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Pàrlamaid na h-Alba

Official Report

FINANCE COMMITTEE

Wednesday 15 January 2014

Session 4

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FINANCE COMMITTEE
2nd Meeting 2014, Session 4

CONVENER

*Kenneth Gibson (Cunninghame North) (SNP)

DEPUTY CONVENER

*John Mason (Glasgow Shettleston) (SNP)

COMMITTEE MEMBERS

*Gavin Brown (Lothian) (Con)
*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)
*Michael McMahon (Uddingston and Bellshill) (Lab)
*Jean Urquhart (Highlands and Islands) (Ind)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Sir Harry Burns (Scottish Government)
Aileen Campbell (Minister for Children and Young People)
Dr Anne Hendry (Joint Improvement Team)
Pete Knight (Joint Improvement Team)
Gerry Power (Joint Improvement Team)
Dr Margaret Whoriskey (Joint Improvement Team)

CLERK TO THE COMMITTEE

James Johnston

LOCATION

Committee Room 5

Scottish Parliament

Finance Committee

Wednesday 15 January 2014

[The Convener *opened the meeting at 09:30*]

Early Years Change Fund

The Convener (Kenneth Gibson): Good morning and welcome to the second meeting in 2014 of the Finance Committee of the Scottish Parliament. First of all, I remind everyone to turn off their mobile phones or any other electronic devices that they have. Michael McMahon is not here, but we have not received any apologies from him so he might simply be running late.

The first item on our agenda is to take evidence on the early years change fund from the Minister for Children and Young People, the chief medical officer and two Scottish Government officials. I welcome to the meeting Aileen Campbell, Sir Harry Burns, Shirley Laing and Philip Raines. I understand that the minister would like to make a brief opening statement.

The Minister for Children and Young People (Aileen Campbell): On behalf of the early years task force, I thank you for inviting us to discuss the progress of the early years change fund. As the task force's co-chairs, Sir Harry Burns and I will represent its views. Unfortunately, our local government co-chair, Councillor Chapman, is unable to attend today and sends his apologies.

The early years framework signified an important milestone in encouraging partnership working to deliver a shared commitment to giving children the best start in life and improving the life chances of children, young people and families at risk. The early years task force shares that commitment.

Established in November 2011, the task force has the role of developing the strategic direction for the early years change programme and of co-ordinating policy across Government and the wider public sector to ensure that early years spending is prioritised by the whole public sector. In setting out its vision and priorities in March 2012, the task force made it clear that the establishment of the early years change fund signified a significant shift to preventative spend over the current parliamentary session.

That is because the early years change fund is the first time we have collectively discussed a financial mechanism for delivering on the aspirations of the early years framework. Each year, the public sector spends £2.7 billion on children in their early years, and the change fund presents a huge opportunity and a good starting point for the Scottish Government, local government and NHS Scotland to fulfil their joint intention to shift resource to where it makes the most difference by supporting prevention and early intervention.

The clear expectation set out by the task force is that, through the early years change fund, partners can consider how they can better support universal services to deliver better for children in their early years and their families; raise public awareness of the significance of the early years to children's healthy development; and bring the totality of their resources to discussions on how best to deliver the aspirations of the early years framework.

We know that from the outset the early years change fund has had an impact. For example, in its year 1 change fund return, Angus has told us of its plans to integrate education, early years services and social work family support services to provide locally based early intervention and prevention teams. That is but one example. Returns from all community planning partnerships have been overwhelmingly positive, providing us with strong evidence of a move towards prevention and early intervention.

The early years task force always viewed the change fund as a good first step to achieving the longer term goals of prevention and transformational change in service delivery. Given its very nature as a change fund, its lifespan was designed to be limited. The funding commitments from health and local government will end in 2014-15, and the Scottish Government has committed £8.5 million to the early years change fund for 2015-16 to support the transition away from the change fund model.

However, the fund's impact and legacy will continue. Together with the task force's wider work, it has enabled the development and establishment of the early years collaborative, which is the world's first multi-agency quality improvement programme. The collaborative provides us with the method of continuing to ensure that the Scottish Government, health and local government embed prevention and improvement at a local level. Delivered at a national scale, this locally based work is helping us collectively bridge the gap between what we know works and what we do through improvement science to improve outcomes for our children and families.

The ambition of the early years collaborative is nothing short of making Scotland the best place in the world to grow up. All 32 CPPs in Scotland have embraced the approach and are actively looking to build on the good things they already do and to learn from others to improve the outcomes

for Scotland's children with regard to stillbirth, infant mortality and the reaching of developmental milestones. Although it is still early days for this groundbreaking work, we are already starting to see that small changes are having an impact.

In March 2012, the early years task force made it clear that its aim is to put Scotland squarely on course to shift the balance of public services towards early intervention and prevention by 2016 and to sustain that change to 2018 and beyond. The early years change fund has got us off to a good start, and the early years collaborative, as a vehicle for embedding this prevention and improvement, provides us with the way forward.

Thank you, convener, for allowing me to make those opening remarks. We stand ready to answer any questions you have.

The Convener: Thank you, minister. You are probably aware of how this committee works—I will ask a few initial questions and then open up the session to colleagues around the table.

I found your introductory remarks very interesting. In fact, you have partly answered one of the questions that I was going to ask, which was whether further money would be allocated to the early years change fund from the health and local government budget, by saying that that will not happen. In 2014-15, the Scottish Government, health and local government will put £99.25 million into the fund but, the year after, the funding will fall dramatically to only £8.5 million from the Scottish Government. What impact is that likely to have on delivery?

Aileen Campbell: As I have said, the change fund was intended to be the mechanism by which we would establish the culture of change and encourage people in the 32 CPPs to bring to the table the totality of their resources to help improve the lives of children in their earliest years.

The £8.5 million that you have mentioned is for the transition from the change fund itself to embedding the changed behaviour further. Of course, the method by which we are delivering this change is the early years collaborative, which will take forward many of the early intervention measures and measures to prevent problems before they arise that we want if we are to improve children's lives.

As the lasting legacy of the change fund and the task force, the early years collaborative will move forward with embedding changed behaviour and ensuring that improvement science is used to analyse any changes that have been effected by improved service delivery. The £8.5 million is for the transition away from the change fund model, which, as I have said, was designed to be limited in its lifespan.

The Convener: I fully appreciate that, but is there any evidence that it has delivered fully enough to allow us to downsize the available funds to such an extent over a one-year period?

Aileen Campbell: As I have said, the change fund was designed to be limited in its lifespan. It has already led to some very good examples of prevention in action, and the collaborative will take forward a lot of that work. The £50 million from the Scottish Government was new money and the £8.5 million is for the transition away from the change fund model to embedding some of the changes that we expected to see through the work of the task force and the change fund itself.

The Convener: You have already mentioned the early years collaborative. How does the early years change fund impact on that, and what do you expect the collaborative to deliver in this specific area?

Aileen Campbell: I will ask Sir Harry Burns to talk in general about the collaborative, but I can say that the model for delivery, which will change from a deficit model to a model in which we build on assets to improve children's lives and to prevent problems before they develop into crises, has been subject to improvement science and has come through the collaborative. It has already reaped real rewards; for example, it is improving the way we work with children and families in their earliest years. The task force has overseen that work and the change fund, and it has paved the way in setting up in Scotland what is a world-leading collaborative.

As I have said, Sir Harry Burns will be able to give you more specific details about the collaborative.

Sir Harry Burns (Scottish Government): Would it be helpful for me to describe what a collaborative is and how it works?

The Convener: It certainly would.

Sir Harry Burns: A lot of international evidence going back 40-odd years shows that early intervention transforms life chances by improving not only health but educational attainment and employability and reducing offending behaviour. In fact, much of that evidence comes from the United States, where President Johnson's huge social reforming agenda in the 1960s delivered a lot of early years interventions.

A few years ago, we got a fellowship for a public health doctor to spend a year at Harvard reviewing that evidence. They came back with a convincing set of interventions that had been evaluated by Nobel prize-winning economists, which showed that the longer you left them running, the bigger the return on investment.

The real returns began to appear when the children who experienced those early years interventions hit their mid-teens. By then they were succeeding at school, had not had serious illness—which often arises as a result of violence in American inner-city communities—and were not getting involved in offending behaviour.

That work has gone on and now, after about 30 or 40 years, we are looking at return on investment of about $50 or $60 for every $1 spent on intervention. At the same time, a range of new scientific studies showed the importance of supportive, nurturing environments in creating attachment behaviour, which explained why the early interventions were so successful in a social sense.

What we lacked was a method for implementing those changes. Historically, all Governments have typically made changes by coming up with three-year projects. They have said, "Let's have a project; let's fund it for three years and see what happens." Usually, when the money runs out, the project dies. To be honest, we are all fed up with that: good ideas have flourished and then faded away.

We decided that we needed a method that would last, be done at scale—it would be a whole-Scotland set of interventions—and engage the front line. Typically, the great and the good get together and write a report that gets published and then ministers say, "Yes—we'll all go and do this," but if the front line is not involved in shaping the interventions, the sense of ownership will not be as good as it should be and take-up will be patchy.

The collaborative methodology brings together the front line; front-line staff, working with parents, voluntary agencies and so on, help to shape the interventions and how they will be delivered. We say to them, "We need to help parents who do not know how to be parents attach to and nurture their children, and do the kinds of things for their children that we know will prepare them for school." Across Scotland, all CPPs come together every four or five months and say what they have done to do that.

For example, reading bedtime stories to children helps improve their vocabulary, speech and learning. We can tell you how many children get a bedtime story most nights of the week and we can tell you the CPPs where that is above 90 per cent, because CPPs are testing it. They go out and do things: they give parents aide-memoires and books, and they measure. The next day they ask the kids, "How many of you guys had a bedtime story last night?" The CPPs measure it constantly and then come together and share their experience, so that their learning is spread.

We do not get the change in scale overnight, but over a period of maybe two or three years we begin to see the successes—the things that work—being shared across the whole of Scotland and they become embedded in what we do. This is a behaviour change programme, which will embed good practice across the whole of Scotland as quickly as possible. We have learned from the patient safety programme, which uses the same methodology and which has been staggeringly successful—I would not have believed how successful the patient safety programme has been in transforming the quality and safety of healthcare in Scotland. After five or six years, we have very hard data on how things have improved. It will take five or six years to see the same for this programme.

One of the aims of the early years collaborative is to reduce infant mortality by 15 per cent by 2015. If we reduce it by 15 per cent, we will be down at the same level as the Scandinavian countries. We already have the lowest infant mortality of the four United Kingdom countries, and we will get down to levels similar to those of places such as Sweden if we achieve our aims. There is maybe just a wee sense that that is beginning to happen. I would not want to promise anything yet, but we are beginning to see things in small pockets, and they will be scaled up.

The collaborative is reorienting the way in which the public sector, working with voluntary agencies and Government, does things. It is a process that is in train and one that has really been active for only a year—it is early days yet.

09:45

The Convener: As you say, it is early days, and these things do not happen overnight. You say that you want to involve the front line. In the evidence that the committee took on the draft budget, we heard concerns that the delivery is fairly patchy across Scotland, despite what you have said about the CPPs. As you are probably aware, that issue is covered in our report on the draft budget. What does the Government intend to do to try to remove and address the barriers that still exist to cultural and structural changes?

Sir Harry Burns: The patchiness is absolutely what we would expect. The whole point is that we do not dictate to people what local circumstances require them to do. People will develop things, and those in different parts of Scotland will develop different aspects of the change at different rates, but they will come together. We will get successes. For example, Lothian will do some things successfully and other things less successfully, as will Perth and Kinross. The areas will then come together, and people will ask, "How

did you do that?" and decide that they will do it, too.

The patchiness will disappear as the collaborative matures, but it will take two or three years for that to happen. There is nothing unexpected about the current situation at this stage. The collaborative is designed to avoid the attitudinal and cultural barriers in public sector organisations to which you refer—such as people thinking, "Who are they to tell us what to do?"—because the local staff are out there testing and measuring what works. The approach is not about a smart Alec such as a chief medical officer telling people what to do; it is about staff saying, "Hey, we've tried this and it works."

The collaborative seeks to provide a culture change, but that does not happen overnight.

Aileen Campbell: The—

Sir Harry Burns: However, it is the best way to deliver what we want. Sorry, minister.

The Convener: Let the minister have a word. [*Laughter*.]

Aileen Campbell: The collaborative exists and the momentum behind it is incredible. Even though there is a national approach, it is respectful of the local approaches that will take forward the improvement that we expect.

Aside from the collaborative, the change fund and the early years task force, we have the legislative programme that accompanies the Government's wider public sector reform, which includes the Children and Young People (Scotland) Bill. That bill will embed a degree of consistency in the approach to children's services by putting elements of the getting it right for every child programme on a statutory footing. That should help with consistency, but it is still respectful of the different approaches that each local authority will want to take and how they can best tackle issues to do with children's services and dealing with children and young people and their families.

Aside from the collaborative, therefore, there is the work that we are doing through legislation to try to ensure that every young person across Scotland gets access to much more co-ordinated and joined-up services, such as those in the pathfinder programme in the Highlands. The aim is to ensure that many more children across the country receive such services.

As well as the legislative tools, we have a leadership strand within the early years collaborative, because we need leaders to take forward the message, too. Of course, the approach is also being informed by the fantastic work of front-line practitioners.

The Convener: I will ask one more question and then allow colleagues to come in, as they will want to explore some of the issues in greater depth.

In our report on the draft budget, the committee asked what progress has been made on developing a monitoring and evaluation framework for the early years change fund—the Government stated in January 2012 that it would produce such a framework—and when an evaluation report will be published.

Aileen Campbell: We have asked each local authority to provide returns on their activities. That was taken forward by a sub-group of the early years task force headed up by David Martin, who is the chief executive of Renfrewshire Council and a member of the task force. In those returns, we have examples that clearly demonstrate the work that CPPs are doing to live up to the aspirations of all of us in the early years task force.

That has been a first stab, and it has in itself been a learning process. As we proceed, we will be able to be more sophisticated in the way in which we get back the information that we require to see how effective the approach has been. As a first attempt, it certainly has shown that each local authority and CPP is committed to the agenda, along with their other partners, including the third sector. That information is available publicly if the committee wants to see it.

The Convener: Monitoring and evaluation are important. If we are going to eliminate some of the patchiness, we need to know that there is a degree of commonality in the way in which progress is being evaluated across the country.

I now open up the session to members. The first question will be from Jamie Hepburn, to be followed by Jean Urquhart.

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): The submission that the Government has provided says:

> "The Change Fund is the first time that we have collectively discussed a financial mechanism for delivering on the aspirations of the Early Years Framework".

The minister emphasised that in her opening remarks. It might be helpful to know what the position was previously and what happened before the new approach was taken.

Aileen Campbell: The task force and the change fund are about bringing people together and people bringing the totality of resources to the table. The early years change fund is a first step towards transforming how we use that money and towards getting the maximum benefit so that children and families have the best possible outcomes.

The point of the initiative was always about changing the culture and stopping the silo mentality. The CPPs brought people together but, at the higher level, the task force has meant that we can talk about how to shift resource and make a first attempt at ensuring that the money that we use in the early years brings maximum benefit. Because the early years change fund is now funding the collaborative, as we heard from Harry Burns, that is significantly changing the approaches that local authorities are taking. They are sharing information in a safe way so that they can learn from one another. Even if some things do not work out, that still provides learning. So we have made the first step towards changing our approach to our finances in the early years. The collaborative has been funded and it will bring further transformation.

Jamie Hepburn: Before the change fund and the new approach, was there little evidence of that type of collective working, or was it patchy across the country?

Aileen Campbell: It probably would not have been so consistent. There have always been pockets of good practice around the country, but we need to make it the rule rather than the exception. The task force is bringing together the key players from local government, health and the third sector, and parents as well. A range of different people are getting round the table to monitor how some of the resources are spent. The change fund has now funded the early years collaborative, which will further embed collaborative working.

The public does not see public money as health money or local authority money—they just want to have good services. The initiative is about making sure that those services can be provided in the best possible way. Resources are tight, so we need to make the best use of what we have. A considerable amount of money—about £2.7 billion—is being used for early years. That is about 10 times the amount that we have in the change fund, so it is about how we use that to make maximum impact and get maximum benefit. The key is to make sure that prevention is our hallmark, as Harry Burns outlined. The best use of money is to get good outcomes later in life. If we spend early, we can prevent some of the persistent social problems.

Jamie Hepburn: You referred to the figure of £2.7 billion, which is also mentioned in the submission. We are focusing on the change fund, which is a lot smaller but, in relation to the work of the collaborative and the task force, are you looking at the whole pot of money rather than just the change fund?

Aileen Campbell: Yes. It is important to recognise that the key players that we are talking about had not sat round a table together before the task force was set up. Of course, one of your committee members sits on the task force, so it also has cross-party political representation. It is about making the best use of the money that we have. The task force and the change fund have given us the mechanism by which we can do that.

Sir Harry Burns: On the question whether the current way is better than the old way, I worked in health boards for a decade or so and I found the old way intensely frustrating. The typical way of trying out things was to have a call for bids, and five or six health boards or whatever would be successful and go off and do things with three months' funding, but the thing would stop when the funding ran out and it would not be embedded in practice. The extent of the learning across the country from such projects was limited according to the extent to which people shouted about them. We suffer a bit from the not-invented-here syndrome so that, if Edinburgh does something, the question is whether Glasgow will pick it up—maybe, but maybe not. However, with a collaborative approach, there is continual quality improvement and sharing of successes, which just becomes the way in which we do things.

There has been a big transformation, which is attracting quite a lot of international attention. As far as I can tell, we are the first people to have applied the collaborative methodology to something other than healthcare. As I said, that is attracting quite a lot of attention.

Jamie Hepburn: The paper that the Government provided refers to the

"objective of our joint early years change programme and our ... work on the Early Years Collaborative".

There are three bullet points on the outcomes from that objective. They are:

"Deliver tangible improvement in outcomes and reduce inequalities for Scotland's vulnerable children.

Put Scotland squarely on course to shifting the balance of public services towards early intervention and prevention by 2016.

Sustain this change to 2018 and beyond."

I accept the chief medical officer's point that it will be many years hence before we can see some of the changes. He said that he had a wee sense of there being some changes, although he asked us not to hold him to that, so I will not. However, can you set out what progress there has been in achieving the three outcomes, in so far as it is possible to assess that?

Aileen Campbell: There has been a culture change, not least that by which the task force has allowed us to get together to ensure that we are working holistically to improve children's services. There are already indications in the returns from

community planning partnerships that local authorities are changing the way in which they do business. For example, I previously gave the example of Angus, which is integrating education with social work for the early years. West Lothian has a preventative interventions board, and Highland Council has allocated an additional recurring £2 million for early years services, with £1 million each for 2013-14 and 2014-15. Work is taking place to identify further preventative spend across partners.

The returns—which are available online should the committee wish to look at them—show clear examples from each local authority that has given us returns that they are doing things differently. Again, that lives up to the aspirations that we set of ensuring that the approach is put on a sustainable footing by 2016 and is sustained beyond 2018.

Sir Harry Burns: The high-level outcomes that Scotland has agreed on are: reduce infant mortality by 15 per cent; reduce the number of children with developmental delay at the 30-month assessment; and reduce the number of children with developmental delay when they reach school. Underneath those high-level outcomes, there is a set of processes on which we have evidence that, if we do them at scale, we will deliver those outcomes.

At present, we have evidence of process change in relation to things such as nurturing behaviour through the family nurse partnership, which is spreading round Scotland; reading to children; and healthy-start vitamins and other nutritional things. We can see processes changing, but achieving the high-level outcomes is a bit like winning an Olympic medal. As Chris Hoy said, the British cycling team won all its Olympic medals through the accumulation of small gains across lots of different areas. The small gains added up to big change. Similarly, we are seeing small changes across hundreds of different processes in the early years, which will ultimately produce the big changes that we are aiming for.

Jamie Hepburn: So we can see a change in culture and process, but it is too early to see a change in outcomes.

Sir Harry Burns: Yes.

Jamie Hepburn: With regard to the minister's answer a minute ago about local examples, one of the things that the committee asked for was evidence of additional resources that the change fund had leveraged in to local authorities. Presumably, the examples that you gave, which you said are publicly available, are evidence that that is happening.

Aileen Campbell: Yes, absolutely. Of course, the family fund within the change fund has also levered in Big Lottery funding to make the total pot larger. Again, that is leveraging in money from not just local authorities or health but the third sector. In the returns, local authorities have pointed to funding from the third sector to help to deliver local projects that they have worked on. Beyond the funding in local authorities and health boards, we can point to additional funding because of the changed approach and culture and everyone's recognition that the best way to spend the money is on prevention.

10:00

Sir Harry Burns: Typically, we will see backfill. When health visitors get involved with the family nurse partnership, their jobs as health visitors working with general practitioners and so on will be backfilled. That is where a lot of the stuff is coming from. People are picking up new roles and tasks, and to give them time to do them, other funding is being made available to backfill the space that they have left in their traditional roles. It is about reorientating how we deliver services.

Jamie Hepburn: There was an announcement last week about free school meals for primary 1s to primary 3s. How does that fit in with the issue that we are discussing? Could that also be viewed as part of early intervention and the preventative spend agenda, in which the committee has taken a real interest? Will that be measurable? Will we be able to see a change in outcomes for those youngsters?

Aileen Campbell: The early years go beyond the pre-school years; they go up to the age of eight. To reflect that, there is a new workstream through which we will look at how we can improve the life chances of children in that cohort. I absolutely think that, once we can examine the free school meals initiative, we will see that it has had an impact on children of those ages. We know that the approach will help their health, wellbeing and attainment, as they can learn much more ably if they do not feel hungry and are not worried about that in their life. I imagine that that will have a positive impact in the collaborative work that we are taking forward. However, that is a new workstream with which we are moving forward.

Jean Urquhart (Highlands and Islands) (Ind): I want to ask about the end of the change fund. The minister said that, by then, the front-line services that are delivering will, we hope, be working in a new culture, and that will be that but, in a sense, that is not reflected in the reports that we have had of local authorities being nervous about the end of the fund and perhaps their understanding of what the change means. One reading of that is that the funding is a kind of add-on and that, instead of its making a change, the service will stop when the funding is withdrawn.

Will the task force continue when the funding ends? What monitoring or evaluation will there be? As Sir Harry Burns said, our infant mortality rates are moving towards Swedish rates, which is fantastic. How will the measurement look to you in practical terms? How will we have confidence that the change has been made?

Aileen Campbell: On the early years change fund, I said that the approximately £50 million of new money is Government money, and that will come to an end. The £8.5 million will be for the transition away from the change fund. The fund was only ever designed to be limited in its lifespan to bring about the change in culture that we expect. The funding from local authorities and the national health service brought their resources to the table, too, and that remains in place going forward. We expect that the cultural changes that will have happened through the change fund will remain, and the £8.5 million will be helpful in the transition. I hope that that answers some of your questions.

The early years task force has been reviewed. We refreshed it quite recently, not least to reflect the fact that there is the new workstream that goes up to the age of eight. Bill Maxwell from Education Scotland is taking forward the work that will be happening in schools because of that new age group. We will look to review that thereafter, following the changes in the change funds. We have just reviewed the work, and we will review it again.

Sir Harry Burns: A whole load of monitoring goes on all the time anyway, of things such as hospital admission rates. One of the unanticipated consequences of the smoking ban was a significant fall in the number of children who are admitted to hospital with acute asthmatic attacks. That implies that people have not only given up smoking in public places but stopped smoking at home when children are present. We monitor such things all the time, so we get a picture of people's health, and in addition a number of things are monitored in education.

There is a lot of routinely collected data. The challenge is to put it together in ways that give us a global picture of the way in which performance across a range of dimensions of child wellbeing is improving in Scotland, and work to do that will continue. The money is already out there. It is being used to produce routine statistics and so on, and that will continue.

Aileen Campbell: There are also opportunities in the Children and Young People (Scotland) Bill, because it requires local authorities and health boards to prepare reports about how they jointly plan their services to deal with children and families. There are opportunities through the guidance that will accompany the legislation to make sure that it dovetails with the work of the collaborative and other work that is going on across Government, whether that is through the getting it right for every child programme board or the work that we do for looked-after children. There are opportunities to ensure that the work that Sir Harry spoke about goes into the returns that we get through the plans that local authorities and health boards will jointly have to prepare when the provisions in the bill come into effect.

Jean Urquhart: The plans sound exciting and they are hugely appealing. I know about some of the difficulties in the early days involving NHS Highland and Highland Council, but the appeal of the plans lies in the fact that they will bring CPPs together. I therefore assume that they could be seen as grass-roots, bottom-up solutions, with people at the front line sharing their experiences.

Aileen Campbell: Absolutely. The Christie commission spoke about things being top down and people not working with communities and with families' assets. The collaborative is about changing that and turning it on its head, as it is reflecting local environments, working with people to demonstrate to them what they can do and helping them to improve their lives, and the CPPs have absolutely bought into that.

At the learning sessions that accompany the collaborative—I think that the fourth one will be held in a couple of weeks—we have had 700-plus people in one room at the Scottish exhibition and conference centre, talking about how they can collectively change the way in which they do business to ensure that the early years are prioritised, that prevention is the hallmark of what they do and that they embed good local practice and share that knowledge. The enthusiasm has never stinted or wavered at all through those learning sessions. I cannot be dead certain, but it is probably the first time that we have had that number of people in one room talking about these things collectively. There is a session coming up soon, and if members want to see it for themselves and get a feel for the change that the collaborative is inspiring right across Scotland, we are absolutely happy to extend an invitation to you.

Harry Burns may want to add to that.

Sir Harry Burns: I tend not to be fazed by public speaking, but the energy in the room at those sessions is astonishing. The first time I walked in, I thought, "Wow." There were 800 people sitting there, with people from every single CPP in Scotland plus people from voluntary agencies and so on, and boy do they want to pick this up and run with it. Ultimately, they are the ones who are delivering the change, and it will be embedded in their practice. The sessions really

are worth a visit. You will not have seen anything like it.

Aileen Campbell: It is probably also worth while for members to try to get a feel for and a grasp of the tests of change that are happening in your local areas. There will be ones in each of your local authorities that you can go and see. One good tangible example that I have seen is delayed cord clamping, which is happening in the midwife-led maternity unit in Montrose. The point at which the cord between mother and child is cut is delayed, which allows some of the blood to flow back. I am no medical expert—I am just paraphrasing—but that allows the nutrients to go back into the baby, which allows the baby to thrive a bit more quickly.

The unit is testing that small change, and if it can demonstrate that it works and can gather the data, it can start to consider how it might scale up such changes. Members can not only look at what is going on in their areas, but ask for the data to demonstrate the impact that the changes are having on children's lives.

Jean Urquhart: One of the actions that Finland took on diet was educating people along with switching from farming dairy to farming berries as a basic. Scotland is in a similar situation. Is diet part of the programme too, given that it is recognised more and more as a huge part of health?

Aileen Campbell: I see that Harry Burns is itching to come in, but I wanted to add that Perthshire, where I am from, is the soft fruit capital, and that the Clyde valley, the area that I represent, is also famous for its soft fruit. Given the abundance of local produce in Scotland, we should perhaps look towards the Finnish example. As Jean Urquhart pointed out, Finland recognised that it had a problem and used its resources to tackle it.

Jean Urquhart: In addition, some of the agencies that we are talking about bringing together to deliver change are part of organisations that do not necessarily promote healthy eating. There is still criticism of hospital food, for example.

Aileen Campbell: I think that Harry Burns wants to come in now.

Sir Harry Burns: Finland is a sore point with me.

Aileen Campbell: Oh—sorry.

Sir Harry Burns: The percentage fall in heart disease mortality from the 1960s to the 1990s in Finland, which it attributed to the change in taxation and subsidies for farmers, is exactly the same as the percentage fall in heart disease that occurred in Scotland over the same time. We attribute the fall in Finnish heart disease to a significant fall in male smoking rates and an increase in the use of new therapies such as statins. It is hard to attribute the fall in heart disease in Finland to a change in diet.

In addition, the evidence base for five-a-day actually came from the fruit growers of America. There are a lot of myths out there but, having said that, I think that it is clearly very important to avoid obesity. The high-fat, high-sugar diet that a lot of us eat is certainly the driver behind much of that problem, and there is no question but that eating more healthily will improve health and wellbeing. For example, the impact of the childsmile programme has been as great as the impact of fluoridation would have been. It has been astonishing, and it has centred on a dietary intervention—namely, breakfast clubs.

There is a lot that we can do, but we must be mindful of what our expected outcomes are. I am certainly with the minister in taking the view that we need to tackle obesity in a significant way.

Aileen Campbell: Going back to Jamie Hepburn's point about the importance of the free school meals policy and the opportunity that it presents, I think that there has been a huge improvement in school meals, and there is a further opportunity to build on that.

John Mason (Glasgow Shettleston) (SNP): I am already feeling slightly less guilty that I do not eat five portions of fruit a day—

Sir Harry Burns: Oh, you should. You must.

The Convener: And vegetables—there are potatoes in chips.

John Mason: And there is marmalade, too.

As I understand it, the change fund, which has been the main focus of our discussions, provides a bit of extra money in the short term to try to change attitudes. We have talked about the way in which we do things; I am interested in disinvestment and whether we are really shifting—and whether we can shift—resources from one group to another.

Minister, you are responsible for children and young people, and if we shifted resources from older people to younger people, that would probably boost your budget. However, in your area of responsibility, we are wanting to spend less money on 16-year-olds and more money on three-year-olds—that type of thing. I refer to a report that we published in which we mentioned that a couple of times. We said,

"The Committee is concerned that there appears to be a real lack of evidence of the necessary disinvestment taking place to support the shift towards a preventative agenda",

and we asked the Government to provide examples of resources being unlocked for preventative measures. Can we move resources from an older age group to a younger age group?

10:15

Aileen Campbell: We have established the early years collaborative because we know that spending on the early years pays dividends in later life, but I would hesitate to say that that means that we should not spend money on 16-year-olds. We should always remember that we can intervene effectively in a young person's life at many different points to change their life course. For instance, last week we announced that we want to allow looked-after children to stay in foster, residential or kinship care up to the age of 21 if they want to, because we know that that can help them to lead more positive lives and avoid graduating to Polmont, where a disproportionately large number of young people who were looked-after children end up. We are doing such things to prevent negative consequences later in life. That is an example of why we do not always want to concentrate on the early years and how we can intervene effectively at many different points in a young person's life to prevent problems from arising.

The question of disinvestment is a good one and is probably much more tricky to answer because we have not had any specific examples, from the change fund returns, of that happening. Nevertheless, people are working together to achieve their shared priorities at a CPP or task force level and are pooling their resources to allow that to happen. We need to try to be a bit more sophisticated in teasing out potential examples of disinvestment through further monitoring of how the change fund has worked and what change has happened.

Sir Harry Burns: If we enhance attachment and nurturing behaviour in early life, we will have fewer looked-after children and fewer young men in prison. If we think about the demographic issues that are affecting the whole of western society—the small base of young productive people and the big base of dependent elderly people—we see that the situation is worse than we thought because the small base of young productive people is made even smaller by the fact that 10 or 20 per cent of them are not contributing; indeed, they are costing society a lot to be looked after. The aim of the early years collaborative is to broaden the base, as those young people who are not contributing will become the dependent elderly. You will hear more later about work that is being done to reduce the burden of dependency in the older population.

There are big macroeconomic consequences of this that should not necessarily mean active disinvestment but might mean that we just do not spend money on looking after children who have not experienced adverse events through drug-misusing or violent parents or whatever but have just lost their way. That is what the American economic evaluation showed led to far more stable families with children growing up to be actively involved in the labour market and not sustaining serious illness.

John Mason: So we might not see what some of us thought we would see—major changes in the way that we use resources within, say, the health service or whatever. The change will be more in the way that we use the resources for particular age groups.

Sir Harry Burns: It will happen naturally. If we reduce the number of looked-after children by 50 per cent, there will be a natural realignment of spend. I do not think that anyone is saying that we are actively going to take money away from areas that we anticipate will not need it in the future.

John Mason: You have cited figures such as that for every $1 that was spent in the States in the 1960s, there has been a saving of $50 or $60. I am an accountant and I want to see where that $50 or $60 is.

Sir Harry Burns: It is a return on investment of $50 or $60, which will be in things such as increased tax income because people are in employment who would not have been in employment. A return on investment is different from a saving.

John Mason: Okay. So some of that is a saving and some of it is extra income or whatever.

Sir Harry Burns: Yes.

John Mason: We were told about a case somewhere in the States in which a decision was made not to build another prison but to put the resources into children or whatever, which sounded like a great idea. That was a real saving—mind you, I do not know what was done with the extra prisoners in the meantime.

Sir Harry Burns: I would not be the least bit surprised if, 20 years from now, we shut a prison, because young people do not end up there.

When I was asked for an opinion for the review of community planning, I said that the early years collaborative would get things started off well but that we should have a reducing offending and reoffending collaborative, because the turbulent young parents who end up in prison go back home and create a turbulent early environment for their children. We should get them on the right track while they are in prison. We should also consider having a collaborative to reduce dependency in

older people and to keep them fit, active and engaged. Added up, all that will transform people's quality of life.

The registrar general's report talks about the fact that, at the moment, there are about 750 people in Scotland who are over the age of 100. He anticipates that, by 2035, there will be 8,000 people over the age of 100. We must get those 8,000 people out there running half marathons and things like that. We need to be ambitious about transforming people's quality of life, their productivity and their connectedness within society.

John Mason: Yes. I suppose that I am still a bit puzzled, because the change fund is a short-term, temporary measure to kick-start something new. If I have understood the minister correctly, the resources that have been put into the change fund from health and local government will still be there to do the work in the future but, going forward, do we not need to spend more money on one to three-year-olds, or is it all about collaborating and doing things differently? If we need to spend more money on the young kids, that money has to come from older people or teenagers—surely it must come from somewhere.

Aileen Campbell: As I have said, the change fund is about kick-starting the change to allow us to ensure that we can bend the spend on the early years more effectively. Local authorities and health spend £2.7 billion per annum on the early years. How can we use that to maximise the potential that we can achieve if we do things in a better way, as outlined by the collaborative and Harry, in what he has said today? We want to bring about that change, and the change fund has allowed that to happen and has enabled us to move forward to the work that the collaborative is doing.

John Mason: You do not think that we need to bring in more resources from somewhere so that we can put more into the early years. It is more a case of how we use the resources and rearranging things.

Aileen Campbell: In the first instance, that is what we are doing—we are trying to change the way in which we spend but, of course, other things are happening, not least welfare reform, which local authorities have cited as a particular challenge that they have to deal with. We are in a climate in which other things are happening that need to be coped with.

However, the collaborative is demonstrating results. Brain science tells us that we should be doing more in the early years. If we know that we can provide nurturing, loving homes for children and can care for them in the nine months before they are born, that can set them on a firm footing for a positive life later on, in which they can contribute fully to society and to the economy, and can have their own children who will be born into a nurturing environment. We are talking about a perpetual cycle that can have long-lasting implications for Scotland as a whole, not just socially but economically. We are taking the first steps on that journey with the change fund and the collaborative. As we have said, we are in the early stages of bringing about the transformational change that we want to see.

Sir Harry Burns: A number of local authorities have said to us that they are using the change fund—as we anticipated—as bridging finance. While they reorientate from one pattern of spend to another, there is a bit of double running. In the context of two and a bit billion pounds, the change fund is pretty marginal. It is designed to provide such bridging. I think that it is being used for what we anticipated that it would be used for but, as the minister says, all sorts of unanticipated things will have to be dealt with in the future. There will be new science and all sorts of social changes that may cause bigger problems. It is hard to predict but, at the moment, it is behaving as we expected it to, and is allowing a reorientation of activity.

The Convener: You talk about a reorientation of activity, but difficult decisions regarding disinvestment will have to be made to ensure that preventative spending becomes integral to service delivery. In its guidance on the early years change fund, the early years task force states:

"The decision to disinvest will be difficult, but if we are to make the shift we need, those decisions are crucial."

That suggests that disinvestment is essential if we are to access the resources that we need to put into the areas that will provide the benefits that we all seek, given the challenging economic times.

Sir Harry Burns: But we would hope that that disinvestment would come because CPPs and areas in general discovered better ways of doing things.

An academic from the south of England recently produced a report that calculated that, over the course of several years, a looked-after child costs society £2 million, on average. How many looked-after children do we have to avoid having in order to be able to fund the change? The number is relatively small. The aim would be to have every family being a nurturing place so that we are in a position in which very few children end up in that unfortunate position.

The Convener: You mentioned the issue of running in parallel. Do we have the resources to enable us to do that? We have got these folk in care just now, whether we like it or not, and we have to fund them. Obviously, we want to ensure that there are fewer of them in future but, while we

are creating the environment that enables us to have fewer people in care in future, we still have to fund those who are already in care. That is surely where the difficulty lies.

Sir Harry Burns: We have to see what emerges. The point about the collaborative and letting those on the front line design the change is that they will come up with things that we cannot anticipate. That is emergent thinking. They will find things that, with the best will in the world, we could never have predicted. We have to let things run and see how quickly they produce the change. The American experience would suggest that it will be at least a decade before we begin to see the full benefits of reduced spend in dealing with adversity.

Aileen Campbell: It is also worth pointing out that, at a CPP level, jointly agreed priorities will be set out in each of the single outcome agreements as well. People will have to get into quite rigorous and robust discussions about where the priorities will be and where they will direct their spending. I cited the example of Angus Council integrating early years services and social work family support. That integration will allow the council to move forward in a positive way, and it is the result of discussions within the council to try to achieve the priorities that it has set itself, working in tandem with what is going on in the collaborative and what we expect of the council with regard to its responsibility in relation to early years.

The Convener: You have mentioned the Angus Council example twice now—

Aileen Campbell: It was just a for instance. There are probably good examples—

The Convener: Is that being rolled out across the country? Do you have an example of something that is being rolled out elsewhere in the country as a result of a collaborative?

Aileen Campbell: I am sorry—an example of what?

The Convener: One of these initiatives. Earlier, Mr Burns was talking about eliminating patchiness and sharing best practice. Do you have an example of how that is working in relation to the collaborative? Is the example of what Angus Council has done being rolled out, or is it just going to help the people of Carnoustie and Arbroath?

Aileen Campbell: The collaborative provides a method whereby, at each learning session, every local authority will discuss its good practice and the things that it has done to help it to achieve the collaborative's stretch aims. However, one example of a national roll-out that has come about through the change fund would be the family nurse partnership. That is being rolled out across the country. It will be working in partnership with good parenting programmes in each local authority and, at a local level, some other work that will be done with the third sector.

10:30

The other thing that we have rolled out is roots of empathy. That decision was taken by members of the task force for the change fund. Scotland is the only country in the world that will have rolled out roots of empathy countrywide. That will not be for every school, but it will be for every school that requires that additional assistance. Those are things that we are doing in the earliest years of a child's life to enable us to realise social and economic benefits later on. They will enable those children to form relationships and attachments in adult life, allowing them to be good parents and keeping the perpetual positive cycle moving forward.

Those are two examples of national roll-out of good practice that will be working with local authorities to allow that to happen. It will be happening in schools in members' local authorities. That is the local dimension to the national roll-out.

The Convener: I have already visited a school in my constituency that has roots of empathy.

Aileen Campbell: It is very good, is it not?

Gavin Brown (Lothian) (Con): When the change funds—not just for the early years but all the various change funds—were being set up, a number of stakeholders who gave evidence to the committee said that they were worried that not all the money would end up going on preventative spend. A year and a half or so into it, in your view has all or most of that money gone on preventative spend? Is that something that you track and can tell the committee about?

Aileen Campbell: The £50 million that was new money has gone on a number of projects, not least roots of empathy and play, talk, read—all of those things that we know work to enable parents to be as good as they can be.

The early years change fund returns are available online and you can look for more examples of what local authorities have told us they are doing in their CPPs to try to bring about the preventative approach that we seek. Although a lot of what is happening will be very much the nitty-gritty, some of the headline findings are in the change fund returns.

Sir Harry Burns: It certainly seems as if the money has facilitated preventative spend. As we have said, some of it might be used to backfill staff who are involved in prevention development work. Technically speaking, therefore, the money is

being used in a slightly different way, but it is still facilitating preventative spend, and I guess that it would be logged against that.

Gavin Brown: You have given some good examples of where the money has gone on preventative spend. I just wonder whether, if we were to invite the same stakeholders back to give evidence two years down the line, they would raise the same fears with us or whether they would say that they were worried about it initially but that, in practice, the money had pretty much gone on preventative spend. Do you track that specifically?

Aileen Campbell: We have had the first run at getting feedback on what local authorities are doing individually at the CPP level—the changes that they have made and how they have approached the change fund in their area. We have got some of that information back, but it has been a learning exercise in itself. We will probably need to reflect on what we have been told and what stakeholders have told the committee, and find out what we can do to monitor the change fund and improve on the information that we get back as we go forward.

Nevertheless, it has been a catalyst for change, which has enabled collaborative and other forms of work and ensured that there is more joint working and more of a joined-up approach. There has also been more embracing of the third sector and what it can do to allow us to achieve the aims that we have set out, whether that is in the early years framework, the early years task force or the early years change fund. The Children and Young People (Scotland) Bill is another important tool in bringing about a much greater level of working together in local authorities and health boards throughout the country.

Gavin Brown: One of the issues that cropped up was the high-level outcomes, which you outlined. You suggested that there are a number of processes underneath each of those outcomes; I think you said that most of the work and the analysis so far has looked at the change to processes. I accept entirely that it is early days, but has any work been done on the high-level outcomes? You have anecdotal stuff, obviously, but has there been any formal measurement?

Sir Harry Burns: There is constant observation, which is part of our routine monitoring. That is why we chose the high-level outcomes: we were measuring them anyway, so we would see the change.

The experts on collaboratives, who have seen them in many different settings—mainly in the delivery of healthcare—say that for the first two or three times that learning sets come together, there is intense frustration because people want to see change but it has not yet happened. We are beginning to build it up. We are about to have learning set 4, in which some significant changes will begin to be reported.

It is far too early to see the high-level outcomes. The first learning set was in January 2013, so it has been going for a year. We would report such things as infant mortality a year behind, so we have not seen that yet. I do not want to pre-empt anything, although I am itching to see those results.

Gavin Brown: Sure. I will not pressure you on the point.

Aileen Campbell: There are probably good examples in your own patch of Lothian and in Edinburgh. One such example is that by the end of 2013, 90 per cent of parents at Tynecastle nursery sang or said number rhymes and songs for their child at least three times a week. That aim has been achieved with the morning group and because that seems to have worked, it has been scaled up to include the afternoon group.

There are high-level aims but, beneath that, tests of small changes are showing that once we are confident that we know what works, we can scale it up to benefit far more children. I offer that as an example in your area.

Gavin Brown: Thank you.

You touched on disinvestment and answered a number of questions on it from the convener and the deputy convener. Paragraph 2 of your paper says:

"The Health and Local Government monies"—

which is the lion's share of the money—

"are a blend of currently allocated and redeployed resources."

I still feel that we have not got to the bottom of the issue of redeployed resources. Some great interventions are happening—you have highlighted a number of them—but if those resources have been redeployed, they must have come from somewhere else. It is not all new money; only the Scottish Government slices new money. Where has that money been deployed from and are there interventions that are being scaled back or ceased either because they do not work at all or because they are not as effective as the collaborative approach? Something must have been scaled back if moneys have been redeployed.

Aileen Campbell: It would be for local authorities to talk about where they have taken a local decision about how they have brought their share of the pot of money to their partners at CPP level. Local government money has been a blend of new and currently deployed money. Beneath

that, it would need to be a question for the 32 local authorities about what they have done locally—how they have come to bring that particular part of their pot to the table and what they have done to redeploy it. In the returns, that is the message that we have had: it has been redeployed and it has been maybe additional money as well.

Our money is the new money and health has brought to the table money that is currently deployed. The childsmile programme used one parcel of the money that health brought to the table, and it has now been expanded to enable a lot more children to benefit from it. There is a blend of old and new money. Scottish Government money is new money, but that is only a small percentage of the larger pot that is spent on children, which is £2.7 billion. The pot of money for early years is 10 times what we have in the change fund.

Gavin Brown: Forgive me for dwelling on that point, but at this stage you are not sure where the money is being deployed from; you would have to check with local authorities. Will you ask them that question?

Aileen Campbell: Each local authority has done it in its own way and taken that decision locally. We know that the money may have been new, additional or realigned. The returns from the CPPs show some examples of what they have done, which is additional.

I mentioned the Highlands model, which is an additional recurring £2 million for early years services. That has been allocated by Highland Council for 2013-14 and 2014-15, and work is taking place to identify further preventative spend across partners. Highland Council is therefore working collaboratively to find out where it can leverage in more money at local level, but that will not be the same for all the 31 other councils. We will have to drill down further and ask them what they have done to create the pot that they have brought to the table.

Michael McMahon (Uddingston and Bellshill) (Lab): My question is also about disinvestment. Sir Harry Burns mentioned that a lot of the ideas that we are dealing with here are not new; they have been around for a long time. We have also had change funds in different forms. We used to call it pump priming, and we have heard it being referred to as bridge funding. The ideas are not new.

The Finance Committee said in 2011:

"difficult decisions regarding disinvestment will need to be made".

We have taken evidence previously from the directors of social work, who said that such decisions were being made and had always been made but that difficulties arose when leadership was required about budget decisions or political decisions; that is part of the problem.

In order to avoid déjà vu happening all over again, how do we get to a position in which, when the decisions that have to be made to shift budgets to redesign services and to make viable change happen—decisions that all the practitioners such as the clinicians and the front-line staff can buy into—they are not made because of short-termism?

Aileen Campbell: Harry Burns has talked about this. We are looking at the long term and talking about avoiding what happened in the past when people suffered from projectitis and new things were springing up continually. We are ensuring that a longer-term approach is taken to tackling some of the persistent issues that we face in Scotland.

You mentioned the leadership role. There is an expectation within the joint work that CPPs do and clear expectations that local authorities and NHS and other public bodies will sit around the table, share budgets and resources, and have discussions about that at that level, as well as deploying those resources in a way that meets the priorities and needs that have been set out, whether those are local priorities or the priorities that are set in the single outcome agreements. Those are some of the ways in which we expect leadership to be shown, so that resource is shared and we get the maximum benefit from the money.

Sir Harry Burns: One would hope that disinvestment decisions would be made on the basis of taking money away from things that do not work and putting it into things that work. The whole point about the early years collaborative—the whole point about any collaborative methodology—is the test of change. You have heard the term "test of change". That test is about finding out what works. We do it to three people today and, if it works, we do it to five people tomorrow; if it still works, we tell everyone about it. That is it.

We are doing something here. We are doing something with mothers and pregnant women who smoke, and what we are doing works because it stops them smoking. Let us therefore put money into that and then find the things that are not working and which do not contribute to the aim of making Scotland the best place in the world for kids to grow up. That is the principle underlying the initiative.

Although I understand perfectly that Michael McMahon wants to follow the money, it is the time that is money. We are talking about shifting the time that people spend doing things that do not work. Social workers tell me about all the

bureaucracy and the form filling that they have to do, so maybe they will do less of that in order to do more of the things that work. Those are the kinds of decisions that will have to be made.

Aileen Campbell: Again, making the system a bit more slick is one of the reasons for having the Children and Young People (Scotland) Bill. We want to allow people to do what they want to do, which is support families and children. Once the bill has been enacted, we will ensure that the guidance is robust enough to allow people to reduce some of the bureaucracy, to free them up to share the information that they need, and to allow them to help the most vulnerable in society. A lot of work is going on that complements the actions of the collaborative, and the bill is part of that.

10:45

Michael McMahon: I am not so much asking about chasing the money, or even about projectitis—I liked that phrase, minister. It is not about saying that a certain amount of money has been set aside for three years and we will now measure whether it worked. That is not what concerns me. I am concerned about the fact that history is littered with reports, analyses and programmes that have been devised with the buy-in of clinicians and service providers, but which have been prevented from progressing by the decisions of budget holders and, unfortunately, even politicians. I am not pointing the finger at anyone, because every political party is guilty of making short-term decisions to avoid bad headlines or to try to create headlines for political benefit. We are talking about a cultural change but, from my experience, we do not need a cultural change within the services, because the clinicians will lead the changes and will be enthusiastic about reform and development of services. The problem comes when the leadership from those who have the budgets does not allow that transformation to take place.

Sir Harry is nodding, so perhaps he wants to respond.

Sir Harry Burns: That makes a lot of sense to me, because I have lived through that time. I am confident that, in the next year or two, we will see movement on some of the high-level aims. Who would want to reverse that? We have to go on the basis of the evidence. As I mentioned, last week, I had 40 international people here in Edinburgh, all of whom are involved in a programme that started off as a programme to transform healthcare. However, after we had spoken to them, it became a programme to transform health and, after that, it became about transforming the notion of assets in delivering health. Those academics, who were predominantly from all over Europe and North America, although some were from Africa, have seen in our approach the most striking evidence, and they now have confidence that it will succeed. They want to know more about it, and to come back in six months.

We have struck a chord internationally, so I would be intensely disappointed, not to say furious, if middle managers in the system dismantled something that has a real chance of transforming thousands of lives. If I get any scent of that happening, I will come back and name names. We have something very important here, and we need to stick with it.

Aileen Campbell: To back that up, I point out that the reason why we have the leadership strand in the early years collaborative is to ensure that we get buy-in at the top levels. I think that that will go some way to enabling the process to continue at the current pace and to continue the momentum. If members want to come to the collaborative's next learning session, just to get a feel for the amount of good will and commitment to the agenda, an invitation is open to you. The next one will be on 28 and 29 January, if you would like to come along.

The Convener: I will certainly consider that.

I thank colleagues for their questions. Obviously, Malcolm Chisholm, because of his involvement in the task force, had a self-denying ordinance in terms of asking questions.

I see that the witnesses have decided to pack up, but Ah'm no finished yet, so haud yer horses.

Aileen Campbell: Sorry.

The Convener: Obviously, I am concerned about Sir Harry's comment that there are still projects out there that do not work and which we are still spending public money on. Michael McMahon talked about leadership. A couple of years ago, when we took evidence from Birmingham City Council, we were told that, although the leadership is in place there, sometimes there is real inertia on the ground. The council told its social work department that some of the practices in the department had, over 20 years, failed to produce any positive outcomes whatsoever. The difficulty was that the people who had been delivering the service had an emotional attachment to it and thought that it was positive and effective, but it did not turn out to be so when the outcomes were analysed. Inertia can creep into a system and prevent change at every level.

Another thing that has come out in evidence to the committee is that the change funds are being used to prop up existing service provision at a time of financial challenges to mitigate funding pressures. I am keen on hearing how we can tackle that. However, I return to one of my initial

questions because I want to finish on this issue. NHS Greater Glasgow and Clyde stated that it needs

"breathing space to provide some of the bridging finance that enables us to address ... issues simultaneously",

which means changing while maintaining existing services. NHS Fife said that there is a need to extend the change funds for another couple of years beyond 2015

"to fully deliver the future model of delivery that we all envisage."

That view was shared by Glasgow City Council, which said that

"people are changing, and we must allow enough time for those changes to be delivered."

The issue is whether it is appropriate to end, in effect, the involvement of health and local government funding from 2015-16 when so many health boards and local authorities say that they need a bit more space if they are going to deliver what the Scottish Government seeks.

Aileen Campbell: The funding remains. The new funding of £8.5 million from the Scottish Government will tail off in the last part of the £50 million funding, but the local government and health money is money that those sectors have brought to the table. So, that money is there for them to be able to continue some of the changes that they may have made as a result of the change fund being in place. The money is still there for them to be able to move forward on the change agenda.

The Convener: The figures in your submission show that the money from health and local government is £92 million for 2014-15, but that will go to zero the following year. The point that I am trying to make is that it is clearly not being specifically allocated for the purpose of change.

Aileen Campbell: Yes, but they still have their resources to deploy in light of the evidence from the collaborative approach and the decisions and recommendations from the task force. That money remains with health and local authorities to enable them to continue to have the local discussions at the CPP level that we would expect them to have on sharing resource and budget. The money will enable them to continue down that path.

The Convener: But given the concerns that have been expressed, which I have outlined, is there not a concern that there will be a loss of momentum in terms of delivery?

Aileen Campbell: The collaborative approach remains; it is not stopping with the change fund and the task force. As I have said, we will review the task force in 12 to 18 months' time to think about the work going forward. However, the collaborative approach, as Harry Burns and others have said, is not a short-term project; it is a long-term approach that will demonstrate long-term benefits. I imagine that the collaborative approach's momentum will continue because it is changing lives and will change lives in the future. That momentum will continue beyond the lifespan of the change fund.

The Convener: Thank you very much. Do you wish to make any further points to the committee before we wind up the session?

Aileen Campbell: I do not think so. Thank you for your questions and your interest.

The Convener: Thank you very much for answering our questions. I thank committee members, too.

We will have a short suspension until 11 o'clock to enable members to have a natural break and for a change of witnesses.

10:53

Meeting suspended.

11:01

On resuming—

Reshaping Care for Older People Change Fund

The Convener: The second item on our agenda is evidence from the joint improvement team on the reshaping care for older people change fund. I warmly welcome to the meeting Dr Margaret Whoriskey, Dr Anne Hendry, Mr Pete Knight and Mr Gerry Power. Dr Whoriskey will begin with a short opening statement.

Dr Margaret Whoriskey (Joint Improvement Team): Good morning. On behalf of the joint improvement team, I thank the committee for inviting us here today to discuss the reshaping care for older people change fund.

The joint improvement team is a strategic improvement partnership between the Scottish Government, NHS Scotland, the Convention of Scottish Local Authorities and the third, independent and housing sectors. We are governed by a joint improvement partnership board that represents those sectors. We work with health, social care and housing partnerships to help create the conditions for implementing national strategies and to deliver and sustain improved outcomes for people.

The document "Reshaping Care for Older People: A Programme for Change 2011-2021", which was launched in 2012, sets out a 10-year whole-system transformation programme that seeks not only to shift the location of care from institution to community, but to transform the culture and philosophy of care from reactive services that are provided to people to preventative, anticipatory and co-ordinated care and support at home that are delivered with people.

The £230 million invested so far through the change fund has provided partnerships with additional resources and capacity to progress with policy goals and outcomes to enable older people to remain as independent as possible and live in their own homes or in local community settings for as long as possible and as long as they wish to. The change fund is a catalyst to enable partnerships to accelerate local progress and develop plans to drive sustainable improvements through greater collaboration and integrated working within and across sectors. Sustainable change requires the longer-term transformation and integrated working that are being enabled by joint strategic commissioning and the integration of health and social care.

The joint improvement team, on behalf of our national partners, invited all partnerships to submit a summary of local progress by the end of September 2013—that followed similar processes that were undertaken in 2011 and 2012. Therefore, we have had a series of progress reports since the inception of the change fund for older people. The main purpose of the reports is to share examples of how local partnerships have developed their change fund to make a difference to the lives of older people and their carers across Scotland.

Many of the examples that have been submitted by partnerships are initiatives that have been tested and found to provide benefits, and they are now being embedded in practice. There is evidence of some spread of particular initiatives that have been found to be of benefit. There are other examples of recent initiatives that are yet to be fully evaluated but which are already showing some early benefits, and they provide valuable insight into how local partnerships have deployed their change fund.

It has become clear that, first of all, preventative approaches are reflected across many pillars of the reshaping care for older people pathway and are not confined to the preventative and anticipatory care pillar alone. Secondly, we are seeing evidence that partnerships are beginning to join up interventions within a locality to amplify their impact. Thirdly, examples that describe benefits for carers were evident across all pillars of the pathway and more generally are seen as enablers of the reshaping care for older people programme. Fourthly, partnerships are developing different models of care as alternatives to admission to hospitals and care homes. In many cases, those models utilise the assets of all partners in providing an integrated response.

However, there are still some challenges in evidencing attribution from preventative supports and services. Partnerships also seek greater engagement and involvement of secondary care and acute services, and there is a real recognition of the imperative to build on work that is already under way and to develop robust joint commissioning plans to address issues of investment and disinvestment.

We are encouraged by the shift in partnership behaviours and evidence from local and national outcomes and indicators of a difference in the delivery of health and care across Scotland. With the focus now on strategic commissioning for older people's services and integration of all adult services, the change fund has acted as an important first step in changing our view of the design of services and how we collaborate across sectors and boundaries. We believe that it has acted as a catalyst for bringing all relevant players

to the table and, crucially, has led to co-production with individuals and their carers increasingly becoming the norm rather than merely something that is nice to do.

Thank you for the opportunity to make an opening statement, convener. I welcome the committee's questions.

The Convener: Thank you, Dr Whoriskey. As this is your first time before the committee, I should explain what will happen now. I will ask a few questions, which you or one or more of your colleagues can answer, after which I will open out the session to colleagues around the table.

Given our wee chat before the session began, you will know that the committee is concerned about performance over the past five years in relation to the national indicator of reducing emergency admissions to hospital. The appendix to your excellent submission shows that although the figure for the average daily beds used for emergency admissions of people over 65 has reduced significantly, there has been a general rise in the number of admissions of patients over 75. As you know, that is using up 5 per cent of the entire Scottish Government budget. Why has there not been the reduction in the number of admissions of those patients that we hoped to see?

Dr Whoriskey: I invite my colleague Pete Knight to give you an initial response with regard to the data and my colleague Anne Hendry to elaborate on the service aspects.

Pete Knight (Joint Improvement Team): Good morning.

Just to get behind the issues a little bit, I should explain that when the reshaping care for older people programme began a few years ago, one major concern—which, in fact, remains a concern—was that many older people were in hospital for very long periods of time. Evidence showed that that was not a very good situation to be in and that the longer the older person remained in hospital, the harder it was to get them out and, particularly, to get them back home again.

As a result, the programme initially focused a lot on that issue, and that approach was matched with the health improvement, efficiency and governance, access and treatment, or HEAT, target of reducing the rate of emergency admission bed days, the focus of which was on getting people out of hospital once they had been admitted. Of course, it was accepted that many people have to be admitted to hospital. This was not about putting the barriers up on the doors but about ensuring that once a person had been admitted there was a good flow back out again and that the person could leave—and, one would hope, go back to their own home—as quickly and as safely as possible.

More recently, however, we have become aware that, as a result of a number of factors that have not been fully identified, admissions of older people coming through the door have continued to rise, despite the marked change in the bed days situation, which is shown in one of the charts on page 21.

Our improvement work has focused on the issue of emergency admissions, which is now very much part of our interest. We have data that might begin to explain why there has been a continuing rise in emergency admissions. For example, we now know that a disproportionate number of those extra admissions are for relatively short stays. I have not shown the data in the sample in our submission, but we have gone below the surface to begin to understand what the issues are. We are then able to begin to consider what actions will be necessary in order to deal with that particular unfavourable trend.

As you can see, I have presented the emergency admissions chart in our submission on a rolling annual basis. Without putting my neck on the block and saying that we are perhaps reaching a plateau, I would say that we have certainly reached a more encouraging position in terms of trends than was the case six months or a year ago.

I will happily hand over to Anne Hendry to follow up on some of the detail.

Dr Anne Hendry (Joint Improvement Team): I will rewind to October 2008, when there was quite a large consensus conference event with health and social care partners throughout Scotland. One challenge that we faced was that an ambition to reduce emergency admissions for older people that was not matched by a HEAT target to reduce emergency admissions for all ages was perceived by practitioners—and, arguably, by the public—as intrinsically ageist. What we really wanted to do was reduce inappropriate emergency admissions to hospital, but that is very difficult to measure as a national target.

We emerged from that consensus conversation with the service with the idea that we wanted to focus more sharply on the rate of emergency bed days that were spent in hospital as a consequence of an emergency admission, which essentially compounded that admission with an inappropriately long length of stay. When we did that, it changed the climate in the service. People bought into that ambition, and my clinical community now believes in and gets behind the over-75 emergency bed days target.

As you can see from the graph on page 21, which shows the difference in the emergency bed

day rate, a 10 per cent reduction has been achieved in three years. When I talk about that throughout the UK and in Europe, people are staggered. We need to take care to focus on the right measure, and we must remember—as Pete Knight said—that some of the increase in the zero to one-day length of stay, which has undoubtedly gone up, involves inappropriate or avoidable admissions of people who could, if the right care and support had been rapidly available when the GP made the phone call, have been kept at home.

Equally, a significant proportion includes those people with chest pain or an acute exacerbation of respiratory disease who need access to rapid diagnostics, which they cannot get at home. With a preventative ethos, it is far better to have one or two zero or one-day emergency admissions for someone who has had a minor stroke or a mini stroke than one six-week life-changing admission as the result of a major stroke.

We have to be quite nuanced in the way in which we look at that particular target. During the past nine months, I have been very encouraged to see that we are now beginning to grow the menu of alternatives to emergency admission—through, for example, what we describe as intermediate care services. Across Scotland, most localities are starting to enhance the menu of hospital-at-home alternatives to emergency admission.

11:15

The Convener: As I pointed out, however, the national indicator talks about reducing emergency admissions to hospital, not just the number of bed days.

Dr Hendry: The global national indicator in the performance framework looks at all-age emergency admissions. Sitting below that is the HEAT target for over-75 bed days. The other relevant HEAT target relates to delayed discharge.

The Convener: Thank you. We will move on to something slightly different.

In evidence to the Health and Sport Committee, the Coalition of Care and Support Providers in Scotland expressed concern that

"some of the change fund has been used to fund short-term preventative interventions, so once the change fund stops, so will they. The change fund was supposed to be a kind of lever to shift the bulk of spending that was behind it; it has, in fact, been used in creative ways, but almost as an isolated project fund."—[*Official Report*, *Health and Sport Committee*, 8 October 2013; c 4447.]

We have talked about progress on, for example, the number of daily beds. No doubt, progress has been made elsewhere that we will talk about later. What concerns do you have about that good work lasting beyond the change funds?

Dr Whoriskey: I will start with that and Gerry Power and other colleagues might want to add to what I say.

It is a good question and observation. As I described at the beginning of my evidence, the change fund was not set up in isolation as an end in itself. In the very first set of change fund guidance, one of the objectives was about partnerships developing robust, long-term joint strategic commissioning plans. We have worked with all sectors and local partnerships to build some of the capacity and capability to do that. As was pointed out during the discussion on the early years, something like 1 to 2 per cent of the total spend on older people is represented by the change fund. The key is how we use the change fund to access and redesign that wider resource.

From day 1, the change fund was set in the context of partnerships being supported to work on the bigger strategic planning, and that is progressing relatively well across Scotland. We recognised that there was quite a lot of work and development to do, so we invested Scottish Government funding in a programme of developing and training partnerships to support that.

The work that we have supported through our improvement network is also trying to ensure that we are capturing early information and examples of improvement to share. Although everything cannot transfer exactly from one locality to another, we need to pull out the learning and challenges around what is and is not working well to inform the rest of Scotland. That is a big focus.

The opportunity for partnerships to develop the bigger picture will, in part, address some of the concerns raised by the Coalition of Care and Support Providers in Scotland, but we recognise that it is also important to continue to focus on the funding, where it is going and its sustainability. The committee will have noticed that, in our current review of the change plans, for the first time we asked for evidence of the spread and how initiatives are being mainstreamed. It is very important to keep those things at the forefront.

I ask Gerry Power to come in with any additional points.

Gerry Power (Joint Improvement Team): Those concerns are not a surprise to me. Traditionally, the third sector has been funded on the basis of short-term grants, and there is a legacy of concern about that continuing. However, I came into the JIT right at the start of the process and my experience has been that influence and confidence have built up around local partnerships, particularly in the third sector, being full partners in determining how services should be developed in the future. They have gone from a

standing start, finding it difficult to influence the process, to being seen by all partners as central to decision making on how services go forward.

The bigger picture of how the third sector is able to influence the continuation of service models has changed significantly, and that will continue regardless of whether the change fund comes or goes and of how funding takes place. As Margaret Whoriskey said, the idea is not about the £300 million change fund, which was a catalyst to influence the £4.5 billion of health and social care services. In many ways, the greatest achievement that I have seen is the influence that the third sector has on the greater picture, and I do not think that that will stop simply because the change fund comes to an end. I think that that influence will continue and grow stronger.

On Monday, I was at a meeting between the Edinburgh and Glasgow partnerships. It was a shared learning event, and one of the things that came out from both partnerships, which started from different points before working together, was how influential the whole change fund process had been in bringing those partners together to influence matters. Going forward, I have confidence that the third sector will be able to continue to influence the bigger picture. We need to see the process from that perspective.

The Convener: Thank you. Your report states:

"Partnerships provided 234 examples that offer valuable insight into how the Change Fund has been used to make a difference to the lives of older people and their carers across Scotland".

Could you touch on a couple of those for us?

Dr Whoriskey: It is a challenge to extract lots of examples, but we are working on developing a number of shorter publications to support the overview progress report, which will allow thematic areas to be drawn down. I ask Anne Hendry to provide a few specific examples.

Dr Hendry: We invited partnerships to describe up to five examples of practice with at least one of them from each of the pillars of the pathway, which is a tool to get them to focus not just on one part of the life stage or the setting of care. The examples that they described are around anticipatory care planning. It is not just community nursing teams and social work practitioners who are making those thinking-ahead plans to help people to plan for what they might want to do or to be done with them at the point of a crisis; we are also now working with primary care GPs as part of the quality and outcomes framework.

Anticipatory care planning is now being rolled out across Scotland, and examples of that are evident. We have a little publication and a DVD—which I am happy to leave with you—which show the impact on people and their families of those anticipatory care planning conversations. In the past 12 months, another 40,000 people will have had the opportunity to have those anticipatory care plans, and the information contained in the plans is automatically shared electronically with emergency services so that the right things happen if people have to use emergency services such as NHS 24 or the ambulance in the middle of the night, when their usual care manager is not available.

Examples also included intermediate care, such as the introduction and roll-out of a reablement approach to care and support at home. There are partnerships such as the one in South Lanarkshire, where reablement is now being embedded in the way that care and support at home teams do their business.

Linked to that is the introduction of more integrated care and support services at home, such as the integrated community support team in South Lanarkshire and Dumfries and Galloway's integrated hub. The community ward teams in North, South and East Ayrshire are now providing integrated health and social care support that is specific to the locality, which is making a difference in supporting people to remain at home.

Other examples that I could point to include the work that is being done on telehealth care. We are moving from a pilot that provides such care to 20 people with chronic obstructive pulmonary disease to working with a collection of seven partnerships across the Ayrshires, the Lanarkshires, East Renfrewshire and Renfrewshire to help them to scale up that provision and take it to an ambitious level of 10,000 users by 2015.

That is a selection of examples of practice that has been shared and which involves people working together across the country. It is very similar to what the chief medical officer described as the collaborative model, but we tend to have a series of almost mini-collaboratives that work together on specific topics.

The Convener: Thank you very much.

I have one more question before I open the session to colleagues. Many other committees feed into our draft budget scrutiny. The Local Government and Regeneration Committee has said:

"we remain to be convinced the delivery of the preventative spending agenda is keeping pace with the ever-growing demographic pressure local authorities are facing."

What is your view on that?

Dr Whoriskey: The opportunities and challenges that our demography presents are well known. We must look at the fact that the focus on what is, increasingly, an ageing population

provides assets as well as a requirement for services.

Pete Knight referred to information that projected forward. When we started the reshaping care engagement exercise with leaders across Scotland, a projection was made that looked at where we were likely to be in three or four years' time if we continued to do what we were doing. At that point, we projected that, among other things, we would require a new district general hospital to be built every three years and a new care home to be built every two weeks.

Over the piece, we have been able to evidence—as part of the work that was done in advance of reshaping care through the long-term conditions collaborative and shifting the balance of care—a redirection of people's activity, which has meant that, for some, the locus of support has shifted. In addition, we have seen a levelling off in the number of people who enter a care home on a long-term basis. If the level had kept pace with demographic change, there would have had to be significant growth in care home capacity but, in fact, the number of residents is slightly smaller than it was a number of years ago. Therefore, there is some evidence of those shifts.

One of the challenges that we need to address is the shift in the workforce. It is possible to shift the location of care and support, but the big opportunity is how we shift the workforce. Again, I think that we can learn from some of the work that we did a number of years ago on mental health and learning disability, which saw a significant redesign and a move away from institutional care to a much more upstream approach that involved providing services that are supportive of people's lives and how they want to live.

Pete Knight might want to say something about the demographic challenge and the shift to prevention.

Pete Knight: We acknowledge the fact that the demographic shifts are quite strong. The first chart in the annex to our submission reminds us that Scotland's changing profile is constantly in the background. However, as Margaret Whoriskey mentioned, the second chart—which is on care homes—illustrates the fact that change has been under way for some time, particularly in local authorities. Whether we can answer directly the question that you have asked is a moot point, but we can see a number of distinct trends beginning to emerge.

Another trend is the adoption of reablement in local authorities, whether the intention is prevention or trying to avoid people becoming dependent on services in advance of their genuinely needing them. Local authorities are addressing some of those issues in that way. I have not put any evidence about home care in that particular example, but we are beginning to see a reduction in the home care that is being delivered.

11:30

Dr Hendry: There are a lot of examples and there is quite a lot of energy around the health and wellbeing and social inclusion, connectedness and physical activity areas, as well.

I listened to the CMO referring to physical activity and diet. Many partnerships are quite active in supporting physical activity. For example, Aberdeen ran its golden games last year. Other partnerships are looking in particular at promoting physical activity in sheltered housing and care home settings, and we have been working quite closely with NHS Health Scotland on how we can provide support and guidance for partnerships that want to do such activities. We have also been working on that with the older people's assembly and a number of older people advocacy groups. The partnership with seniors together in South Lanarkshire is quite a good example of a partnership that we have had.

It is probably over a year ago now, although it may be even longer than that, since two of your colleagues—Stewart Maxwell and Richard Simpson—hosted in Parliament a celebration of active ageing in the path to active ageing conference. The Musical Minds dementia choir performed at that. We are keen to keep a focus on that aspect of prevention, obviously in partnership with our colleagues in public health and sport, and not to lose the chance of the Commonwealth games legacy being relevant to that age group.

The Convener: Okay. Thank you very much.

I will now open out the session. Malcolm Chisholm will be the first member to ask questions.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): What you said about emergency admissions was really interesting. In a way, they have become the indicator of whether there has been progress on this agenda. The agenda has been around for a long time. People have talked about words that you have used, such as "continuous", "integrated" and "anticipatory" care in the community, for a long time. For example, such care was the central recommendation in the Kerr report 10 years ago.

There is a lot of good work going on, but it is almost being discounted because everyone is focusing on the emergency admissions indicator. Could other indicators be used, or does the Government need to sort out that indicator? There seems to be a contradiction between what it says in Scotland performs and what it says in the health

department. Dr Hendry said that there are inappropriate admissions. Is it possible to quantify the inappropriate admissions and accept that the other admissions will not reduce, not least because of demography?

Dr Hendry: It is certainly possible to get to that kind of detail at a local level, and partnerships are taking that deeper dive. Their local improvement measures and metrics will involve that level of scrutiny and challenge around their admissions. For example, a partnership with which I worked looked in great detail at every emergency admission of someone over the age of 65 across all its hospitals for a week, and it could say robustly which were avoidable and which were not.

We will never be able to get that level of reliable judgment at a national level, even with some of the measures that are used internationally, such as ambulatory care-sensitive conditions, which members may have heard of. It is very difficult on a case-by-case basis to say that everyone who has asthma or COPD has an ambulatory care-sensitive condition and that their episode was avoidable.

It is great to have the ambition to reduce emergency admissions, but I would argue that it should apply to emergency admissions across all ages, not just to admissions of older people. Also, the target that sits below that could be much more focused on reducing both the admissions and the bed days that are a consequence of those admissions. That is where we have the traction.

The next level of ambition is to see whether we can grow hospital-at-home alternatives where consultant geriatricians, nurse practitioners and allied health professionals are not in the hospital; instead, they are in the community, responding within hours to a crisis and providing the treatments that people would get in hospital in people's own homes.

Can we grow those alternatives at scale across Scotland? They are alive and flourishing in Lanarkshire, in Fife and in some parts of Lothian. I am working with another couple of boards that are at the point of trying to commission such alternatives. However, as Margaret Whoriskey said earlier, we need to learn not only from what worked well in mental health moving to the community but from what did not work well or has caused some difficulties. For example, it is now easier for a GP to get hold of a psychiatrist than it is for a consultant in a hospital because consultants do not have a physical footprint in the community. We need to ensure that specialists for older people have a footprint both in the community and in hospital.

Malcolm Chisholm: The process is obviously related to the question of disinvestment. There has been a lot of discussion on that in relation to the Public Bodies (Joint Working) (Scotland) Bill because a lot of people, particularly perhaps from local authorities, are envisaging a massive transfer of resources from the acute sector to the community as a result of that bill.

We need extra resources to develop the services in the community that you describe but, given what you have said about people's unrealistic expectations about emergency admissions, how realistic is it to expect that acute service budgets can be significantly reduced in order to pay for those services?

Dr Hendry: I am optimistic. Not all beds that are operationally managed and within an acute hospital's budget are delivering acute care and interventions. Some acute hospitals or acute divisions are also supporting off-site facilities that are in a local community and do not have on-site medical staff or on-site diagnostics. Such community-based facilities are ripe for a redesign and for a considered decision—through joint commissioning—about the benefits of a facility and whether there are opportunities to reinvest the resources and the workforce that are wrapped around the beds in the facility into support for people to remain at home.

Such decisions are happening gradually across Scotland. As Margaret Whoriskey described earlier, the challenge is to take that to the next level through joint commissioning and to make some quite hard local decisions. Currently in Scotland, something of the order of 300 people have been delayed in hospital over two weeks. The vast majority of those individuals are not sitting in an acute district general hospital; they are in a hospital bed that does not have on-site doctors or those sorts of facilities. That is a good place to start. The target around reducing delays over two weeks by 2015 is a good place to focus our partnerships with regard to disinvestment and reinvestment.

Malcolm Chisholm: Obviously, delayed discharge is a good example but there are other ways in which we could influence the hospital spend. Is disinvestment possible given the demography? Will the gains that we might make in reprovisioning in the community always be countered by the demography that faces us in the next few years? Is there any realistic prospect of reducing acute budgets in the next decade?

Dr Hendry: One reason that the 2020 vision and the route map to it have a priority around multiple morbidity—multiple chronic illnesses—is our recognition that we are making some progress and gaining some traction on the reshaping care for older people ambition. You heard earlier about

the work on early years, but there is a large cohort of adults under 65—working age—with multiple physical and mental health conditions: think about the alcohol misuse, obesity and mental illness that are causing the trend of the drive in emergency admissions at all ages.

We recognise that we have to do this piece of work in tandem with some quite significant changes in the way that we address adults with multiple conditions, particularly in areas of deprivation, where people experience multiple physical and mental health conditions about 10 years earlier than they do in the more affluent parts of Scotland. It is a challenge given the consequences of demography—of not just older people—and the healthy life expectancy that we have. If we are playing a long game, we have to go much further upstream and ask what we need to do differently with our population in their 40s and 50s to start to get a grip on the problem.

Malcolm Chisholm: What is going to drive the changes? The question is related to the extent to which there is variation at the moment. You do not need to name areas of Scotland, but there must be great variation and some areas must be doing a lot better than others. Taking account of that, can you say what will drive progress across Scotland? Will it be the Public Bodies (Joint Working) (Scotland) Bill? Presumably that will help. Will it be you? What will drive the changes and how do we get rid of the variations, so that everybody will at least be making good progress—although some will be outstanding—whatever situation we have?

Dr Whoriskey: The bill will enable. For many years, we have had the opportunity to develop more integrated ways of working, and the opportunity has been taken forward in a more significant way in one or two areas. The bill will provide for a mandatory legislative requirement on integration.

A number of things will drive the changes. We talked in the early years about leadership and the importance of clarity on the direction of travel and ensuring that there is high-level leadership and engagement, as well as building capacity throughout the organisations and across sectors. Our view is that the change fund and the reshaping care programme are providing a very good foundation for the work on health and social care integration, because they have been shadowing integration and the way that partnerships have been working.

The point about variability is important. Through the support of the community care benchmarking network and other things, we have encouraged partnerships to use information and data to help the conversations around the table and set the improvement targets for the partnership. We have seen more evidence of the incorporation of data and its analysis into the way that people make decisions on their change plans.

We have variability. There is a balance between variability that is expected because of slight differences between populations and contexts, and unexplained variability—for example, if you are 10 times more likely to be admitted to a hospital if you live in one locality with one GP practice than you are if you live a few miles down the road. That is a challenge, and the integrated resource framework has helped by gathering relevant financial information.

I ask Pete Knight to come in, particularly on benchmarking.

Pete Knight: The charts that we have in our submission are Scotland-wide. Malcolm Chisholm identified the central measure of emergency bed days, which we tend to focus on. Lots of things wrap around that, such as the fact that it is the largest spend and the question of what happens next after a person has been admitted—where do they go?

11:45

In conferences, for example, we have issued to partnerships across Scotland similar trend data for each of the partnerships. When people noticed that information on the table in front of them, you could see that they immediately wanted to know where they were in relation to their peer areas. Part of what we are doing is trying to build an awareness across the country of the kind of natural benchmarking that goes on and ensure that the awareness is there at various levels within organisations.

My other comment will partly answer Malcolm Chisholm's previous question. The challenge ahead is a little unknown; we really do not know how people are going to be in the future. The future is always uncertain. Harry Burns mentioned the issue of obesity, and the gains in healthcare might be lost in the future if it is not resolved.

We are trying to get improvements in the information that we have. I think that the work that the Information Services Division is doing, particularly in relation to the integrated resource framework and the linkage of health and social work data, will allow us to develop new ways of examining the information and helping partnerships to identify the issues that they can make improvements on.

We will be able to see that variation on benchmarking. It will be much more possible than it is using the relatively crude measures that we use at the moment, such as the number of emergency bed days and the level of care home

admission. The information will be nuanced. There will be an ability to do an analysis of what is behind the figures in local areas. I am optimistic that we will have more tools available to us over the next two or three years.

Dr Whoriskey: On the issue of what is making a difference, Gerry Power alluded to the need to build capacity for co-production in designing and delivering services. Although it has not always been without its challenges in some areas, the genuine engagement of third sector colleagues and independent care sector colleagues in the discussions on the redesign and what will take us forward in terms of vision and the outcomes for people has brought some of cultural shift that is referred to in your report.

The issue is not just about the money or the way in which we structure things; there is quite a significant cultural aspect. I do not think that we should underestimate that. We must ensure that we keep our focus on supporting that.

John Mason: I want to pick up on some of the things that have been mentioned, particularly the area of partnership. When many of us think about partnership, we primarily think about the NHS and councils, but other bodies have been mentioned—Dr Whoriskey mentioned the housing sector in her opening remarks. However, housing witnesses from the public, private and third sectors have told us that they feel left out, although they believe that the house that someone lives in is a big factor in a lot of the things that we are talking about. How do you see housing fitting into all of this?

Dr Whoriskey: From its inception in 2004-05, the joint improvement team has had housing as part of its focus. We recognise, however, that as the work has evolved with health and social care partnerships, housing has not been at the table in the way that it should be. We have actively been working with our housing colleagues to try to build some of that capacity.

I will give you a concrete example. With regard to the work that partnerships were tasked with in developing their first joint commissioning plan for older people in March and April last year, we worked with housing colleagues—policy colleagues in Government and housing stakeholders—to develop what was referred to as a housing contribution statement, in an effort to ensure that the chief housing officer was engaged in the signing off of the joint commissioning plan.

In a sense that was symbolic, but, over the past few years and particularly in recent months, practical work has been under way to get the housing sector engaged nationally as well as locally. I mentioned that the joint improvement partnership board has a housing representative on it. That is hugely beneficial not only to how we address housing at a strategic level, but to how we support housing at the local partnership level. It is work in progress, but the housing lobby has been particularly constructive in its engagement on health and social care integration. We have seen some progress on the work to reshape care and the change fund, but I know that there is an aspiration for housing to be more ably reflected in legislation, regulations and guidance.

I echo the concerns that have been brought to your attention. However, I offer the assurance that we have clocked those concerns and are working actively and constructively with our housing colleagues to ensure that they are at the table and contributing in a very real way to the work of local partnerships.

John Mason: Is that work easier at a national level, where you may have only one representative covering, say, housing associations? At a more local level in areas such as Glasgow, private house builders, a big housing association in the form of Glasgow Housing Association and loads of small associations are involved. Does that make the work more difficult in practice?

Dr Whoriskey: It is difficult in practice. In fact, in recent months, we facilitated with the housing sector the setting up of the housing co-ordinating group so that we could have all the national partners around the table and try to get some coherence in the housing sector's voice.

A couple of areas have been trying to mirror that by engaging with a range of housing providers and stakeholders. That is a challenge but, as I say, we have seen one or two areas take it up and look at how to get a representative housing voice while recognising that there are a number of stakeholders.

John Mason: What about the third sector? The committee has heard about a bit of variation—Malcolm Chisholm touched on that. One area told us that the third sector was at the table and that everyone was discussing all the issues together, but another said, "Well, the third sector can bid for a contract," which struck me as a slightly different approach.

Dr Whoriskey: I ask Gerry Power to comment on that.

Gerry Power: If I understand the question correctly, the issue is the relationship between the third sector and partnerships. I have heard that some partnerships expect the third sector to bid for a contract, but that happens in only a very small number of isolated cases. In my experience, the vast majority of partnerships see the third sector as a full partner in planning, designing and delivering services, and the issue is who is best to deliver those services.

As I have said, I have seen partnerships go from an approach that is suspicious of the third sector—with 20 people from health and 20 people from the council sitting around the table with one part-time individual from the third sector who has not been given the papers in time and does not speak the language—to one in which there is much better engagement. Let me give an example. The JIT and the Government's third sector unit saw the need to support third sector interfaces to better engage in partnerships. Therefore, along with the Health and Social Care Alliance in Glasgow, we invested in developing and enhancing the role of the third sector team—that does not trip off the tongue very well—dedicated to supporting third sector interfaces to better engage with partnerships. I have seen how that relationship has developed. As I have said, in only a small number of isolated cases has that relationship remained difficult and not become one of integrated working.

John Mason: Do you play any role in trying to roll out best practice to the few remaining difficult cases?

Gerry Power: That is absolutely one of our roles. As I have said, we have, if you like, put our money where our mouth is by investing in and developing assistive practices and a team that will support the third sector in that work. We sit on the steering group for that team along with the third sector unit and any difficulties that emerge come to that table through either the Health and Social Care Alliance or a number of representative third sector groups, particularly the one that represents the third sector interface.

Dr Whoriskey: We have an opportunity in that the JIT has a lead for each of Scotland's 32 partnerships. Obviously they will not be there all the time but they will sit around the partnership table, providing a conduit for national policy and expectations to local partnerships and drawing out some of the issues and challenges. That said, it is not that everything is cosy all the time. As the relationship develops, we can also bring a constructive challenge element to the partnership as well as supporting it on its improvement journey.

As Gerry Power has pointed out, there are some quite useful examples that highlight the significant development of third sector engagement over a relatively short period of time. When the change fund came along coming up for three years ago now, people had to develop the partnership way of working early on. However, a few years down the road, things have matured.

We still need a bit of grit in the oyster. It is useful for those involved in a partnership to have respect for one another and the confidence to work together, but they should also be able to challenge one another to ensure that the partnership does not become overly complacent.

John Mason: The third area with regard to partnerships is family, which I think Dr Hendry mentioned with regard to anticipatory care plans. Where are we in that respect? Indeed, is that not an even more difficult issue? There probably cannot be one representative for all the families in Scotland. Has the situation been changing over time? I recently dealt with a case of two sisters with busy high-powered careers whose father was in a residential home—or, I think, sheltered housing—and who had quite high expectations with regard to the public sector's input. Families have traditionally taken a big responsibility for their elderly relatives; indeed, Asian communities in society are often exemplary in the amount of care that they put into families. Is the situation changing or expected to change?

Gerry Power: I am sorry, but I cannot remember which member of the committee—it might have been Mr Chisholm—asked about the key drivers in taking that forward. A key challenge that the JIT and Government, and public sector organisations beyond it, need to address—and, indeed, one of the key issues for driving change—is public expectations. Speaking from 30 years' experience as a clinician and general manager in the health service, I can say that we were trained with the best possible intentions to deliver a service for people and to people. However, there have been changes in society and things that might have been done within families are not done that way any more.

We therefore need to strike a balance between what public services should be doing to enable people to facilitate their health and wellbeing and understanding what the public's expectations are, and a conversation or a debate—indeed, a change—needs to take place to ensure that we get that balance right. Speaking personally from my 30 years in the health service, I think that we might have gone the other way. We have probably trained our workforce to deliver services to and for people and created expectations in the public about what the workforce does, but as far as prevention is concerned we probably now need to focus on how our workforce enables, facilitates and supports individuals, families and so on in addressing their own needs. Perhaps the expectations of what the public sector will do need to be debated and changed a bit.

12:00

Dr Hendry: There are some practical examples of work that we are taking forward around that in the living it up programme, which is sometimes described as the DALLAS—delivering assisted living lifestyles at scale—programme. In the

programme, the emphasis is on supporting people to use day-to-day technology, social media and digital television to get more information and advice, and empowering them to take more control so that they can manage their life and conditions and get more connected and involved. There is also the work that Gerry Power and colleagues are leading around co-production and working with partnerships and some local authorities in which the ethos is implemented local authority-wide.

John Mason: So not just the individuals but the wider family group are involved.

Dr Hendry: Yes. Another example is the use of family group conferencing for people affected by dementia. Some of our improvement work around the theme of dementia is very much grounded within the wider family network.

John Mason: Thank you.

Jean Urquhart: One thing that I found interesting when listening to the earlier evidence from the minister and others about the early years programme, and which I think everybody in the committee noted, was the description of the meeting with 700 or 800 people in a room getting really excited about how they could influence and improve some of their work practices. Do you do that?

Dr Whoriskey: I mentioned that we have established an improvement network. That was initially for the reshaping care for older people programme, but it now extends to support health and social care integration. It is a network of all partnerships across Scotland and key stakeholders to facilitate cross-sector collaborative learning. We do a range of activities, but to date we have not done the big 800-person collaborative-type sessions. However, we will have a range of national events and regional events, and we are increasingly trying to engage people through our WebEx sessions. That provides the opportunity to engage people while they sit in their own offices and for them to get involved through developing practice guidelines and case studies.

We focus on trying to share learning and improvement through links with national work and through regional and local networking. Anne Hendry might want to comment, because she has been involved in a number of the collaboratives.

Dr Hendry: In 2008, I led work on the long-term conditions collaborative, for which we used a model that was similar to the one that Sir Harry Burns described. However, we learned early on that, for complex and whole-system change in the community, the model that employs a breakthrough collaborative series in which 700 or 800 people meet in a room two or three times a year is not necessarily best for partnerships that are engaged in other types of collaboratives and learning events. The feedback from partnerships during the process was that they wanted more themed learning events involving perhaps 100 or 200 people; events that were much more interactive and perhaps more local; and some virtual learning events for the island boards, which do not want to have to fly people down to go to the SECC.

So we have the same approach, but we have modified it over the years because of feedback from partnerships. For every learning and improvement event that we do, we get feedback from partnerships about what worked and did not work, and what they want to see the next time. We build our programme of learning events on that feedback, and all the events are done in partnership with other improvement organisations, so it is not just the work of the joint improvement team. We have a collaboration between various improvement organisations, including the Improvement Service, Healthcare Improvement Scotland, NHS Education and the Care Inspectorate. All our collaborative learning events are therefore truly collaborative products.

Gerry Power: Building on what Anne Hendry said about collaborating with other areas, I think that the person-centred health collaborative that is being taken forward by the quality unit has a distinctive people-powered health and wellbeing element, which focuses on co-production. That is being led by the alliance. We are very much involved in developing that with the alliance. That is one of those big breakthrough 700-person events.

It is important to say that JIT has run two national conferences on co-production, which have been attended or linked in to by more than 400 people, and we will have another one in April. Along with the Scottish Community Development Centre, we have established the Scottish co-production network, which has 400 members who share information and so on, and we have distributed more than 6,000 copies of the book "Co-Production of Health and Wellbeing in Scotland". There are a number of ways in which we link people together, including setting out good practice on our website. We also link in to other aspects of the Scottish Government's work to ensure that it ties in with relevant parts of that agenda.

Dr Hendry: On the issues of intermediate care, the alternatives to hospital admission, supported discharge and anticipatory care planning work, since October, I have been in a room with about 600 people from throughout Scotland, although not at the same time. Between October and December, we had events in Dundee, Kilmarnock, Edinburgh and Fife. We are keeping the energy

going, but not always on the basis of a meeting three or four times a year.

Jean Urquhart: My reasons for raising the issue were twofold. I represent the most rural part of Scotland, from Shetland to the Mull of Kintyre, and I have met a number of organisations, particularly in the third sector, some of which are doing extraordinary and innovative work. However, I have met frustration among those organisations that they are not part of the main stream or able to influence things. That was my reason for asking, so thank you for those answers. Another issue that has come up is that of a change in how those organisations might be funded or in their relationship with other agencies. Will you comment on that?

Dr Whoriskey: Do you mean third sector organisations?

Jean Urquhart: Yes. Will you also comment on access to the change fund and any review of the work that those organisations are doing?

Dr Whoriskey: The joint strategic commissioning work that organisations are engaged in is very much based on partnership. It is not just the statutory sectors sitting in a room, deciding how they will plan and use the resource. Building on the experience of the change fund, the third sector and the independent care sector, which provide a huge amount of care and support throughout Scotland, are engaged in those discussions and in decisions about the funding.

In relation to the change fund, we have moved from a point at the beginning, when people were looking at how they would work together and what the relative voting powers, if you like, of the different sectors would be, to a building of trust and recognition of what the sectors and parties bring to the table and a more shared understanding. There are a number of examples of a collective approach being taken to decisions on funding. The third sector voice should be as strong at that table as that of the statutory sector. We are working hard with our third sector and independent sector colleagues to ensure that that capacity and capability is developed and further supported as we go into the more significant decisions on the wider resource and the joint commissioning plans.

We should always bear that point in mind and we should not be complacent about it. There might be some areas in Scotland where people in the third sector who are doing excellent work are harder to reach. However, the issue is how we ensure that the partnership is reaching out and engaging with stakeholders. We can provide support for that, as well as constructive challenge where that is required.

Jean Urquhart: I do not have the figures with me, but are you aware of any increase in emergency admissions—particularly in overnight and zero-day stays, as you put it—following the introduction of NHS 24?

In rural areas, the process was very different. Doctors were sometimes flown in from Holland, France or somewhere else, so there were language and geography difficulties. If a doctor did not know someone's family history, for example, it was, in case of doubt, better to send them to hospital in an ambulance. That approach was becoming common currency, and people were aware of it. Did that have any effect on the unusual increase in overnight-stay admissions?

Dr Whoriskey: Yes. Pete Knight can comment specifically on the data, and on any aspects of the service side.

Pete Knight: The furthest that I can go is to say that that is a possible explanation. There has been an increase in the past five years in the number of people attending accident and emergency departments, and there will be a spin-off from that in admissions to hospital. However, people might well suggest other reasons, which makes it difficult to say yes or no with regard to attributing an increase to that particular reason, other than noting that it is a possible issue.

Jean Urquhart: You made it clear that you looked at only one area—Aberdeen or somewhere—and analysed those figures, so I just wondered whether there was any evidence.

Pete Knight: The whole of Scotland is covered. It is clear that the number of emergency admissions in the past five years has risen pretty well in proportion to the ageing of the population. That could be coincidence, or it could be a factor. However, the proportion of those who are admitted for very short stays—a zero length of stay; they are admitted and discharged on the same day or admitted for one night only—has risen much faster than the general figure, but it is proportionally a smaller group of people.

Dr Whoriskey: Anne Hendry mentioned that the partnership looked in detail at everybody over 65 who was admitted over a week. Have you anything to add on that, Anne?

Dr Hendry: The increase in emergency admissions is not just a Scottish phenomenon, but a globally recognised issue, certainly in developed countries. There is no obvious single cause-and-effect relationship; greater minds than ours have been put to that question.

Some changes in system access are probably contributing, as are, undoubtedly, some changes in clinician behaviours, as well as a significant change in public expectations and behaviours, and

attitudes to managing risk. All those factors are contributing, which is, in a sense, why we have an unscheduled care action plan, and why all boards and partnerships are progressing a set of actions—which are not just about older people—across the system.

Gavin Brown: I have a couple of specific questions on the change fund. First, am I right in thinking that, although the work will continue, the change fund itself ends in the financial year 2015-16? Secondly, when it ends, will it taper downwards or is there in effect a cliff edge at which it goes to zero or close to zero? Thirdly, if it is the latter, are there any risks attached to that, or will the fund—in your view—have served its purpose by that point?

12:15

Dr Whoriskey: The change fund is a four-year fund, which went from £70 million in year 1 to £80 million in years 2 and 3 and will go back to £70 million in April this year, for the fourth year. The new integrated care fund was announced as part of the spending review and work is under way to develop the guidance and principles for how that will work. It is important that that is not seen as year 5 of the change fund. It will build on the change fund but will be more widely applicable.

That has been signposted to partnerships from the beginning. If you remember, in the first year we had only a year and until the spending review there was a bit of nervousness around investing in any developments that might have recurring costs for the following year. We saw a delay in implementation between when money hit partnerships and when services and initiatives started. My sense is that we are running about six months behind the allocation of the finances.

The work on joint strategic commissioning, to which we have made several references, is key. From day 1, the change fund guidance heralded the importance of partnerships thinking in the long term about sustainability and embedding initiatives that work.

Some of our third sector colleagues have expressed anxieties about work that they are involved in with the partnership and how that will be sustained. However, a focus on the evolution to joint strategic commissioning and the opportunities around the new integrated care fund, which, as I said, will have a wider reach—particularly in taking account of adults with multiple morbidity, as well as older people—will be important.

The Convener: That concludes questions from committee members. I have one final question: how could the delivery of the change fund be improved?

Dr Whoriskey: That is always a good question. We have probably underestimated the start-up time for engaging partnerships in dialogue and conversation. You can look transactionally at a change plan, ticking boxes and developing initiatives, but collectively we underestimated the time that would be required to develop the culture and ways of working. There were unrealistic expectations in year 1 that caused pressure on partnerships.

The evolution from a one-year fund to a longer-term fund was important. If you have only a year's fund, it encourages short-termism and projectitis. I ask my colleagues if they have any thoughts, because they have probably all reflected on that question.

Dr Hendry: Can you clarify the question, convener? I am not sure whether you mean delivery of the change fund nationally or its implementation at local level.

The Convener: How can it be implemented at local level to ensure the changes in culture and the construction and delivery of services that we want to see?

Dr Hendry: Okay. I will go back to the joint commissioning issue as well. I am seeing a step change in people. At the beginning, in 2011-12, people saw it as a change fund and took a fairly narrow view. Now, the conversations that I am involved in around partnership tables are about seeing the bigger picture. I would focus my energy on helping partnerships to manage that shift in ambition and scale from the 1.5 per cent to the totality of the budget.

Gerry Power: For me, the answer is about partnerships focusing on the wider picture and the ultimate goal of what can be achieved. The change fund was only for four years, but the reshaping care for older people strategy will last for 10 years; it will not end after year 4.

Allied to that is the Public Bodies (Joint Working) (Scotland) Bill. The policy memorandum in particular is quite clear about the Government's vision for the future of services in Scotland. If I was to advise any partnership on how it should see the change fund, I would say that it should see it in that wider context and continue to focus, as we have all said, on not just the £300 million, but the £4.5 billion. That is the great aim.

We have to continue to focus on that and we have to remind partnerships that that is what we are trying to achieve; that will not last for just four years.

The Convener: Do the witnesses wish to make any further points before we wind up the session?

Dr Whoriskey: Not really. That was useful and your range of questions will help us to reflect on

our role in and contribution to this work. Thank you very much.

The Convener: Thank you, Dr Whoriskey, and your colleagues. It has been very illuminating.

Meeting closed at 12:20.

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