The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Friday 21 June 2013

Session 4

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HEALTH AND SPORT COMMITTEE
21st Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

Richard Lyle (Central 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:

Jayne Baxter (Mid Scotland and Fife) (Lab) (Committee Substitute)
Elaine Brown (Stirling Alcohol and Drug Partnership)
Paul Davison (Stirling Council)
Joe Hamill (NHS Forth Valley)
Johnny Keenan (NHS Forth Valley)
Anne Knox (Stirlingshire Voluntary Enterprise)
Elaine Lawlor (Forth Valley Alcohol and Drug Partnership)
Lynne McKinley (Stirling Council)
Kathy O'Neill (NHS Forth Valley)
Dr Ken Thomson (Forth Valley College)
Alasdair Tollemache (Stirlingshire Voluntary Enterprise)
Dr Anne Maree Wallace (NHS Forth Valley)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Stirling Council

Scottish Parliament

Health and Sport Committee

Friday 21 June 2013

[The Convener *opened the meeting at 13:30*]

Health Inequalities

The Convener (Duncan McNeil): Good afternoon and welcome to the 21st meeting in 2013 of the Scottish Parliament's Health and Sport Committee. We are delighted to be meeting in Stirling for the first time, and we thank Stirling Council very much for the use of its chamber—it is much appreciated. I also take the opportunity to express the committee's appreciation for all the work that local partners have done to give us access to local community projects, and for all the good work that is going on in the area. I speak on behalf of all my colleagues who participated in the events last night and earlier today when I say that we really appreciate the welcome that we have had. Thank you all very much for your efforts.

As usual, I remind all who are present to switch off all mobile phones and BlackBerrys, because they interfere with the sound system—I am hurriedly ensuring that mine is off. People may notice that some members and officials are using iPads, which we do instead of using hard copies of committee papers.

The first and only item on the agenda is to take evidence from local partners on the steps that they are taking to address health inequalities. The meeting will be a round table, which involves interspersing members with witnesses. For the benefit of first-time participants, I say that I will always give precedence to the witnesses over the MSPs. It is difficult for politicians like me to do a bit of listening, but that is what the process is about. We are more interested in the engagement between the witnesses, although I am sure that my colleagues will participate to encourage that process.

When we have a round-table meeting, we usually invite everyone to introduce themselves before we begin. I will start. I am the convener of the Health and Sport Committee in the Scottish Parliament and the MSP for Greenock and Inverclyde.

Kathy O'Neill (NHS Forth Valley): Good afternoon. I am the general manager for the community health partnerships in NHS Forth Valley. I am also the chair of the healthy Stirling partnership.

Alasdair Tollemache (Stirlingshire Voluntary Enterprise): I am the chief executive of Stirlingshire Voluntary Enterprise, which is the organisation that represents the third sector in Stirling.

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

Paul Davison (Stirling Council): I am a research officer here at Stirling Council. I am involved in the development of the evidence that backs up our single outcome agreement, some of which has made it through to the paper that committee members have in front of them.

Dr Anne Maree Wallace (NHS Forth Valley): I am the director of public health and planning for NHS Forth Valley.

Gil Paterson (Clydebank and Milngavie) (SNP): I am a member of the committee and I represent the Clydebank and Milngavie constituency.

Joe Hamill (NHS Forth Valley): I am a senior health promotion officer with NHS Forth Valley. I am here to report on some of the work of the healthy Stirling partnership in relation to keep well and the Fallin healthy village.

Dr Ken Thomson (Forth Valley College): I am the depute principal at Forth Valley College. I am here in my capacity as chair of the local employability partnership.

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

Elaine Lawlor (Forth Valley Alcohol and Drug Partnership): I am the co-ordinator of the Forth valley alcohol and drug partnership. I have a role in developing strategy and ensuring that the access targets are delivered.

Elaine Brown (Stirling Alcohol and Drug Partnership): I am the lead officer for the Stirling alcohol and drug partnership.

Lynne McKinley (Stirling Council): I am team leader of community engagement at Stirling Council and one of the core leads for Fallin healthy village.

Jayne Baxter (Mid Scotland and Fife) (Lab): I am a Mid Scotland and Fife MSP.

Johnny Keenan (NHS Forth Valley): I am head of health improvement and community health partnership corporate services for the CHPs in NHS Forth Valley and am also a member of the healthy Stirling partnership.

Anne Knox (Stirlingshire Voluntary Enterprise): I am the change fund engagement officer for the third and independent sectors in Stirling and am based in Stirlingshire Voluntary Enterprise, which is the third sector interface.

The Convener: Thank you for that. Such meetings are always a bit strange; we were all chatting together only last night and this morning and suddenly we all seemed to become strangers in the ice-breaking session. In any case, it is great that you are all here and we really appreciate your willingness to work with the committee, and the time that you are giving us today.

Before we move to questions and our open exchange of views, Dr Anne Maree Wallace will make short introductory remarks and speak to the submission. I believe that Johnny Keenan will follow up on that. We will see where that takes us and whether we can relax a bit more.

Dr Wallace: If that is possible.

The Convener: Indeed.

Dr Wallace: Thank you very much, convener. I want to set out for the committee a strategic perspective on our approach to health inequalities in Stirling, and the people around the table who can help with that are Johnny Keenan, Paul Davison, Elaine Lawlor and Alasdair Tollemache. The other witnesses have more to do with implementation.

Although there is obviously a national context for how we tackle health inequalities in Stirling, I do not want to go into that. In our NHS Forth Valley approach to tackling health inequalities in general, targeted elements that are aimed at particular areas or groups are complemented by a more general element, because our disadvantaged groups do not necessarily identify themselves easily. We use a health inequalities impact assessment systematically on projects and we are using recent evidence on tackling inequalities to develop our new strategy, which is in the pipeline.

In NHS Forth Valley, we spent a long time debating what our priorities should be. The three key areas, which are set out in our paper are: early years, which is not confined to the very young as it has been more recently, but is aimed at young children in general and covers parenting and health improvement in schools; anticipatory care, which relates not just to, say, the keep well project, but to a preventative approach across the life course; and employability. We think that those priorities still stand us in good stead across the piece.

Before I hand over to Johnny Keenan, I point out that we are also trying to develop an asset-based—or co-production—approach. We have a lot to learn about that from our third sector partners and the council representatives around the table, so we are generally looking at a more systematic approach.

Johnny Keenan: I want to describe the community planning partnership context. The single outcome agreement for 2013 to 2023 has been developed to ensure a priority focus on addressing and mitigating the impact of health inequalities. Stirling's population is approximately 90,000, with a 65 per cent to 35 per cent urban-rural split. On the whole, it compares favourably with national averages for a range of indicators on health and health inequalities and their determinants. However, when we drill down into local geographic areas, we often see stark differences between areas that are in very close proximity to each other.

Figure 1 in the submission describes that diversity through a range of indicators of health inequalities and their determinants for specific geographic areas and life stages. The key is very simple: red is where, for a specific indicator, an area is performing worse than the Scottish average; blue means that it is performing better; and white means that it is there or thereabouts. Long vertical lines of red underneath a particular area indicate the persistence of poor outcomes throughout the life course.

The evidence that people can experience poor outcomes throughout their lives has influenced the community planning partnership to adopt a life-course approach to addressing and mitigating the impact of health inequalities. We also believe that that will enable us to target the geographical communities that are in the greatest need and that, by targeting key life-stage transition points, we will be able to address need across the whole community, which could otherwise go unrecognised.

There are seven independent outcomes in the single outcome agreement. They are informed by evidence of need, highlights of which are provided in figure 2 in the paper. They have been collated by life stage in order to demonstrate our life-stage approach. The outcomes have also been informed by a range of stakeholders' perspectives of need and attribution, which have been accessed through a project called outcomes for Stirling, which my colleague Paul Davison has been heavily involved in, in designing it and in analysing the information. He can provide further information on the methodology and the findings. The outcomes have also been informed by key structural themes, including public sector reform, welfare reform and economic uncertainty, and changing demographics.

The healthy Stirling partnership is chaired by Kathy O'Neill, who is general manager of the Forth Valley community health partnerships. The partnership takes the lead and is the key strategic planning group for ensuring that we are taking a strategic, co-ordinated and targeted approach to

addressing health inequalities. In the light of the review of the single outcome agreement, the partnership is sharpening its focus even further on health inequalities.

The membership of that planning group is linked to a range of key strategic planning groups that address other priorities that are related to the causes and effects of health inequalities, and I have listed some of those in my paper. Dr Ken Thomson, who is here today, is the chair of the local employability partnership. We have made particular reference to the Stirling alcohol and drug partnership in our paper because we recognise the significant impact that alcohol and drug abuse has on individuals and families, how it can devastate whole communities, and the impact that it can have on health inequalities.

A range of initiatives are being started around addressing waiting times and increasing access to brief interventions. An innovative programme of social influencing has been taken forward across the whole NHS Forth Valley area in schools and community settings. We are fortunate to have on the panel today Elaine Lawlor, who is the co-ordinator for the Forth Valley alcohol and drug partnership, and Elaine Brown, who is in the Stirling alcohol and drug partnership. They will be able to inform discussion and answer any questions that you have around alcohol and drug use and the action that we are taking to respond to that.

In taking a life-stage approach, the community planning partnership is in the process of developing a suite of early intervention and prevention action plans. Figure 3 in the paper shows that we have collated some of the key activities that we believe can contribute to addressing the causes and effects of health inequalities. That is not an exhaustive list; it is a range of activities that we thought were particularly pertinent and the committee would interested in.

I will hand back to Dr Wallace.

13:45

Dr Wallace: I believe that that is a sufficient introduction to the strategic approach. We are happy to answer questions.

The Convener: I do not want people to make their own presentations, but I think that we should hear something about partnership from the voluntary sector and from a local government representative. What is the nature of partnership? Do people feel that they are equal partners in terms of development of the strategic priorities and the direction of budgets?

Alasdair Tollemache: The partnership approach is evolving. In Stirling, I would say that we have reached a point at which Stirlingshire Voluntary Enterprise, in its representative role, is regarded as an equal partner. It has taken a few years to get to that stage, but we are there now. For example, when the draft single outcome agreement for Stirling is signed off, we will sign off on it, too. That previously was not the case.

The partnership approach needs to go beyond the strategic level; it must also be part of what happens at operational level. The Fallin healthy village project, which Lynne McKinley and Joe Hamill referred to earlier and which the inequalities group works on, is an example of how we can all work together at the appropriate level. Fallin is an ex-mining community not too far from Stirling and it does not do well with regard to a lot of the indicators that we mentioned earlier. Our approach, which has come from the community planning partners, has been to see what we can do with the people to work on that. I stress that we are working with the people, not for them. Of course, it is easy to say that and less easy to do in practice.

The project involves voluntary groups, community groups and so on and tries to get away from the philosophy that we do things “for” people. People need to be responsible for what they do for themselves. We want to facilitate that. We are not taking away the support that we give—we are not saying, “Over to you. We’re not giving you any support.”

We are on a journey—we should always say that we are on a journey and that we have not reached the end of the journey yet—to see how communities, along with the voluntary sector, can influence their own futures.

Figure 1 in the papers contains interesting statistics. Paul Davison worked hard on that chart, and it is good to see the information, but a lot of us could have predicted that it would say what it says. We do not want to come back in 10 years and see the same results, so we need to ask what we can all do together. The voluntary sector—or the third sector, or whatever phrase you want to use—is an important component of that, but it is not the only component.

It is important to understand that we all have different roles to play, and the sum of those roles is greater than each individual role. We want to work together, and we do so. However, if that does not produce better outcomes for the people with whom we work, we have not succeeded.

The key ingredient is for us all to put forward our views and to come up with collaborative answers. However, if that does not involve the people whom we are trying to help, it will not work. Lynne McKinley or Joe Hamill could give you some input into that.

The Convener: Can we change the colour of the bar in figure 1? What is the timeframe? What is the ambition? Is there a 10-year plan or something else?

In taking evidence on health inequalities, it has been hard to judge whether a difference is being made or not. It is exciting to start projects, but what has been dropped in order for a new project to start?

What are you doing that is going to change the colour of the map in Stirling, and how much of that will influence and inform work in other parts of Scotland?

Paul Davison: People around the table will tell you about what they are doing. With regard to changing the colour of the map, there is an issue around the lag between the work that is done and the effects of that work being seen, and how we can link a particular cause to an effect. We are talking about long-term indicators and targets; the SOA covers 10 years. However, if we change a couple of red squares on the chart to white, that would indicate that there had been a significant change.

It is worth highlighting the fact that, in the past four or five years—since the economic downturn—there has been an increase in the polarisation of the Stirling Council area. Stirling is described as a heavily polarised area, with large affluent communities that can mask the more deprived communities in which health inequalities are most evident. Even in the past four years, that gap has stretched further, so the affluent have become more affluent and have moved up the scale, and the deprived communities have dropped into even lower deciles—the ninth and 10th deciles—of deprivation. That demographic is quite interesting in itself, in that there is hardly anything in the middle ground in Stirling, and it has a big influence over how the services are geared up to address different issues.

Instead of having lots of information traditionally collated and presented without much consideration, we have, as is shown in the examples, thought about different structures for presenting data in terms of life stages, looking geographically across the area, and engaging with different kinds of people and communities to gather their information. We rely not just on hard stats but on softer, greyer information from communities about what they see as being important. That has been key in the process, although getting a good understanding of the area remains a challenge. Turning one box from red to blue is a huge challenge.

Bob Doris: I will not list all the various initiatives that you are involved with, as there are a lot of them. They are all well intentioned and will all, I hope, be successful to varying degrees but, as Alasdair Tollemache said, we are interested in initiatives that work with communities, rather than being imposed on them. Can you pick out an initiative where you did not go into a community and say, "Here's what we're going to do to you," but you consulted people and your initiative was a derivative of that consultation? I hate the jargon, but that is the asset-based approach that everyone talks about. Can you give us an example of an area where that has happened?

Lynne McKinley: Joe Hamill and I are working on Fallin healthy village. Reference was made earlier to projects and the initial enthusiasm. The asset-based approach in Fallin is not about developing a plan, strategic policies or priorities within the council or the national health service. We have started by going out and asking people basic questions about what they think a healthy village is, what makes a person healthy and whether there are any particular things that they would like to change about their health, their family's health or the community's health. That has taken quite a long time.

We have done the majority of the work on the street at various times, on different days of the week and in all sorts of weather. We have been mindful of the attendance of partners to create a plan according to the policies that we have to work to, which will yield some success but not enduring change. The work in Fallin has been about asking those questions. The healthy village is an approach rather than a project, and community organisations have drafted a vision for Fallin healthy village from the information that they generated. They are talking about it being Fallin—a 2020 vision. That is what they have come up with. It is a slightly shorter timescale than the one for the outcomes for Stirling.

I will highlight some of the things that are in that vision. The healthy village is a place where community spirit is important and strong; where the health and wellbeing of every individual is important and valued; where education and learning are valued; where employment and training opportunities are vital; and where people make the most of their location and the quality of their environment. The key point is that the healthy village is a place where every person, irrespective of their age, has a voice. That vision has been drafted and we hosted the first session, bringing services, agencies and voluntary sector organisations together to map what they are doing to achieve that vision. I hope that, from the information that the community has created, statutory and third sector agencies will recognise how the vision connects to their strategies and policies. I hope that it will be seen not as a project but, with the initial enthusiasm, as a concept that spreads throughout Fallin as people see it, feel it

and believe it. I hope that any agency or service that works with people in the area buys into it and recognises its value.

There have been some small changes while the work has been going on. The primary school has worked with Active Stirling and the NHS, although the school may possibly have focused on the health of the children. They did the big fit walk. We asked the school to consider involving the parents whenever it does an activity with the children. The parents got involved in the big fit walk and, following a chat on the day between the worker from Active Stirling and a volunteer, a group of parents have decided to continue to meet on a weekly basis.

I hope that every service and agency takes an approach that is about building on the assets—because, despite the statistics, Fallin has phenomenal assets. Different organisations manage two social venues and a community centre. The Deputy Presiding Officer also visited the recyke-a-bike project at Fallin Community Enterprises, which is a large social enterprise company. I hope that people value the assets and build on them, and that the vision that folk in Fallin have created is not lost.

14:00

Bob Doris: That is very helpful. It is about trying to touch and feel what is happening at the coalface, beyond the consultation. Things are starting to happen there. Capacity building in communities, where you are helping them on their journey, sometimes needs financial assistance, whether through support workers or community workers, but sometimes there is not a huge amount of money available. It is about getting relationships going and developing them. Is there a budget line that goes with that? You begin work on the healthy village and you do the consultation. At that point, is it identified that partner agencies have committed £X to that project irrespective of what the community decides to do, which may be against the strategic priorities of those agencies? I suppose that I am asking how the work is funded.

Lynne McKinley: No budget was allocated to the work. From the outset, the existing resources of the partners that were committed to the work were used. We have had a lot of discussion about how to avoid the pitfall of the partnerships that form because there is a pot of money being less strong once the money is not there.

The draft vision is available. The community needs to work on the action plan. We then need to work with the community, the services and the agencies to look at how the project can be resourced and whether that should come from a change in mainline provision. Not everything that has been identified is a new service or project; it is about changing how people approach things.

Bob Doris: Your point on the issue not being about finding a pot of cash is a relevant one. There is a lot of money and resource, including staff, expertise and assets, in the system. We need the public bodies to respond to the community's needs. The issue is not about finding a new resource; it is about giving control of the resource to the community. It would appear that that is happening.

I hope that we will come back and find out how Fallin is doing in a year's time and monitor its progress. Is that a pilot? Is it happening elsewhere? Is it a one-off project?

Lynne McKinley: This morning, you visited Cultenhove, where the same idea is being used. Fallin was chosen following consideration of a number of communities across Stirling. The healthy Stirling partnership invited people to consider evidence and the statistics.

Cultenhove was already fairly developed, with a strong community organisation, so Fallin was considered for a healthy village—nobody knew what a healthy village was—pilot. We are trying not to use the word pilot because that suggests that it will be temporary. The guidance from the healthy Stirling partnership and the inequalities sub-group is that we must learn the lessons and look at other communities that might benefit from such an approach.

Bob Doris: Thank you.

The Convener: As Bob Doris said, this is about empowering communities and how they can influence matters. A great example was the community that influenced at a practical level what was being done at the school. That did not cost a penny, but the end result was an increase in parental involvement. The challenge to those who represent the budget holders is how to empower communities.

Joe Hamill: That is at the heart of what Lynne McKinley and I have been doing in Fallin. We are both employed by statutory organisations. We work with the community to find out its needs and then work with partners to deliver them.

We have approached partners to say, "These are some of the things the people have said they need fixed." In terms of community safety, it is about pavements that old people cannot use because they are full of potholes and the paving stones are at different levels, so older people cannot get out. We approached the transport manager who sits on the healthy Stirling partnership. It has come up with a separate action plan to sort out some of that, so that the elderly can get out of their houses and be part of the

community. Small stuff such as that does not cost a lot of money—not that we get a big budget to do that.

When we were on the street speaking to people last year, because it was a really good Scottish hot summer—not—we found that more people were then attending community council events in Fallin on particular issues. The community council has gone from being a small group to a wider group with a bigger voice. That is because people asked questions and the attitude changed from "We're out here to do it for you," to "We're going to work with you to develop this whole approach." That has been a positive step. We are going back to services and saying "This is some of the stuff we've found. What can we do working together?" The community is at the heart of the work, because it—not us—must take ownership eventually of the whole process. It is a step-by-step approach. Sometimes the professionals wanted to rush it, but Lynne McKinley and I said, "No, this is a long-term approach to this type of work." The lessons that we are learning are all evidence based and will be taken forward to the wider assets in the community.

Kathy O'Neill: I will make an observation. There are core principles for community engagement, community-led health work and asset-based approaches, but I do not think that you can necessarily have the same approach for every community. We must recognise that all communities are different.

A project that Elaine Brown could talk about is the Stirling city north project, which came at issues in the community from a different perspective. That demonstrates that we need to be flexible and responsive to what the community really wants. Perhaps she can say a few words about that project.

Elaine Brown: Stirling city centre north is an area that covers the top of the town and leads up to the castle. Through the community planning partnership, there was recognition that, although a lot of different partners were going in to work there, perhaps they were not working together as much as they could. We recognised that we were not getting the collaborative advantage of working together. However, the situation was different from that in Fallin because people in the community did not recognise themselves as a community. There was a split with regard to, for example, people's opinions of drug and alcohol users. There is a strong population of students there, but they are transient and perhaps did not want to be part of an on-going community. It was therefore difficult to go in and speak to a community voice, because the community did not come together as one. The work there was different from that in Fallin.

We have completed phase 1 of the project, which is probably the easier phase, because it is very much about the environmental issues in the area. People did not open their curtains and feel good about where they lived, because there was graffiti and the rubbish was not put out properly. Dog fouling was also high on people's list of things that made the area not a nice place to live. We have completed that environmental work, and the place looks better. The kind of impact that we have seen from that comes, for example, from people coming to speak to us when we are walking down there, and the people there now have better relationships with the police in terms of reporting crime.

The next phase for us is about tackling the health inequalities in the area. Now that a bit of trust has built up with members who live down there and the statutory and voluntary services that go in, what Fallin is doing is our next phase. However, it feeds into what Elaine Brown said about not all communities being the same and about how we cannot just take the approach for one community into another one. It is about understanding the needs of different areas.

The Convener: Dr Thomson, can we bring you in at this point? Places such as Fallin or Greenock and Port Glasgow, in my area, had a reason to exist many years ago. However, there has long been significant disempowerment there. We have had discussions about what work now is and about how, sometimes, it is not satisfying for body and soul nor financially. For people to continue to live in Fallin—or, in my case, Port Glasgow—they must have some prospect of earning a living, paying their rent and so on. What is going on to address such issues?

Dr Thomson: Let me take you back a little bit, because there is a story here, to which Alasdair Tollemache and Stirlingshire Voluntary Enterprise were pretty central. A few years ago, the community planning partnership was a good talking shop and we had good discussions. We came forward with a project that we would call skills for success. It was a third sector partnership programme for delivering training through the voluntary sector to support people in the communities into business, self-employment and running their own organisations. It was a comprehensive programme, which was funded by the council in order to get things to the stage of implementation. We reached the stage of implementation but, by that time, there were no funds to deliver on the programme. Very disappointingly and frustratingly, it just sat.

Last year, with agreement from the community planning partnership through the economic partnership, we set up the local employability partnership. There are a number of local

employability partnerships throughout Scotland, but this one was different. Only six months ago, it brought together in Stirling people who had a clear agenda to ensure that funds were better used and that there was a sharing of responsibility and a sharing of information, with an opportunity to identify projects such as those that you are hearing about today, in order to take people who are a long distance from employment right through to a position of employment. Their own health is a main theme of that.

The SCOPE programme is an example. It came out of skills for success. It was parked for a little while, but we brought it back. It was made possible only because we had involvement from the voluntary sector, through Alasdair Tollemache's area, from the NHS, from Stirling Council, through employability services, and from Jobcentre Plus. They all came together and asked, "What do we need? What do the communities need?"

A programme was designed, and it was called SCOPE—Stirling's communities: opportunity for progress into employment. We had to get some words that fitted "SCOPE". You might forget the full name, but you will remember "SCOPE". That programme has just finished. Thirty-two young people from all over went through the programme. They were referred to us, and they completed a customer service training work experience employability workshop. Everything was bespoke, and was designed, with the involvement of local communities, by people in the voluntary sector, who inputted into it. We helped to deliver that.

At the end of the programme, a certificate is awarded. There is an awareness that the person can go on and do something, as their confidence has been raised. There are links and there is progression into college programmes and on to the next stage of the skills pipeline. A person may move from somewhere in the voluntary sector that is very distant from employment on to the next stage, with a good referral process having been put in place.

There are some particular measures that we have introduced—I know about them because we had a fire drill at the college today and, when the SCOPE people came out of the gym, we discussed with them what they were doing. They had been spending time in the gym developing their own awareness of health and of what they needed to do. We asked them why they were doing that. They said that it was because they had had training in manual handling, first aid, life skills and communication. That is all about a whole-system approach.

We have gone from talking about things, a few years back, to an action-orientated approach. Those are bespoke programmes, which have been designed by the voluntary sector with us and with communities, linking to business. We are only a short period into this, but the next stage is to ensure that there are places for progression.

There is a risk in all this. There might be employability funded programmes for a period, and they are well meant. When those are complete, the people involved get a qualification—but then what? An expectation is built up, only to be followed by frustration if all the places are full and there is no work. We are ensuring that the progress that is made is as seamless as it can be—with the partnership, with Skills Development Scotland, with Jobcentre Plus, with the voluntary sector and with Uncle Tom Cobbleigh and all.

It is very much a whole-system approach. For me, it is working very well. It is new, and it has been happening for about nine months now. The outcome will depend on what we see down the line, but positive attributes are coming out, with opportunities for people.

14:15

The Convener: There have been some frustrations. We want to rock the boat a wee bit. It is all a wee bit cosy. The approach is delivering, and everything is great and whatever.

Let me pick up on your point regarding the previous frustration. We will all have experienced that in our own communities. Bob Doris spoke about people being well meaning and so on. Nobody will have been doing anything bad. Some people are working very hard but are doing the same things all the time and not making a difference.

What are the current frustrations for people such as you who are on the front line and delivering? How could we do things better? Do you need more flexibility on the ground? Do we need the national strategies? Should we nationally just take our nose out of it a wee bit? We are directing some of the ring-fenced programmes, funding and budgets, and we have received evidence on whether they reduce or, indeed, even widen health inequalities. Certain people avail themselves of whatever there is and get more out of that than people who are not as empowered. What are the frustrations? How can we do better?

Alasdair Tollemache: It is a matter of having a strategy, discussing it and getting to a level at which we have talked about it enough and understood it. What tends to happen is that there is a strategy, something else comes in 18 months later and the strategy is reinvented. Let us not reinvent strategies. We have to be careful not to do that.

The other issue is allowing the operational levels of organisations to work together and facilitating that. That is where the work is done. I will give an example of that. There is a group in Stirling called the right direction, which is a group of young men who wanted to do small things together to improve their own circumstances. All the statutory agencies in Stirling work together, but they do so at the operational level. That is a small and very incremental development and there is not much funding, but we do not know what evolves out of that. Let us have a strategy. As Ken Thomson said, we need some level of strategy, and that is probably where I provide input. However, we get frustrated looking at the statistics. If we just talk, that does not do anything.

I do not know how to do it and I do not have any magic answer, but we should all commit ourselves as partners to allow the appropriate people to do the appropriate things.

The Convener: You cited a project in which people work together at a very practical level. Why should that be the exception?

Alasdair Tollemache: I am not sure that it is. I just gave an example.

The Convener: I am just trying to stir it up.

Joe Hamill: When I have looked at that type of work, especially when I have been out on the streets for the past year, that has taken me back to an engagement process that I have missed for quite a while. When I look at the structures in organisations—a lot of which are statutory organisations, which are currently the biggest providers of employment around here—I think that some of those structures could simply be done away with. Thousands of people work on strategy; everybody you talk to works on strategy. That is fine. We can work on a strategy and build on it, but how do we deliver it if we do not have the people on the ground to do so? We need more people on the ground who understand how our communities work and what to do instead of people sitting in an office somewhere and saying, "We know what they do and what they want." It is a matter of going to talk to people and involving them.

If we are looking at developing a whole asset-based approach across Scotland, which is one of the priorities along with a lot of other drivers to put into that, we have to resource that not through more money but perhaps through a change of engagement with staff. The Christie commission report points to a lot of that change. I certainly use that report quite a lot in my work in saying, "We have a duty and responsibility here to get things done for the people who are employed through organisations." It is always about taking those people with us and giving them responsibility. In Scotland, there has been a we-can-do-for-you culture for a while. Changing that will take a while, and it will take a while before organisations come back and say, "We're going to hand responsibility and some budgets over to communities and give them that empowerment process totally."

Dr Wallace: I was going to say something similar, but I feel that I had better defend the strategy, being a strategic person myself.

It is important that we set out a strategic approach so that we are clear about the direction in which we are going. However, writing a tome—a "War and Peace"-type strategy—would be a waste of time. The strategy should be short and succinct, and should simply set the direction so that everyone is facing the same way.

I am completely for an asset-based approach—or co-production approach, or whatever you want to call it—to working with people, but I think that we need two complementary approaches. We can use a community-based approach, which is very resource intensive and time consuming, for those communities in which it is needed. However, all our statutory services need to take a much more asset-based—or co-production—approach to everything that they do when they are working with people. We need a general approach across all the services that involves changing our culture and the way in which we work with people.

There will be a tension, because we are fond of targets—particularly in the health service—and very fond of measuring. We measure the things that we can. However, if we take a true asset-based approach, the communities will decide what they think is important. Those decisions might not fit in with the performance measures that statutory organisations are under some pressure to deliver. We need to be mindful of that tension, although I have no idea how we will sort that issue—I just wanted to put it out there.

The Convener: That is interesting. Elaine Lawlor can go next, because she has not yet said anything.

Elaine Lawlor: Convener, you mentioned that you would like to change the colour of the map in figure 1. When I looked closely at the map and the indicators, I made some stark observations.

Communities such as Fallin, Cultenhove and city centre north have been stripped of their assets by the blight of drug and alcohol use. We need to reinstate those assets to the individual, who may seek help for their alcohol and drug problem. If we reinvigorate their personal assets, they can rejuvenate their communities. Without rejuvenating the individual, there will be no community asset regeneration.

Fergus Ewing made the point clear some time ago that, if we want to change behaviour, we must

first change it in the service user in relation to their alcohol and drug abuse. There is a big push to use such approaches, but one frustration of mine is that, although we already have the tools in our armoury, we do not use them as well as we should.

We know that there are things that we can do to reduce alcohol and drug harm, but we do not do them collectively enough. We need to strengthen our resolve on lots of things—such as licensing and other measures—that will improve the lives of individuals.

Of the indicators, 30 can be affected by drug use reduction and 17 by alcohol use reduction, so a change could be effected within a few years. I will not have retired by then, so I will be held accountable for that. It is important that we recognise that we can do things to make a big change if we join forces.

Dr Thomson: I wanted to pick up on Dr Wallace's comments about how we approach the task. I think that the term "empowerment" is overused, but we pulled teams together from the local employability partnership, with funding to run a two-day workshop, and the idea was that, at the end of the programme, we would have an agreement to work together.

Within 10 minutes of the coming together of the group, which included key people who were enthusiasts, the question was asked, "Based on the strategy"—you need a strategy—"what is the plan?" That was to define the parameters in which we work. The next question was, "Are we going to work together?" Those were the questions that we were going to ask at the end, and they asked them at the beginning. The answer was yes.

Next, we asked, "How are we going to do this from a financial perspective?" We all had some pots of money—we did not have a big one, but we all had a little bit to bring. As a consequence, we were able to start to implement projects.

The impact of those projects was seen on the ground, and the projects were therefore seen as money well spent. It is clear that short-life working groups are essential and that there is a link back to the overall plan that is in place.

Given the results in the colour chart in figure 1, it will be an interesting issue to look at what happens. You have been to the new campus at Stirling; there was no college in Stirling until last year. It will be really interesting to see the impact of all the joint service work that we have been doing in the community. We have seen the support staff from the Raploch, and we have an engagement with the Raploch Urban Regeneration Company on progressing young people into construction. I think that a review in a couple of years' time will show a relatively quick change.

Kathy O'Neill: I will make a couple of observations on your challenge about Government policy and Government-funded initiatives.

Government initiatives are probably double-edged swords. Sometimes they can be catalysts for enormous change. One example relates to the three-week addictions target. In the Forth Valley board area, two or three years ago people had to wait months to get access to treatment for addictions. When the national target was introduced, it became a catalyst for change, and we knew that we had to come together and work more collaboratively to address that target. We are now meeting it.

National initiatives are therefore good, but sometimes they can be quite narrow in their definition—in the sense that they are health targets, for example, and it is not easy to turn them into collaborative projects. We still want the Government to fund things—we still want some money—but it should fund approaches. For example, the early years collaborative approach is funding to initiate a different way of working rather than the Government saying that it wants us to implement an initiative in a certain way and give it returns every few months.

My suggestion is that, in future, the Government should fund approaches.

The Convener: I see some people nodding at that comment, which also reflects some of the discussion that we have had. The top priority with which the health portfolio is tasked is reducing health inequalities. It considers mortality and all that sort of stuff. However, that target is not reflected in the other portfolios. That is the way that the Government works.

You have just given an indication that such thinking at a Government level has an impact at a local level. We reported on teenage pregnancy this week. You are talking about how education and aspiration for jobs or careers will determine the choices that people make on drugs and alcohol, for instance. We recognise that we are doing a bit of the work, too. Does anybody want to respond?

Johnny Keenan: I concur with that, convener.

The Convener: We will close the meeting, then. [*Laughter*.]

Johnny Keenan: I am relatively new to the Stirling area and to my role. If you look at the single outcome agreement, you can see that each of the outcomes is mapped across to the national outcome for reducing health inequalities. That previously was a frustration for me working in other community planning partnership areas

where it was perhaps not appreciated that a range of partners have a contribution to make.

Often, the problem is that the term health inequalities perpetuates the idea that it is a concern for health services and the term health services is used synonymously with NHS services. That has been a particular frustration for me, but I find it refreshing that the community planning partnership in Stirling is addressing the issue, in the sense that all the different partners are embracing the fact that they have a contribution to make to reducing health inequalities.

I will add a comment on the map. It will be interesting to see the difference when you come back in a few years' time. Rather than collating information on all the things that are potentially wrong with an area, perhaps we should have thought about mapping the assets. It would be interesting to see such a collection of information on what is right with the resources that individuals, communities, organisations and partnerships have in the area. We could then look to harness those resources and assets, and ask the partnerships what work they are doing to reduce the risks and to increase the health-enhancing resources in order to turn the red on the map to blue.

14:30

We are evolving from a deficit-focused approach, which has historically been the approach taken in the NHS. I initially joined the NHS as a mental health nurse because I wanted to learn how to fix people, and it took me some time to realise that people have the capacity within themselves, although it is often untapped and unrecognised by others. It has to be recognised that people have skills, knowledge and capacity that need to be built on. We need to build resilience so that people can take control of their own health and wellbeing; it is the same for whole communities, organisations and us as a partnership.

Lynne McKinley: I will pick up on Johnny Keenan's point about a deficit-focused approach having previously been taken. Information about the deficits was certainly available when we started working in Fallin, but our approach was about the assets. The information that could be provided on the assets took up only one side of an A4 sheet of paper, which meant that we did not see the information that the community has generated about its assets, whether it be physical assets, skills or people who are involved in things.

The question that we had to ask was: if the community manages its own physical resources—to a greater or lesser extent—and it has those assets, why does it still appear in the top 5 per cent in unemployment statistics? Why are these things still happening? Those were among the questions that we asked people. We also asked: what makes this place good?

There is a disconnect in Fallin. When we asked people for their thoughts about a healthy person, they rattled off the national messages, and when we asked them about their personal health, we heard some of the national messages, but very few people admitted to drinking alcohol—whether to a greater or lesser extent—and it was always somebody else's drug use that was a problem. We asked people about their family and about the community. We have been trying to take an approach that focuses on assets, although we bear it in mind that key concerns need to be addressed.

The people have created the vision, and I wish that I had had a camera last week to record a conversation at one of the sessions. When we asked people about the issues, they were scapegoating certain individuals who live in the community—I will not repeat the language that they used. However, we turned that round. We asked: if everybody is to have a voice and is to be encouraged to take positive steps to improve their health and wellbeing, what do we need to do?

Elaine Brown had a conversation with one of the most vocal community councillors, who was scapegoating people. Elaine gently explained the signposting services, described the experience of somebody who has an addiction problem, and pointed out that they do not feel connected to the community. In response, the woman repeatedly said, "I had never thought of that."

From that conversation, a discussion emerged about how we could make contact with folk who have addictions—bearing it in mind that we must respect their confidentiality, because they use services elsewhere—and ask them questions that would enable us to bring them into the community and to support and value them.

Elaine Brown has set a challenge because a set of questions has to be produced that can be asked of folk who are using the services. It is a balance: we need to go with the assets but, if we are going to make a difference, we need to be mindful of where the deficits are.

Johnny Keenan: Yes. There needs to be a redressing of the balance.

Elaine Lawlor: We have come a long way in terms of community recovery. There is a real issue with stigma in Scotland and we all have a role in reducing that. When people get over their issues and want to go into employment or volunteering, they are often blocked by the views of people who do not allow that recovery and do not accept the changes that they have made in their lives. Until such problems come to their door, that is

unfortunately the position that many people hold. We can work with that situation and coach people into thinking that everyone has a voice and should be included, but sometimes their views are the problems that drive inequalities.

Elaine Brown: The point was made about there being a separation in Government and how sometimes policies make the situation more difficult at a local level. I have two examples—one strategic and one operational—that show that there have been difficulties, certainly for a local partnership.

The first example is from last year, when alcohol and drug partnerships were aligned more closely to community planning as per Government direction. We were asked to develop our delivery plan but, at the same time, the single outcome agreements were not due for review until this year, so we were trying to develop outcomes for a strong partnership with community planning but community planning was not being asked to do that until a year later. That made it difficult for us.

The operational example relates to waiting times, which Kathy O'Neill has already touched on. Meeting the waiting times target was a huge capacity issue for services locally, and a lot of work was put into working differently. As commissioners, we had high expectations of our services meeting the target, but at the same time other policies were coming out, such as getting our priorities right, in which there was an expectation that addiction services would make home visits.

Therefore, on the one hand, we were saying to services that they needed to work smarter and see people more quickly and efficiently, and on the other—although we recognise how important home visits are—we were also asking services to stretch themselves further to ensure they were dealing with children who were affected by parental substance misuse. At monitoring meetings, those services were understandably telling us that they were struggling to meet the waiting times targets and do home visits. That was just an example of policies coming from two different Government departments and working against each other.

The Convener: That is interesting. We have had a couple of insights today about the impact of policies and the demands they make as well as how priorities can be set in one year and another priority can be set later while people are still trying to work through the first one. Measurement was also a significant point, and I do not think that we have brought out how we measure health inequalities and how everything we do against them distorts working together.

Bob Doris: I found a lot of that very interesting. I am going to come back to ask about the opportunities with the proposed community empowerment and renewal bill, and whether the witnesses have given any thought to the disposal of community assets for community-run hubs.

I also want to raise another issue, which I am happy to leave sitting as long as we do not completely ignore it. We have heard a lot about how income inequality drives health inequality. The United Kingdom economy and welfare cuts do not sit in isolation from all the initiatives that the witnesses are working with. I will leave that comment sitting, because I want to have a positive discussion about what the witnesses can do to turn things around, but it is only fair to put it on record that they do not work in isolation and that there are UK policies that are working directly against what they are trying to do.

I have said that bit—as diplomatically as I can—so now I return to the bit that we have power and control over: the community empowerment and renewal bill that will be going through the Scottish Parliament. I know that a number of local authorities are looking at disposal of community assets, and there has been concern that some local authorities will use that to disinvest from communities, rather than to empower the communities themselves. Has thought been given to how that kind of initiative can—in a positive way, if handled correctly—help with empowerment and co-production in the Stirling area?

The Convener: This is a good point to remind everyone that we are coming to the end of the session, so this is an opportunity for the witnesses to respond and to influence our thinking.

Lynne McKinley: Stirling Council has a policy in place that looks at less-than-best-value leases and the process for asset transfer. There are a number of examples across the council where we have gone through a lease process with community organisations. Two have gone through the asset transfer, and another is doing that in a staged way—it is going for a lease and working on a longer-term business plan, after which we hope that it will consider asset transfer. It is an unwritten mantra that it is an asset that we are transferring, not a liability.

Organisations are given support to go through a rigorous planning and development process before a proposal goes in front of the elected members, who ultimately make the decision about a transfer. We have good practice in place in Stirling, and maybe at some point we will get the unwritten mantra embedded in the policy.

Kathy O'Neill: My personal observation is that one of the challenges is ensuring that it is not only affluent communities that are better placed to

access such policies and get the benefit of asset transfer. There could be an unexpected outcome that might polarise communities more.

Lynne McKinley: Can I respond to that?

The Convener: Yes, certainly.

Lynne McKinley: The example that I described was of the Ochil centre, in the Raploch area, which has worked on a business plan and which already manages the resource. The decision was taken to work on a lease and to work in the longer term on transferring the asset because there are plans for the centre that need more thought and support.

If people are going to run a facility on their own, they need to experience that before they jump. We are not focusing only on Killearn and Gargunnock. If anybody comes forward with a proposal, we will look at how we can support them and whether it should go through the less-than-best-value process, because public money is involved.

Dr Thomson: I will make a plug for awareness of a risk. Here we are talking to the Health and Sport Committee, and my area is education, but something that was said about policy struck a chord. The policies that are made here have impacts elsewhere, and the policies that are made elsewhere have impacts here.

One risk that the committee needs to be aware of is highlighted by the example of Ace Cornton, a community organisation that does a fantastic job of training in the Cornton community. It has seen a huge influx of older people—not in the 16-to-24 cohort at which employability funding can be targeted, but older than that—who need to use information technology to fill in a form so that they can claim under the new work and benefit requirements and who cannot do that.

In the community, our key target audience for training is people who want to be able to use IT. The people who are being asked to do that training are in the post-24 age group, but no funding is available for that. There are a number of areas in Skills Development Scotland, but if Ace Cornton is seriously asking my college and other institutions how to deal with the new target audience that is coming through and where those people should go after that, we are keen to support that kind of initiative. What I have described is a risk.

14:45

Dr Wallace: To build on a theme that I hope has emerged in the discussion, I would say that, at all levels, we are being asked to work on a multiagency basis. We are responding to that, because that is how all the aspects that underpin health are best joined up. The health consequences of inequalities are merely the end product of many other things that have happened in people's lives. The question is how we get the Government to be a bit more joined up and ensure that its different departments influence the situation more collectively.

The Convener: Do I have any more bids for responses?

Kathy O'Neill: We have not said much about older people this afternoon. When we talk about health inequalities, we should not forget the importance of ensuring that older people are connected with communities. We are carrying out focused and targeted work with them to ensure that they can stay healthy and independent for as long as possible.

The Convener: That is another significant issue on which the committee has done a lot of work over the session. We will continue that work, given the big focus on the elderly in the legislative programme. The scrutiny of the bill—which I have been calling the integration of health and social care bill, although I believe that its name has changed—lies ahead of us; I would welcome any comments that anyone wants to make on that.

Anne Knox: As Kathy O'Neill has said, we completed the public consultation on joint services for older people just the other night, and our strapline for that is, "The right service in the right place at the right time." That was very much what communities said to us when we did the consultation; we are slightly behind some of the other areas, because we wanted to ensure that we had spoken to our communities, that they understood the effects and that their voice had been taken into consideration.

To go back to Ken Thomson's comments about IT and the fact that people are talking about using telehealth care a lot more to help people stay longer in their homes, I note that, in the feedback that we received, one lady said that it would have been nice to understand how her hearing aid worked before she needed to use one. In the information that we are getting, people have made it clear that, although these things are all good, people need to understand how to use them before they can get on. People are also frightened when anything new like that comes along, so education is definitely needed.

On another issue, the partnership to address the change fund and reshaping care for older people has been successful, and everyone around the table has managed to work together on that. In August, we will hold a stakeholder event on the theme of co-production and the asset-based approach, to ensure that we all understand what that means and how we can assist communities in the future. We are all talking together about that.

The Convener: That is certainly a significant challenge. As someone who is getting elderly, I should say that not all older people are dependent on others; however, we are all fast becoming carers. Given that we can look forward to the prospect of a long life and being cared for at some point, it is important to all of us that we get that right. I know from my community—and I am sure that I speak for others when I say this—that those who have retired and are no longer in the workplace are significant assets not only in their homes but to the community.

We looked at that during our sports inquiry in considering the importance of volunteers and how many of them—hundreds of thousands of them—sustain lots of sports, exercise and all the rest of it in their communities. We value older people when they are active and I hope that we can provide the right service in the right place at the right time, which is a challenge for us.

I thank Kathy O'Neill for the reminder about that subject. If there are other areas that the witnesses feel have not been covered and which they feel need to be covered briefly, now is the time for that, as there are just a few minutes left before we finish.

Dr Wallace: I ask Elaine Lawlor to talk about the social influencing model, which is quite a novel approach.

Elaine Lawlor: Two of the challenges on the colourful map were to reduce the number of teenage pregnancies and to prevent young people from using drugs and alcohol. We undertook research in the Falkirk area a couple of years back. At that point, we brought to Scotland an American model called the social norms model in our call for evidence, to see what could work to prevent young people from using substances of all kinds. We researched that programme and had funding from the Scottish Government and the Robertson Trust to deliver that research.

The findings were not what we had assumed they would be. The model was not totally transferable to the Scottish education setting, but we found that it worked for some in the pre-maturation age group. We thought that we would build on that, and we have now developed a new model called the social influencing model.

When we were a bit disappointed that the social norms model was not totally applicable to the Scottish setting, we thought that we should horizon scan to see whether there were other unintended outcomes. We were amazed at what we found in the Denny cluster—that area was matched to the control school of Grangemouth high school because they were alike for socioeconomic factors.

We found that antisocial behaviour in the Denny cluster had been reduced markedly—it was really profound—to the extent that I thought that the analyst had maybe made a mistake. We looked at the data again, and it was clear that there was a community benefit from the young people at the school concerned receiving the interventions. When they went home, the benefits filtered out into the wider community—into youth settings and their families. After that, Falkirk Council immediately put the money on the table for the programme to be rolled out.

Since then, we have developed the programme—in fact, the person who has been appointed to it starts today—and we are working with Barnardo's to deliver it in Stirling's schools. It is of national interest because it covers multiple risk factors. It covers sexual behaviour, drug taking, alcohol consumption and smoking.

The programme is vital to reduce drug taking and smoking and we have funded it collectively. We have funding from the blood-borne virus strategy group under the sexual health and blood-borne virus framework and from the tobacco action group. We also receive funding from the alcohol and drug partnerships, the police and the Scottish Government. Everyone is looking to see whether we can change young people's behaviours and build resilience. If we can make them resist, we could see a huge difference. I would like to welcome the committee back to see the results in a couple of years' time.

A Forth valley approach will be taken and we have sampled schools in urban and rural areas so that we get the spread that we need. Mr Christie wanted us to do such things and I hope that he would be proud of us.

The Convener: That is very interesting. I am sure that the other committee members would welcome additional information. If any papers are available that you can get to the clerks, they will ensure that the committee sees those papers. That links into some of the work that the committee has done, and it would be appreciated if you circulated that information, please.

Elaine Lawlor: I will do so.

The Convener: Does anyone else want to get something on the record?

Joe Hamill: As part of the work that we are doing on anticipatory care and through the keep well programmes across Forth valley, nurses have carried out some 11,500 health assessments. We had a men's health service in place before the keep well projects came on board, and we have now integrated the two.

The approach to men's health in Scotland is renowned worldwide. We work with men from

deprived areas, in particular, to get them to have health checks. That process is community based rather than general practitioner based. Between that and the keep well work that we are doing across that theme, we are targeting people between the ages of 40 and 65 who live in highly deprived areas.

In addition, we are doing major work with social work departments to target offenders and ex-offenders in that age group. We have dropped the age limit for that, because there are significant barriers to getting such people to work with health services. Once we have engaged with offenders, we can look at the development of other services. Training and education are provided on the back of the keep well programmes.

Through the multicultural partnership, we recently held a successful event that targeted women from ethnic minorities, who we know sometimes do not take up services. About 65 women attended for health checks, which was amazing.

This week, we extended that group. A major piece of partnership work on the keep well outcomes of that is to continue for the next three years. We are learning a lot about cultural differences and things that are not understood. Part of that work is about providing information in the relevant languages and getting people who are champions in their community to engage with the health service and to help others from ethnic minority communities to access it. Sometimes people do not see a way in, or they are not treated very well.

An immense amount has been learned from that group in the past two weeks alone. We will take that forward over the next three years. A plan is being developed. Something will not happen every week, but there will be engagement with wider services and activity at strategic level to identify how we need to change the NHS in relation to working with people. That hits the quality outcomes that we are all involved in working towards.

The Convener: There is no doubt—not just from what we have heard in the committee meeting but from our engagement last night and today—that a lot of good work is being done here in Stirling. As a community, you have issues to face, but I am sure that I speak for others when I say that I have been impressed by the level of work that is being done, by the strategies that have been laid out and—I am looking at some of the people in the gallery whom we met in the community this morning—what is more important, by the practical application of those strategies, which is making a significant difference to people's lives. That is what we are all about, as professionals or as politicians. We want to influence things to benefit the people whom we represent.

I have enjoyed the couple of days that we have spent in Stirling and I wish everyone well with all their work. We look forward to seeing some fruits of that labour at some future time. I thank you all for your participation and your evidence. Enjoy the weekend—the sun is starting to come out. Thank you all very much.

Meeting closed at 14:59.

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