning issues that we have touched on are massive. Let us get new facilities right and not struggle with the issues that we currently face in relation to schools.

On legacy, there is an interesting question about how we change funding. As I am sure members know, in the 10 years between the clubgolf programme winning the bid and the Ryder cup, the programme is receiving £0.5 million a year. The clubgolf programme has legacy programmes and the results show the sustainability that the programme has been working towards. That shows that there is an understanding that legacy costs money. There is a question about how we look at the legacy beyond what we are currently delivering. If we want a legacy for community sport of more people being more active, that will cost. If we take that issue seriously, there is an opportunity.

The health improvement angle, which Ian Hooper also touched on, is a huge opportunity. Again, we are talking not necessarily about more money for sport, but about a shift towards health improvement in health budgets—and potentially education budgets—to take seriously the priorities that we have all identified. Some of the change funds were set up on the back of discussions about preventative spend. Perhaps this is just our lack of knowledge or appropriate intelligence, but we are not aware of sport being involved in any way in any of those funds. Were any of the funds deliberately targeted at sport? I guess that I know the answer to that. Steps have been taken on prevention, but I do not feel that sport and physical activity have necessarily contributed to that as much as they might have.

Nanette Milne: Kim Atkinson touched on my question, which is to do with achieving physical literacy among primary school children and the provision of skilled PE teaching. I have raised with ministers the issue of fully qualified PE teachers. It appears that, on the ground, there is more of an inclination to provide PE by training generic primary school teachers to do that. Do you know what the shortfall is in skilled staff if we are to achieve what you would like? This is probably more to do with the education budget than the health one, but is there a need for more qualified PE teachers if the goal is to be achieved?

Kim Atkinson: Stewart Harris is probably closest to that issue, given the work that sportscotland has done to deliver the two hours of PE a week for all children. As Nanette Milne said, there is a question about generic teachers versus skilled PE teachers. The sense that we get from our members is that the issue is more about having the right person with the right mentality and confidence. I am sure that some of the best deliverers of PE are generic teachers who just love PE and who have the necessary skills and confidence. Our key point is that every teacher who delivers PE, whatever their training background, should have the skills and the confidence to deliver physically literate children against the benchmark. This is a much-quoted phrase, but the simplistic form of that among our members is that children should be able to run, jump, throw, catch and swim.

I do not know what the shortfall in qualified PE teachers is. Stewart Harris might be closer to that issue. As I say, whoever delivers the PE should have the skills that allow young people to be as physically literate as possible, and they should have the confidence to do it. For generic teachers, confidence is a big issue and the continuing professional development opportunities around that are massive. Our strong sense is that we are not there yet. Fingers crossed—we are moving in the right direction, but I sense that more can be done.

Stewart Harris: I talked about making best use of existing resources. Sportscotland and Education Scotland have got together to support a CPD programme in every authority in Scotland. That has produced a budget of close on £6 million in addition to what was already there.

There is a tension around leadership. Ian Hooper spoke earlier about the value of a national message. When we debate the notion of having two hours of PE in schools, most people intuitively think that we should all aspire to that, as we can see from the amount of discussion it produces. However, a lot of people will say, "I hated PE when I was young, and it wasn't the best experience." That grates on me a bit as a former PE teacher, but it is to do with quality, which needs to be improved. The tension is around strategy and leadership. Headteachers in schools can make a lot of decisions: they can either make it happen or they can prevent it from happening. That is a fact, and—to an extent—an implicit criticism. I believe that all young people are entitled to be physically literate and to be able to learn cognitively and physically through school. I was brought up with that idea, and I was aware of it when I was a PE teacher. I do not see enough of that happening, and I would like some additional specialist PE teachers to be provided.

In my experience, however, some of the best PE delivery has come from generic primary school teachers, who are at times even better at it than specialist teachers. We can do as much as we can to improve the quality, and we can probably apply more resources, such as additional staffing. However, if the leadership and direction do not allow that change to happen, or if they inhibit it or act as barriers, we have a problem.

Paul Zealey: With regard to joining things up, it is interesting to hear from education professionals that the Commonwealth games could be a driver for combating some of the negative reaction to PE, and for focusing on the whole school experience and being positive about a more physical and active lifestyle.

I have had some tremendous experiences in seeing how active schools co-ordinators are delivering at local level and how primary schools are linking whole-school involvement with Commonwealth games related activities. Some children will shine at physical activity and some will shine at finding out more about different Commonwealth countries. It is the drive for hearts and minds that makes the games different from what we have done before.

It is interesting that the legacy aspirations for our games are quite different from those for other games. Many global multisport games have had legacy aspirations for an increase in sports participation. The London Olympics organisers tried to do that, but they withdrew from it when they realised that they were not able to deliver what they had hoped they could deliver.

We want more elite athletes and para-athletes for Scotland, but beyond that we have an opportunity to drive a generation to become more physically active, and for that to become accepted as the norm. There is an excitement and buzz around Scotland's hosting the games, and that enthusiasm might drive through changes around curricular opportunities, voluntary sector involvement and what the governing bodies, local authorities, NHS partnerships and others are doing.

The legacy evaluation framework, which is being published this week, contains some interesting measures that relate to how we will value the legacy from the 2014 games. One of the measures concentrates on physical activity and refers to a study in the east end of Glasgow to ascertain whether that can be concentrated at neighbourhood level. People have already said this morning that it may take a generation to demonstrate whether those planned health improvements can materialise.

One other interesting measure relates to the question of whether the 2014 games will provide us with a partnership legacy, and whether that will act as a driver to show how people can work differently together to achieve the shared objectives and outcomes for which we all strive. That creative approach of working together enables us to hit multiple outcomes.

Dr Simpson: To complete that topic, the committee examined the issue of physical literacy in considerable detail in the previous session of Parliament, and we gave the education inspectorate quite a hard time for reporting on numeracy and literacy but not on physical literacy.

Are you comfortable that, with regard to leadership, there are both encouragement and a stick? Is the inspectorate saying to schools, "You are not performing on physical literacy"? Do we have reports on whether every child can, at the age of seven or eight, catch, throw, jump and run, which was the aspiration in the committee's report on pathways into sport?

Stewart Harris: I do not think that we have such reports. We have always said that our relationship with education is key. It is better than it was—we have built that relationship over a number of years around the active schools and support for PE interventions. I probably need to have another conversation with the inspectorate as to where it would like to go.

On my original point on the national strategy, how it is valued and then delivered are important. The message is out there, but there is still an

element of choice around whether it is applied. As I said, there is some fantastic delivery from generic primary school teachers and others. There are some great visionary and innovative headteachers. However, I would like to see more of that and what I will take from this is that I need to go and speak to the inspectorate again and see where it is. It is entirely my responsibility, but I am interested in taking the matter forward and seeing where the inspectorate is going with it.

Kim Atkinson: That was an excellent question. As Dr Simpson said, the two hours of PE was one of the outcomes from the work around what quality is and how we measure it. It was one of our suggestions in our manifesto for sport X years ago as well. Some of the interesting feedback—which, again, the BBC picked up a number of months ago—was about the role of parents, because as Stewart Harris said, it is not all about PE teachers and sport having all the responsibility.

If a parent gets a report card that says that their kid is not as good as they could be at reading, I am sure that the parent will read that and spend time on reading with their kid. If the parent does do not know that their kid cannot run, throw, jump, catch, or swim, we should be helping parents to get that information, too, so that they can do something about it. It provides the additional collective support that is necessary to make that happen. I welcome Stewart Harris's thoughts on that and as Richard Simpson said, it is a great opportunity. This is about schools being at the heart of where every young person has to be and, therefore, being places where they can get those physical literacy opportunities, but we can supplement that through families if they have that information.

Ian Hooper: I was going to mention not only the quality of leadership but the quality of partnership. It is the point that Kim Atkinson made—it is not just about PE teachers alone or even schools alone; it is about the quality of the partnerships between schools, PE staff, active school co-ordinators and sports governing bodies. It is about creating that transition and that pathway and making sure that there is joint working when it comes to PE, school sport and the transition into community sport and club development. Usually, that works well when there is a collective strategy and partnership between local authorities sports development function, active schools, PE staff in the school and sports governing bodies. That creates a holistic experience and an improved pathway. When that does not exist, the situation starts to break down.

Mark McDonald: I want to touch on the issue of outcomes. Like Drew Smith, I am very much a fan of sport for the sake of sport, but in the context of the argument that we should use sport as part of the toolkit for health improvement, I have a range of questions.

How easy is it to measure the input to outcome ratio, given that a number of sports clubs and organisations out there do not see a penny of public funding? You could argue perhaps that the facilitating role of national associations means that they see some of that money, but there will be a lot of clubs that encourage and allow participation but do not receive public funding.

What outcomes should we be looking at and saying that sport plays a role in them? When do you start to see an appreciable difference in outcome from the investment that you make? I imagine that that varies wildly. For example, if you start putting money into the Scottish Football Association early touches schemes that encourage six to eight-year-olds to get involved in football participation, some of the health outcomes may not be seen until those children reach their teens or even adulthood. We are talking about a 10, 15 or 20-year lag between the input and delivery of the outcome, whereas other schemes could be described as quick wins.

Where do we look for the outcomes in which we can say that sport has a role to play? How long will it take from input to outcome? How easy is it to measure the input to outcome ratio, given the landscape of clubs, organisations and facilities that are not publicly funded but which are also playing a role in providing people with physical activity and sport?

12:00

Stewart Harris: That is a tough question; thanks for that. If you look at the impact on the individual of activity—whether it is about being the best you can be, or participating for fun to socialise with friends in the community—I do not believe that we can consider the outcomes to be short term. That is why we have taken the view that we need to take a systematic approach to sport and recreation, whether it is publicly funded or voluntary, or whether it is pieces of the infrastructure, such as facilities or people, that drive and underpin that approach.

We could pick any moment in time and ask people how they feel about themselves when they have had some input into sport or a social event. One year they might feel brilliant, and the next year, if that opportunity is not there, they might not feel great. It is difficult.

However, our knowledge and ability to be robust will improve with a greater degree of committed conversation between health, sport, education and justice to see how we can use the best of sustainable inputs. I am on record as saying this already: we really do not need any more short-

term pilots. We need a mix of activity to be there to underpin the sport and recreation sector.

The best measurement of the outcomes that we are referring to is how people feel about themselves and, having had physical exercise throughout their lives, what that might do. I probably drink too much red wine, but for me a host of other inputs make it difficult to measure the effect of that explicitly. I am not an academic by any manner of means, but it is difficult to answer Mark McDonald's question about outcomes.

Kim Atkinson: The question is very fair. On where we could look for outcomes, Stewart Harris made points about quality of life and other intrinsic benefits, and they are incredibly hard to quantify. At the same time, we should not lose sight of them just because they are difficult to measure.

The national performance framework contains fairly obvious values around increased physical activity. Improved self-assessed general health and mental wellbeing is a big one, too. The NPF has outcomes for which research can show the contribution that sport can make. However, there is a question about whether those outcomes can show the extent of the benefit that sport and physical recreation can have through targeted additional investment in people who are not already involved.

There is already research into mental health and wellbeing, which relates to Mark McDonald's question about timing. The benefits of prescribed antidepressant medication and the benefits of being physically active are at least the same, if not more in favour of being physically active. There is an opportunity in that for some quick hits. Cost is a possible quick hit, but quality of life and mental health are another one; the cross-party group in the Scottish Parliament on sport will look at that during its next meeting, following on from the contribution of sport to preventative spend this time last year. The group will focus on mental health and the contribution that sport makes to that; hopefully some further research will be done, and I am sure that the cross-party group will be willing to share that with the committee.

Mark McDonald asked about the length of time between inputs and outcomes. That is a great question and although there are possible quicker hits around mental health, some results of physical exercise can also show quickly. Ian Hooper has already talked about a number of programmes in which research has been done into the benefits that can be achieved. I do not know whether that has all been pulled together and if so, by whom, but there is a breadth of research that could be pulled together and we can gain confidence from that as we look forward.

We hear about research that shows that if young people were physically active at a very young age, that dictates how physically active and healthy they will be when they are older. To return to Mark McDonald's point, it will take a long time to get the results, but how do we measure the investment that we have to make in that? That question must be asked, but hopefully it will be more than worth it.

I get the point that the voluntary stuff is difficult to measure. There are 13,000 voluntary sports clubs and a fifth of the population are members of sports clubs. Voluntary sport is massive. What people get out of it is sport for sport's sake. Do not get me wrong: our members are all about sport for sport's sake, but they absolutely recognise the contribution that sport and physical activity can make beyond that.

The benefits already exist and are intrinsic. The point that we keep making is that that needs to be pushed further. We need targeted programmes and to invest in new resources to get new people involved. We are good at knowing that, if we do A, we get B. However, we are not very good at how we measure B or what it costs. That is a challenge.

I do not know who will provide the answers to some of those questions, but it is a great opportunity. They are, without question, the right questions. We do not necessarily have answers to them, but we need to find the answers because we keep being asked for proof of the benefits. I am not certain that sport has the proof, but the anecdotes certainly go way beyond everything that we are considering. If we can find a body of research that can prove the benefits, perhaps there will be an additional opportunity for Scotland through physical activity.

Ian Hooper: I will refer to some work that we are doing on sports development in Glasgow with the assistance of some NHS consultants and professionals.

We are trying to construct a logic model around all the programmes and activities that we are doing in relation to sports development. It starts with trying to be clear about what outcomes we want to achieve. That sounds easy, but it is not. Increasing participation in disadvantaged communities might be one outcome. After we have defined the outcomes clearly, we consider how we measure or do not measure each area of activity or programme that we operate directly or indirectly. Specifically, we measure it to see whether it contributes to the outcomes.

We are constructing the logic model to find out whether our investment in various programmes is cost effective. That is measured by whether it contributes to the outcomes. We are at the early

stages of that work, but we are trying to take a much more robust approach to try to answer Mark McDonald's question about how effectively what we do contributes to the outcomes that we are trying to achieve and how clear we are about those outcomes.

The NHS applies a logic model approach quite rigorously across a number of its programmes. However, as far as I know, our work is the first time that it has been applied to sports development.

Bob Doris: If the witnesses have been following our budget scrutiny and sport inquiry, they may recall that Alex Richardson of the Gladiator Programme gave evidence. He had a number of issues with Glasgow Life. I will not go into those, as they are not the reason for mentioning his evidence, although I am hopeful that we can get a constructive and positive outcome on those concerns.

I went to look at the set-up in Easterhouse, which could be relevant to how we support community assets throughout Scotland. Alex Richardson has a facility there. Beside it, there is a Glasgow Life facility. Both look quite tired, to be frank. The area needs investment and there needs to be partnership working. Let us put that alongside the fact that the local authority has a disposal-of-assets policy, which I agree with if it is managed correctly, and that there is a market provider in Glasgow Life. The disposal of assets could lead to a market arrival, if you like, in the provision of sporting activities.

Will sportscotland, the Scottish Sports Association or Mr Hooper identify how the budget works in a co-ordinated way to ensure that there is investment in local sports facilities not only in Glasgow—there are arm's-length leisure partnerships throughout Scotland—and that other community sport providers are not inadvertently squeezed out? I would appreciate your comments on that, because it is something that I am trying to tease out. I am looking to see whether there is a budget line that would support that at a local level, not only in Glasgow but across the country.

Stewart Harris: I might be misunderstanding your question, but the budget itself will not do that. The question is how we, together, can plan. I will deal with the issue from a national perspective and Ian Hooper will deal with it from a local perspective.

In the future, I see a range of public facilities, properly managed and timetabled to deliver the best use, with a range of private facilities, such as the David Lloyd centres. Your point is a good one. Increasingly, in the right circumstances and if properly supported, communities can manage properly on a break-even basis facilities that might not be viable as a commercial concern but which are of great benefit in their context.

My basketball club, for example, operates in the Crags Community Sports Centre in Edinburgh, which is run as a partnership between the club and Basketball Scotland. That is a tough one. I have already had long discussions about making that sustainable.

Nationally, there is a mixed economy, with private, public and, increasingly, community-driven facilities. We have to be careful about how we take that forward. We do not have any specific budget lines that would help to do that, but we are always looking to enhance our partnerships locally and, if we have the right circumstances and if a community group that is given access to a facility wishes to apply to us for resources, that is not a problem; it is possible in the current circumstances.

Ian Hooper: This is a difficult issue in the sense that one has to carefully assess the local circumstances and capacity and the needs of a range of interest groups, stakeholders and community organisations and not necessarily focus on the needs of one particular stakeholder.

In certain circumstances, community management of facilities is the correct way forward. In other circumstances, it might be best to have more of a community sport hub model, which involves a number of clubs coming together to build capacity and work together, so that the needs of one organisation are not supported at the expense of other organisations. In still other circumstances, such as those that have arisen in Glasgow, we have passed responsibility for the management of facilities to community organisations. We have tried to support those organisations, but they have failed and we have taken back the management of those facilities. Those circumstances have arisen possibly because we and the communities were trying to do too much, because facilities management—for example, running a swimming pool with lifeguards and meeting the operating costs—can be costly.

To return to outcomes, the facilities management of the pool is not the outcome. The outcome is increased participation, coach development, volunteer development and so on. Sometimes, we get too hung up about who is managing the physical piece of infrastructure, which can detract from some of the more positive aspects of sports development.

The solution depends on the local circumstances. In some circumstances, it is absolutely right for a single community organisation to manage a facility. For example, the Gladiator Programme manages a community centre that is next to Easterhouse sports centre.

That was a local authority-run centre that was passed over to the Gladiators. The adjacent Easterhouse sports centre is used by the Gladiators and a number of other organisations and individuals for sport, exercise and health programmes—we have a strong GP referral programme there.

Over the past year or two, the Easterhouse sports centre has received some investment and has seen its usage increase quite significantly.

12:15

There is no single solution and that is how it should be. It should be about the particular circumstances in that community and what is best for that community. It is about how close we can be in terms of working with those local communities and clubs. Sometimes, of course, there are tensions, because the solution might not meet the ideal requirements of every stakeholder; we have to balance a number of needs.

Kim Atkinson: On behalf of our members, we have just responded to the Scottish Government's consultation on the community empowerment and renewal bill. One of the points that Bob Doris raised was competition. In our response, we asked who the provisions of the bill would be open to and what would be classified as a charitable/voluntary sector/social enterprise kind of organisation. I am conscious that there are big commercial companies with charitable arms, which is interesting from the point of view of the focus on community-led activity.

That is just a general point about competition.

Bob Doris: I want to stress, on the record, that I am not singling out Glasgow Life, because I think that the structural tension that we are talking about will exist in leisure trusts across the country where there are other community sport providers. I am glad to see that there are opportunities for closer working between organisations such as the Gladiators and the sports facility that you mentioned. However, my view is that a community sport hub is a no-brainer in relation to that situation. I think that we have a situation in which we have a constructive way forward.

Thank you, convener, for allowing me to put that on the record.

The Convener: As there are no further questions, I thank our witnesses for their time and for participating in our discussion—not for the first time, as Stewart Harris and Kim Atkinson were with us for our sport inquiry and Ian Hooper gave us a good welcome to Glasgow recently. We appreciated that day, which was very enjoyable.

Meeting closed at 12:18.

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e-format first available
ISBN 978-1-4061-9766-2

Revised e-format available
ISBN 978-1-4061-9783-9

Printed in Scotland by APS Group Scotland