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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 6 May 2014

Session 4

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HEALTH AND SPORT COMMITTEE
14th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Judith Ainsley (Scottish Government)
Shirley Laing (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Health and Sport Committee

Tuesday 6 May 2014

[The Convener *opened the meeting at 09:45*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the Health and Sport Committee's 14th meeting in 2014. As usual, I ask everyone in the room to switch off mobile phones and other wireless devices, as they can interfere with the sound system and they would certainly interrupt the committee. I ask those attending to note that members and officials are using tablet devices instead of hard copies of their papers.

I have apologies from Nanette Milne and from Jackson Carlaw, who cannot attend the meeting as the Conservative Party's substitute.

Agenda item 1 is to decide whether to take in private item 4, which is consideration of the committee's approach to national health service boards budget scrutiny. Such consideration is normally taken in private. Does the committee agree to take item 4 in private?

Members *indicated agreement.*

Early Years Health Inequalities

09:46

The Convener: Under agenda item 2, we return to our themed work on health inequalities. Today, we will begin a new, short inquiry into early years health inequalities and take evidence on the early years collaborative.

I welcome from the Scottish Government Judith Ainsley, who is head of the early years quality improvement unit, and Shirley Laing, who is deputy director for early years. The committee would welcome a short statement from Shirley Laing.

Shirley Laing (Scottish Government): Thank you for inviting us to the meeting. We are delighted to be here to talk with the committee about the early years collaborative. We provided a background note, but I thought that it might be helpful and useful to set out for members a wee bit of our journey to date on the early years.

As the committeee knows, the policy area is well evidenced. We know that, the more adverse effects and impacts there are on children, the greater will be their chance of developmental delay. If they experience six or seven risk factors, there is a 90 to 100 per cent chance of developmental delay.

It is important to remember that that translates into adulthood. We now have evidence that shows that, if a person experienced seven or eight adverse childhood experiences, the odds of their having adult heart disease are three to one. We are starting to see the evidence of how that plays right through into later life.

I turn to what we have been doing. In 2008, we published our early years framework, which was co-produced with the Convention of Scottish Local Authorities. It set out our transformational aims for children and young people and was a 10-year vision of what we want to do to change the world.

In 2011, we established our early years task force, which brought together early years experts from around Scotland who had the voice in their sector and the credibility to push forward on our shared agenda. In March 2012, it published "The Early Years Taskforce—Shared Vision and Priorities". That took us quite a way down the journey, but we continued to grapple with delivery. How could we make improvements that would have an impact and improve outcomes for our children and families? How could we take the pockets of good practice that we knew existed throughout Scotland and bring them to scale?

That led to us launching the early years collaborative in October 2012. We did that

because we had learned from the Scottish patient safety programme, which had proven successful in leading to health improvements. The method involves using the Institute for Healthcare Improvement's breakthrough series collaborative model. The early years collaborative involves working in partnership, but the word "collaborative" is used in a specific sense that relates to the method and the model that we use.

What does that mean? We brought together early years experts from across Scotland and had a series of conversations with them about the things that would—if we did them well, right and reliably for every child, every time—make the biggest difference and the things that, as a country, we should aspire to for our children, young people and families.

Once we had decided on the things that we needed to focus on, we brought together community planning partnerships, because we decided that they needed to be our delivery vehicle. The approach had to be multi-agency because of the many factors that play into children's and young people's lives.

We brought the CPPs together in learning sessions. The learning sessions that we host are not conferences; they are very much about learning. We teach quality improvement at the events; we do not teach early years, because the people who come along are the experts in early years—they do not need to hear it again.

Our first learning session, in January 2013, taught folks the absolute basics of quality improvement. We brought the attendees back together again in May 2013 to ask them what they had learned, what they had tested, what had gone wrong—because, under the method, people learn as much from failure as they do from things that go well—and where we were on the journey.

In learning session 3, in October 2013, we started to probe folks and ask them whether things were coming out of the method that they might want to take to scale. We had tested things at a very small level, so we asked where that was getting us and what we were learning.

The event in January this year focused on key changes. Having had a year of testing, we had started to gather knowledge from the grass roots up about the areas on which we need to focus, to help us to make the step change to improving outcomes. Our next learning session—learning session 5—will take place at the beginning of June, when we will focus on data and measurement, because having the data to demonstrate that the changes that are being made are leading to the improvements that we want is critical. That is the proof of what we are doing.

There is a lot of detail under all that. Judith Ainsley and I are happy to answer questions and go into any of the aspects or anything that was in our submission in more detail. I just wanted to tell the committee a bit of the story, to set the scene before we get going.

The Convener: Thanks for that. Rhoda Grant has the first question.

Rhoda Grant (Highlands and Islands) (Lab): You talk about shifting service provision and, from listening to your opening statement, it appears to me that that shift is in how children's services are delivered and what is delivered. Is that the case or are services shifting in other areas?

Shirley Laing: There is a mixture of things. In its vision and priorities, the early years task force talked about transformation and preventative spend and asked local government and health services to consider the services that they provide to children and families and how they might want to change that provision to best meet needs.

The early years collaborative method will enable folks to test the improvements that they think will make a difference to the system. As they start to establish, through the data, whether the things that they think will work are working, that should inform decisions that are being taken at CPP level on service provision, budgets and the like. It is public service in its broadest sense—it could be health, education or what is happening in the third sector. That depends on where CPPs are starting from, the services that they have and what they believe needs to change.

Rhoda Grant: I am trying to get to the degree of shift that has happened and where services have shifted from. Where have resources come out of services and what have they been invested in?

Shirley Laing: It is still too early to point to any huge shifts.

Judith Ainsley (Scottish Government): There are the change fund returns. The change fund brings together money from local authorities, health services and the Scottish Government. We assessed the returns last year when trying to answer the question of what had been moving. It was difficult to identify specific things that were moving, as it was quite early.

This year, we are working on what questions we will ask, so that we ask more pointed questions to get to the information. At the moment, it is difficult to tell. For instance, we have an example of something that is happening in Highland, but not an example of what has stopped to enable that to happen.

Rhoda Grant: The goal is to shift service provision by 2016.

Judith Ainsley: Yes.

Rhoda Grant: That is round the corner. We have been working on this for a number of years so, if we cannot tell at this stage whether service provision has shifted, will we be able to tell in 2016 whether that was ever achieved?

Judith Ainsley: I believe that we will. In the previous change fund returns, local authorities indicated that money would be moving, but we could not point to anything specific. In the next lot of returns, we will ask specific questions that local authorities will have to answer, so we will be able to say what has moved.

Rhoda Grant: The change fund was new money that is due to stop—I think that the money will be invested in the new public bodies partnerships. Money is coming in, but it is not money that has been shifted; it came from a different source, which is due to dry up. I am having difficulty in finding out where—

Shirley Laing: The early years change fund is made up of contributions from three areas. You are right that the Scottish Government put £50 million of new money into it over four years. In addition, the health service and local government put in moneys. It was up to them to decide whether their contribution to the change fund would involve things that they were doing that they could provide evidence to demonstrate were helping to achieve the outcomes that they wanted to achieve or whether it would involve taking money from elsewhere to do new and different things. That change fund will come to an end.

When the change fund was set up in 2011, the early years task force was established. Part of its remit was to oversee the change fund and to consider how to make the move towards preventative spend and the accompanying shift of services. As I mentioned, a year into the task force's work, we launched the collaborative. We started that process in 2013. We now have a method for driving the change, which, through the data that it will provide, will help to inform local decision makers as to where their funding needs to go.

I described the process as a journey, which is what it is. The change fund was set up to help people to think through how they need to shift their service provision. With the work of the collaborative and the method that it offers, folk now have the evidence and the data to better inform the decision-making process.

However, it is early days—the collaborative has been running for a year. I should say that participation is not mandatory. We went around the country and spoke to every chief executive. We said that we thought that the collaborative might help, given that they had a challenge on their hands in the form of budgetary constraints and more children and young people with needs coming into the system. We said that we thought that our method might help with doing more with less and maximising the impact, but we left it up to council leaders to decide whether they believed that it would work in their areas. The whole of Scotland came on board—all 32 community planning partnerships are involved.

A year in, councils' enthusiasm for the method and their belief that it is helping them to figure out how they can improve local services continue. We opened the registration for learning session 5 and, by the end of day 1, 290 people had registered to attend. We are at maximum capacity for all sessions.

To answer your point, the change fund's purpose was to set us on a path. We now have the early years collaborative as a method of helping folk at local level to work out what will make a difference, which will help to inform them as they decide what to do with the funding that they have. The only money that will not be provided in the future is the £50 million of new money that the Scottish Government put in. The rest of the £270-odd million that is in the change fund is money that was already in the system. The question is how that money is used in the system. The collaborative will help to inform the better utilisation of that resource. Does that help?

Rhoda Grant: It helps to an extent, but I am still having difficulty in understanding what has changed to date and how we will measure what changes in 2016.

Shirley Laing: There is granular data. The collaborative works by undertaking small-scale tests of change. It starts with one child or one family and involves thinking through how things can be made better for them. For example, a midwife might be frustrated about a bit of process in the hospital or a health visitor might wonder why they have to do X and then Y when they could do both at the same time and make a difference.

The collaborative is about testing different ways of doing little things that might lead to an improvement. If a change can be demonstrated to bring about an improvement with one child and one family, that might lead to its being tried with two children and two families. The process involves a gradual scaling up.

I will give an example from Edinburgh that relates to bedtime reading. There is a lot of evidence that bedtime reading is important for all sorts of reasons, including the benefits that it has for attachment and literacy. After the second learning session, the headteacher of the nursery in the Grassmarket decided that she would encourage more reading with children at her

nursery. The nursery put books that the kids could take away at the front door, so that the parents and the wee ones tripped over them as they left in the evening.

Next, the nursery staff asked the parents whether that was working. The parents said that sometimes their children did not like the book that they had chosen, so the nursery began to allow the kids to take away more than one book—that was the second test. The third test involved issuing a leaflet to the parents to let them know that books were available and that they could take more than one; in other words, it set out the process.

As a result, the number of wee ones in the nursery who got a bedtime story every night went up and up. Data was kept, and there are run charts. The only time when the number dipped was on a really sunny day when there had been a big barbecue and the kids had been out having fun.

10:00

The serious point is that, after a number of weeks of improvement, the headteacher scaled the system up to the Lochrin nursery—the next nursery in the cluster. That happened over the six-week period from our learning session in May 2013 to the schools going into the summer holidays at the end of June. Those wee ones started primary school after that summer, and the primary school's headteacher, who had been working with the pre-school's headteacher for a long time, phoned her to ask, "What on earth have you done to these children? They are more book aware and more ready to learn than any cohort that we have had before."

We have granular data at that level. At one level, it might be called anecdotal, but we have the data and we have the run charts, so we can show how the small-scale changes led to improvements. However, the data is still granular, and it will take time to scale up initiatives. With the method, we do not go to scale immediately. We start small and gradually ramp it up. What we do for one child needs to be tweaked for five, and the system has to be changed again slightly for 25 children and so on.

By the third of our learning sessions, we were starting to have a dialogue with folks about how to take things to scale. When we know that something is working, what is the sensible way to scale it up and ensure that we take the improvement with us? We do not go straight to rolling something out. The approach to having a pilot in one area differs from the approach to rolling it out nationally.

The process is incremental. We have to stick with it. The data is starting to come through, although it is still very local, rather than showing a national impact.

Judith Ainsley: We are perhaps talking about two different kinds of change. There is change in where the money is spent and change in outcomes. I want to clarify that those two things are different.

Ms Grant asked whether we have evidence about how money is being spent differently. We believe that we will have that when we get the change fund returns. As for change in outcomes, are you familiar with driver diagrams? Have you seen them before? There is a big stretch aim at one end and the small-scale tests of change, like those that Shirley Laing described, are down at the other end. The theory is that making the granular changes at one end will drive the change at the other end. That is what we can currently evidence at one end of the diagram but not at the other.

Bob Doris (Glasgow) (SNP): I am caught between asking for another anecdotal example of where the collaborative has identified and rolled out good practice and asking about the targets or hard outcomes. The example that Ms Laing gave seems very much like common sense, but the process involves sharing, planning and managing the measures, such that those working on the ground are in control of rolling them out in a managed and structured way.

What are we measuring? There are the four stretch aims, which are concrete. I will give one of them as an example: it is to ensure that

"90% of all children within each Community Planning Partnership area will have reached all the expected developmental milestones and learning outcomes by the end of Primary 4".

That can be measured and that aim is sitting there. On the other side is sharing best practice across the country and sharing ideas in rolling it out. That goes in another direction completely from the high-end outcomes that are being asked for.

How much empowerment is there locally to let people get on with what they think has value and what they can do, particularly at a community planning partnership level and at a microlocal level? How much freedom do people at those levels have and how much of that is dictated centrally?

I am trying to tease out what the collaborative is. How much is centrally set? To what extent is there local discretion, so that people can get on with sharing best practice and rolling things out? Can we get a flavour of that? Is there a tension between those two sides?

Shirley Laing: We will do a bit of a double act to answer that, if that is okay—I will start and I will then pass over to Judith Ainsley.

When the early years collaborative was set up, the only thing that was set in stone was the ambition and the stretch aims. Those are the things that, as a country, we should be driving towards.

We said to community planning partnerships that they would all be in different places, that they would be proud of some things—their bright spots, where they know that they are doing really good stuff—and that some things would be a challenge for them locally, because of the circumstances of their areas. We said that they would want to think through where they wanted to start. Partnerships might wish to focus on one of the workstreams, because they might already be doing good things there that they wish to build on. Our philosophy is for people to start with what they are good at, because things will ripple out from that, which they will learn from, and they can then move on to the trickier stuff.

What has ended up happening is that most community planning partnerships have taken forward activity across all four workstreams. The activity has been for them to decide on and to choose. We have not said, "Here are the three measurement tools that you must use," or, "Here is the approach that you must take." However, if they have something that they believe is working for them locally, we have asked them to show us their data and let us share it with other community planning partnerships so that they can learn from it. If a CPP is struggling with an area, we have asked it to speak to other CPPs at the learning sessions and learn from them. If a CPP is struggling with something specific and there is an evidence-based programme that can be shown to assist with and improve that area, that might be a good place to start from.

I will hand over to Judith Ainsley to talk about where we have got to with our key changes and other work.

Judith Ainsley: In year 1, we said, "Go off and test anything at all that you want to test." We worked with practitioners and experts and, for year 2, we came up with a list of seven key changes, which we have shared with the committee. Those involve early intervention in pregnancy; attachment and child development; continuity of care in transitions; the 27-to-30-month review; developing parents' skills; family engagement to support learning; and income maximisation/addressing child poverty. Some CPPs are still doing the small-scale tests of change that they chose to do, but we have said that we would like to have pioneer sites that focus on the key changes, because we believe that we have evidence to show that they will make the biggest difference to the outcomes if they are done every time for every child.

We asked for volunteers to do tests of change in those areas. The idea is that we will give them more focused support, that we will learn from them and that they will do things that we can scale up across the country. Forty pioneer sites have come forward. That is more than the 32 CPP areas and the sites are not split evenly across local authorities—some have more than one site and some have none. It was very much up to CPPs to decide whether to do this.

The key changes development was well received across the board by everyone, and the CPPs felt ready to focus on particular areas. That is where we are now. They can still do other tests of change if they want to, but our focus for support is on the key change areas and the pioneer sites.

Bob Doris: How are the key changes driven towards areas where there are far poorer outcomes? Do CPPs direct their funds to address that? What is the mix between targeting initiatives at areas with poorer outcomes and taking a universal approach? Of course, the third way, which I would commend, is a universal approach with targeting of areas where the initiative is less likely to be taken up as a matter of course. How does your approach address inequalities?

Judith Ainsley: The idea is that universal services will improve and that CPPs will be able to spot people who need greater help and target them more effectively. An example of a pioneer site is work that is being done on the uptake of healthy start vitamin vouchers. The first thing that has been identified is that a woman has to be pregnant to be eligible for them. I know that it sounds a bit daft, but what people who are involved in the process define as "pregnant" varies—some judge it to be after a scan and others say that it is on first booking. We hope that consistency in the process will increase uptake of the vouchers.

Bob Doris: I will focus on that example before I let colleagues in. I guess—I could be wrong—that people from more prosperous and affluent backgrounds have healthier diets anyway, so vitamins may have a smaller beneficial impact on them than they have on people from deprived areas whose diet is poorer. Is uptake lower and do fewer people stick to regular scans and take all the health advice in lower socioeconomic areas? What has been done to target uptake at poorer or more deprived areas?

Judith Ainsley: We are not targeting in that way. The CPPs decide where they want to do their tests of change. East Renfrewshire, for example,

has chosen to target in that way with some of its tests of change.

Shirley Laing: The CPP will decide what it wants to look at locally and how it wants to take that forward. They are all doing it differently, but they have a responsibility to their constituents to ensure that they provide services in the best way. The CPPs are aware of the vulnerable families. Some CPPs are taking parts of their area in which there are a lot of vulnerable families and where a lot of work needs to be done, and are doing all their tests of change there. Each CPP does it differently, which is why we cannot give you a blanket response. The issue is very much about improving the universal system while, at the same time, seeking to target appropriately.

Workstream 2 is about the number of children who get the 27 to 30-month child health review. Glasgow was the pathfinder area for introduction of the review. John O'Dowd, who was a consultant in public health in Greater Glasgow and Clyde NHS, has shared with us some of the materials and data that resulted from that work. Glasgow now has data that lets it know that it is reliably reaching about 80 per cent of the children who should be getting a child health review. The data are from last summer; the situation may have changed since then.

Just as it did to us, that immediately prompted in John O'Dowd's mind, as a committed professional, a question about what improvements are needed to the system in order to get to the 20 per cent whom we are not hitting, and who are the ones whose parents are most likely to be disengaged from services. It relates to the point that Bob Doris made about people not turning up for bookings, not having a healthy diet and so on. There are variations across the piece in how it is being done, but ultimately it is about ensuring that we reach our most vulnerable children, young people and families by improving the overall system.

Bob Doris: So, there is a 24 to 30-month review.

Shirley Laing: It is the 27 to 30-month child health review that came into being last April.

Bob Doris: Is that review the responsibility of the national health service?

Shirley Laing: Yes. The work is carried out by health visitors—it is an NHS responsibility. Glasgow was the pathfinder area for that review before it was introduced. The data from John O'Dowd were based on Greater Glasgow and Clyde NHS's pathfinder work.

Bob Doris: I will pursue this briefly, convener, because it is a really interesting example. I promise that I will then let my colleagues in.

The data say that 80 per cent of the children have presented for the review. You can then identify and monitor the households that have not presented. Would that remain an NHS responsibility or would the NHS work jointly with the third sector and the community planning partnership? I can think of a variety of third sector groups in north Glasgow that do a heck of a lot of fantastic outreach work with people who are less likely to engage with the statutory services. Is that information shared with those organisations? From the point of view of data protection, can it be shared?

Shirley Laing: That is a great question. I cannot answer it fully, but I can tell you that in Glasgow it was identified that 80 per cent of the children who should be getting the review were getting it, which, as was said, raises questions about what it should do about the 20 per cent. Because of what Glasgow knew from the 80 per cent that it was assessing, it was able to pick up very early on speech and language needs, for example. Glasgow now has a flow diagram and a logic model—I looked to see whether I had it in my slides, but I do not—that shows that it knows, from the children that it has assessed, that some of them just need a wee bit more X provision, or a positive parenting programme, which is multi-agency and delivered by the third sector, or a blend of approaches. The review has helped to inform what Glasgow does with the 80 per cent. Off the top of my head, I do not know where it has got to in relation to the 20 per cent. However, it now knows that that 20 per cent exists, which it did not know before it did that work. As a result of that journey, it is learning where it should go next to improve its systems, and it is sharing that learning, in whatever way is appropriate, to ensure that the children who are not receiving a service at the moment are identified and receive a service.

10:15

Bob Doris: I have no more questions, convener, but I have a final comment.

Perhaps the committee could ask Greater Glasgow and Clyde NHS about the pathfinder work. I am starting to get a sense of what "collaborative" could mean, and of how universal provision with targeted follow-up could make things work in a co-ordinated way. I will leave that hanging there because, of course, the committee does not know what is happening with the 20 per cent who are not getting the review. Evidence that shows positive things would mean that the work is proper collaborative work. I am at least starting to get a flavour of that now.

Shirley Laing: I would be very happy to provide the clerks with the slides on the data that John O'Dowd provided.

The Convener: I want to get some clarity about the initiative. It is all very well for us to ask who is responsible. Your briefing states:

"The Early Years Collaborative (EYC) is the world's first national multi-agency quality improvement programme. It is a coalition of Community Planning Partners (CPPs) including social services, health, education, police and third sector professionals that are committed to ensuring that every baby, child, mother, father and family in Scotland has access to the best support available."

However, we have heard this morning that this is more about a sharing of ideas, rather than action to deliver "the best support available."

Shirley Laing: I would describe it as an approach that allows practitioners to improve their element of the system. The collaborative then brings the practitioners from the various agencies together to learn from each other. At every learning session they provide a story board—a big poster showing what they have been doing—and the learning that has occurred, so that they can share the learning, which then leads to further actions.

The Convener: We have had a long explanation this morning of how that can work, but how does it affect the lives of children? Are you suggesting that none of that was happening before and that we had to set up the early years collaborative to ensure that people who were responsible for delivery of services for children were speaking to one another?

Shirley Laing: No. What I was asserting was that we knew that there was lots of excellent practice going on across Scotland, but it was in pockets. We were not seeing that excellent practice being brought to scale; it was not happening fully across Scotland. What we are doing now allows us to take pockets of good practice to scale, which is what interested the Scottish Government. Of course people were talking to each other before, but we have also had feedback over the past year from CPPs telling us that they now have far better relationships with their colleagues in health, social work and local government because they are working together and talking to each other. I can best describe it as being about breaking down the silos.

Judith Ainsley: It is useful to break it down into the what and the how. We know that there is lots of evidence about what works. Turning that evidence into practice is what makes the difference to the child. The information that is shared is about how to turn that evidence into practice. It is not about asking, "How's it been going this week and what are you doing?" but "How are you delivering this work and how are you putting what we know works into practice?" That is what is shared and that is what is powerful.

Consideration of people's readiness to change is also useful. At national level, I am sure that all practitioners accept that we can see that some children do better than others, and that outcomes are not equal, which needs to change. At individual practitioner level, some will say that they are doing it already. To follow on from what Shirley Laing said, we can then ask them to share with us how they are doing that, and what the data are. We often find that when people look into their own practice and start to record things, they see that certain things do not happen every time for every child, and that is what can make the difference.

The Convener: Your paper states:

"At present, 16 CPPs ... have come forward with 39 Pioneer Sites."

What about the other 16?

Judith Ainsley: We have 40 pioneer sites—Glasgow is now doing one as well.

The Convener: There are 40 pioneer sites, but only 16 community planning partnerships have come forward with sites. That means that, a year in, 50 per cent have not brought forward a pioneer site. Why?

Judith Ainsley: The rest are still working on key change areas and other tests of change. They have just chosen not to go with the pioneer site process. That will be for various reasons, and I would not like to say why—

The Convener: It is 50 per cent of the community planning partnerships.

Judith Ainsley: They perhaps feel that they do not have the resources to do it themselves. They have to put in the resource from each community planning partnership to deliver. Some have full-time programme managers. Some might feel that they are doing fine with their key changes and do not want to be involved. You would have to ask them.

The Convener: That is fine. It might be useful to find out who is in and who is out so that we can ask them why.

Judith Ainsley: Certainly. I have a note of everyone who is in.

The Convener: The final issue that I want to raise is the target for workstream 1, on stillbirths and child mortality. I am just trying to establish the baseline for the 15 per cent reduction in the rate of stillbirths from the 2010 figure. Could you explain how you came to those targets and why you chose 2010?

Shirley Laing: We finalised the stretch aims in January 2013 because that was when we had our first learning session. The Scottish perinatal and

infant mortality and morbidity statistics are published annually in March.

I should explain that there is a difference between a stretch aim and a target. A stretch aim is something that cannot be achieved within the current system; the system will have to change to enable it to be achieved. The statistics that were available when we were establishing that stretch aim were for 2010.

The Convener: So, that is why 2010 is the baseline. The reason is no more sophisticated than that it was just the moment in time.

Shirley Laing: It was just the moment in time, and we looked at how we could expand beyond that.

The Convener: Will you achieve the target by 2015?

Shirley Laing: We know that there has been a decrease in the rate of stillbirths since 2010. However, the data show that a large part of that improvement occurred before the early years collaborative was up and running, so it would be inappropriate to attribute the change in the statistics to its work because it has only been going for a year. As the data start to come through next March, we will get a clearer view of where we are.

The Convener: The data will probably be meaningless then as well. The collaborative has been going only a year, so will we be able to claim credit or blame for failure in such a short period of time, especially if the results are patchy across Scotland and some CPPs are in and some are out? This is being presented as a serious workstream, but can we defend it as such?

Shirley Laing: I will just clarify that slightly. All 32 CPPs have signed up to the early years collaborative, and all 32 are doing work locally in respect of the stretch aims. Only 16 of them have signed up as pioneer sites to focus on the key change areas, but the other 16 are still carrying out activity on the stretch aims.

The Convener: The workstreams are different from the pioneer sites.

Shirley Laing: On the driver diagram that Judith Ainsley showed earlier, there is a stretch aim at one side, which is the big dot and the thing that we really want to shift, but it will take a range of actions to make the impact that will achieve that shift. For example, for stretch aim 1, it will mean things such as smoking cessation in pregnancy, access to healthy start vitamins, healthy diet, and good housing and social conditions. Those then have to be broken down into factors and what we can do locally to improve on those factors that will push us towards the stretch aim. We are still working on those little dots.

The Convener: So, as expressed in the diagram, the workstreams are stretch aims.

Shirley Laing: Yes.

The Convener: They are not targets.

Shirley Laing: No.

The Convener: I have two quick questions on workstream 2. Your submission says:

"The aim of this workstream is to ensure 85% of all children within each CPP have reached all of the expected developmental milestones".

How far are you stretching? What is the current percentage of children who reach the "expected developmental milestones"?

Shirley Laing: You will have to forgive me, but there is so much detail. In talking about workstream 2, I will refer to the pack that we put together for our first learning session. In April 2013, the 27 to 30-month child health review was introduced, which provided us with an opportunity to capture children's developmental milestones. When setting the stretch aims for workstream 2, we did not have a baseline figure as we did for workstream 1. However, from historical Scottish and international evidence we know that 20 to 30 per cent of children do not meet developmental goals at 27 to 30 months; when we were identifying that aim we knew that. Consequently, our stretch aim was that only 15 per cent would not reach the developmental milestones. The 27 to 30-month child health review came in only last April, so it is early days with regard to what the data will tell us.

The Convener: You do not know what percentage will meet the developmental milestones.

Shirley Laing: We do not know that.

The Convener: You made a guess.

Shirley Laing: We made an educated guess.

The Convener: We do not know whether we will have to improve the figure by 20 per cent, 50 per cent or not at all.

Shirley Laing: A big challenge for us when it comes to the broader social policy is in getting helpful data. If, when the data become available, they suggest that our aim is not challenging enough, we will revisit it.

The Convener: Does the same apply to workstream 3, which is to ensure that

"90% of all children within each CPP have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017."?

Shirley Laing: Yes. It is absolutely the case that we did not have a baseline figure for workstream 3. We knew that local partners across

the country all have mechanisms to understand the levels of child development on entry to primary school, but that they all use different tools and no standardised tool exists. As is the case with workstream 2, 20 to 30 per cent of children do not meet their developmental milestones. Part of the early years collaborative work is to gather data so that we have evidence to inform better what we are doing collectively.

The Convener: We have targets in workstream 3 that should be achieved by 2017.

Shirley Laing: The data are starting to come. The method is predicated on data. The improvements that folk are making at local level will give us data that will inform the national picture.

Gil Paterson (Clydebank and Milngavie) (SNP): I want to talk about the objectives that are referred to in your background note. One is to raise public awareness. Will you give us some information about that? One of the most important groups to reach is the parents, especially those who are in difficult circumstances. What penetration have you had with, and what has been the reaction from, those parents?

Shirley Laing: I will start off and Judith Ainsley may wish to add detail. Each community planning partnership will decide what it wants to do at local level, although they all do lots of work with families. We are capturing our journey, if you like, by videoing a lot of what has been going on. One of our short films was circulated to committee members in advance of the meeting. CPPs are speaking to parents and we are capturing what parents get from the process, and that informs what happens at local level. Parents are engaged. The key changes focus very heavily on parental involvement. More work will be done to determine how best to engage and work with parents.

On raising the broader international profile of the early years, the convener mentioned the fact that we see it as the world's multi-agency programme. The Institute for Healthcare Improvement, whose model we are using, is learning with and alongside us because such a programme has never before been done on a multi-agency basis. International interest in Scotland's approach is phenomenal—we have had visitors from Denmark, America and New Zealand. However, the really important work—what we are doing for our children and families at local level—is under way, and there is lots of direct parental engagement and involvement.

10:30

Judith Ainsley: If I may, I will speak more generally about evaluation, because there have been lots of questions about that. It is something that exercises me, too—actually, because I am a bit sad, I think that it is quite exciting. In the background note, we give a breakdown of the three elements of what we are doing on evaluation. We are just kicking off the process. The first element is a national action learning network, which is about looking at the more qualitative aspects of what we do to share information and work in a multi-agency way, with people coming together, for example. The network is about what we can learn and how we can do it better and change our practice as we proceed.

The second strand is about bringing in the smaller, granular data and any of the national data that we have, so that we can learn as we proceed in an action learning way. The third element is to look at in-depth case studies, such as those in the video that the committee has seen and in some of the stories that we have told.

We have to remember that it is early days and that the change will take time to happen. A couple of weeks ago, when I was at an international forum, I heard about a test at scale that involved 1,500 general practitioner practices. That was not at the same scale as the early years collaborative and was not a multi-agency approach, but people talked about changes being made over a 10-year period, with results over a 10-year period. Clearly, we are looking for results much faster than that—that is just an example of the normal pace of change, to show that we are trying to make a difference much faster.

We are conscious of the need for evaluation. I want sheets of evidence to show the committee why the early years collaborative works well. We are working towards being able to provide that evidence about what we need to do, what works well and what we need to do differently.

Gil Paterson: I asked the question because I paid attention to the video that you gave us, and the reaction from the parents—

Judith Ainsley: It was fabulous, wasn't it?

Gil Paterson: It was good. I know that it is early in the process, but we can certainly see in the video the parents' reaction to what is happening to their children. I wonder whether there is also payback further upstream for the parents. From the information that you have so far, can you say whether there is a change in the parents?

Judith Ainsley: I can speak anecdotally, but it will just be little stories again. It might be worth while for the committee to speak to a programme manager and those who actually run the tests of change with people in front of them. There were comments from women who had not known about the healthy start vitamins programme and who said what a difference it had made to them to be made aware of it and to have access to it.

I ask Shirley Laing whether she has any other examples.

Shirley Laing: For me, where work is happening with families at the local level and there is the sort of positive reaction that members have seen in the footage in the video that we provided, that builds up networks for parents as they mix with other young mums and dads, which is valuable and gives them peer support. At the end of the day, the approach is all about working in communities and drawing on community assets. That is important in itself.

Also, it is powerful when decision makers see the videos. Obviously, they are not in the room with the practitioners, so the videos help to inform the decision makers in making budgetary decisions. If a programme is working and having a powerful impact, that makes people think twice when they are making budget decisions about what to take forward.

There is a ripple effect at a number of levels.

Gil Paterson: Most people take umbrage at being told what to do—that is just human nature—but that was clearly not the case in the video. Both parents were supportive and could see that what was happening was good for their children. In some sections of society, there is a sort of fatalism, which can be a problem. Is there a reluctance to engage, or is there an open door because children are involved? Is it the case that, because we reach the children, we actually reach the parents?

Shirley Laing: I think that that is a fair comment. Nobody sets out to be a bad parent and everybody wants the best for their children. If any mum, dad, grandparent or carer sees their wee one coming on and things happening that are beneficial to their wee one, and it is done in a way that is supportive of the child and the family, that is welcome—it supports them in bringing the wee one on.

As Judith Ainsley said, we hear anecdotally that some people are nervous about going into a club or centre or joining a programme—they think, "Is this for the likes of me?" Not so long ago, I spoke about the early years collaborative to people in Inverclyde, where people were talking about how they could get young single mums in and what they could do differently. They thought that, rather than have a morning meeting at which advice would be given, they could have a coffee morning, which would take the pressure off and would just seem like everybody getting together. That idea came out of a discussion about how they could improve. They thought, "We've got all these leaflets and all this information and we know the things that will really help them, but if we cannae get them through the door, what can we do differently?"

It is not rocket science—it can be about making really small tweaks. It is about understanding human nature and behaviour and how you work with people in your community for the betterment of the community.

Gil Paterson: Thanks for that.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Of course, the focus on early years is not new, although the collaborative aspect is. My first question is about what already exists. It is all very well to have change funds, pioneering efforts and so on, but back at the beginning of the Scottish Parliament when we had our first discussion on the subject, we promoted the sure start programme, which I think has now become the family centre programme. There are 3,500 family centres in England, but there are only 140 or 160 such centres in Scotland. Programmes such as sure start and the charity Home-Start have been around for years, supporting families who have been identified as having particular needs, which can be long term or short term, and can be quite acute at times. How are you working with such groups? Are some CPPs not working on being pioneer sites because they want to build on existing systems?

Shirley Laing: We encourage all CPPs to build on existing systems. The whole premise of early years collaboration is to start from the bright spots—the things that people are good at. They have to find what is good about those things and use that to learn and move into areas where they have challenges.

You are absolutely right that the sure start moneys were distributed differently in Scotland. They were given out to local authorities and used in a different manner. There is a range of constructs in Scotland for supporting families. In some areas, that involves a family centre or a community hub. Such supports are not all called family centres, so it becomes quite difficult to capture the overall number.

Through the early years change fund, we have put out some money through local authorities to enable them to do further work around family support because we recognise its importance. Again, those resources are linked to the early years collaborative, and it is then for community planning partnerships to decide, on the basis of the structures, the resources and the approach that they will take in their locality. For example, they can consider what they would like to do differently and what improvements they think would be valuable. They can use the plan-do-study-act methodology in the gathering of data to try stuff out and see whether it helps.

I think that the only reason why people are not coming forward as pioneer sites is that they are already doing lots of other activities and are happy with what they are focused on at the moment. I do not see that as a negative.

Dr Simpson: We have evidence that sure start works. There is good, published research—the first paper was from Wales—that has direct evidence on that for babies at nine months, and there is indirect evidence for three-year-olds. We have a system that is now 10 or 11 years old. The new stuff is great, but should we not be using the existing mechanisms?

The sure start family centres are inspected by the Care Inspectorate, so a bit of redefinition might be needed to include community hubs as part of such provision. That has been done in England, where the definition includes not just the classic sure start family centre but a range of things. We should ensure that the Care Inspectorate inspects centres against the model of what works in relation to early reading to children, for example. Is the Care Inspectorate involved in that way? What discussions have you had with the Care Inspectorate on ensuring that the mechanisms that we already have in place are fulfilling the best objectives?

Shirley Laing: I am the deputy director for early years, and the early years collaborative is one element of the policies that I have responsibility for but, in the broader sense, my responsibilities cover parenting, family support, early learning and childcare across the piece. I have discussions with the Care Inspectorate on a range of things. Through our national parenting strategy and the work that we are doing on family support and public-social partnerships, we are looking to ensure that anything that happens in localities is done in the best interests of children and families. However, we recognise that it is for localities to decide what is best for them; that is not mandated from the centre.

Dr Simpson: Convener, unless anyone wants to ask a supplementary, I will go on to my second area.

The Convener: I have no bids. Richard Lyle is next to speak, but I think that he wants to raise something different.

Richard Lyle (Central Scotland) (SNP): I am interested in Richard Simpson's point that we have many organisations that are doing everything differently. Why is that?

Shirley Laing: Decisions are made locally about the best support to provide in communities. We hope that, through the early years collaborative, people across the country will learn from local initiatives that are leading to super results for children and families. Over time, we may see a convergence, so that really great things happen across the piece rather than in pockets. Our position is that it is for localities and communities to decide what works best for them, after drawing on evidence and looking at local resources and skills.

Colin Keir (Edinburgh Western) (SNP): That is interesting. I will ask about something that I am a wee bit unclear about—you might have touched on it. Given all the local differences and different starting points, can we assume that assessments in different areas are of the same level? Given that local systems differ, how are they generally assessed?

Shirley Laing: That is a great question; I will think through the best answer. The position depends on the service. We have national bodies such as Education Scotland and the Care Inspectorate that inspect and regulate services. As education authorities, the responsibility of local authorities is to know, when wee ones start school, where they are starting from. As I said, local authorities all use different tools, but they all measure where wee ones are at developmentally when they start school. They use different tools, but those tools are accredited. There is no standard, blanket approach across Scotland, but we recognise that the tools and assessments that are used are all validated in their own way.

Colin Keir: Given the problems that you have outlined, how do you—as somebody who sits at the top of the tree, trying to evaluate all the systems—put all that into a system that is understandable to people such as us, and how do you say with any certainty where we are on assessments?

Shirley Laing: The data that we have talked about is predominantly data for improvement; it is real-time data that is based on small-scale tests. That is very different from national statistics and a snapshot at a point in time, although we still have our national statistics. As the data collections are produced each year, the hope is that we will see the shift and a change in the trend. The aim is to use real-time data from smaller-scale tests—the data for improvement—to increase the pace at which change and improvement happen, rather than to wait for a snapshot once a year, which does not provide the richness of understanding about what is going on locally.

The Convener: We have more questions on this theme.

Bob Doris: I have a supplementary that is inspired by Dr Simpson's comments about sure start and the comparison of traditional bricks and mortar family centres in England with provision in Scotland. In the Maryhill corridor in north Glasgow, One Parent Families Scotland provides a service;

there is also Home-Start Glasgow North West and Stepping Stones for Families. I am sure that they are all part of the early years collaborative.

Has the collaborative identified the need to properly map, for the first time, all the provision that is out there, to identify whether the picture is complex or whether it is difficult to compare the more structured approach to what is happening in England with the more organic provision in Scotland, particularly from the third sector? Has the collaborative identified whether there would be any benefit from that? Are we getting to the stage at which we can say, "Here are all the organisations in each locality that actively support parents and young people"? I am interested in whether benefits have emerged. Has there been a mapping exercise that perhaps shows additional provision from the third sector that we were not even aware of? The third sector is quite vibrant in my area.

10:45

Shirley Laing: The third sector is a very important—

The Convener: I am sorry, but I ask Rhoda Grant to ask the final supplementary question on this theme. I will throw in a supplementary as well. How do the inspection agencies that have been mentioned fit with the collaborative clearly and with accountability?

Once those questions have been answered, we will move back to Richard Simpson's second question before Richard Lyle asks his questions.

Rhoda Grant: Do you want me to ask my supplementary question now?

The Convener: Yes.

Rhoda Grant: It is on the same theme. I think that Colin Keir said that we are comparing apples with pears. The inquiry is about people with inequalities. We have the benchmarks that children should reach, but we all know that children who suffer from inequalities and are brought up in povertyerty have less chance of reaching them. An intervention could make a huge difference, but might not bring them up to the same level. How are things evaluated to ensure that the interventions that really work for those who suffer from inequalities are not lost? When children start from a much lower benchmark, how is that measured?

Shirley Laing: I will start and then hand over to Judith Ainsley, if that is okay.

The Convener: Yes. Thank you. That would be helpful.

Shirley Laing: We have not carried out a national mapping exercise, but when each community planning partnership has considered the workstreams and what it is doing around each of them, it has basically done its own driver diagram of where it is—if it is trying to achieve stretch aim 1—and what it is doing locally that will help with that. That helps to flush out excellent practice or gaps that they need to consider.

I genuinely do not know whether each CPP has done a local mapping exercise, but I know that the third sector is intertwined and embedded in that work. Judith Ainsley will come on to the work of our national partners shortly. We do not have a national mapping exercise, but in addition to the cultural and behavioural changes that we started to see in the first year of the collaborative, with people talking to one another—I alluded to that earlier—quite pointed questions are now being asked about whether services are achieving what it was thought they would achieve, where the data is around that, and what is needed if the approach is not working. People are starting to get into the territory of where the gaps are. That takes us back to how we should look at our services and the reconfiguration that we need.

Rhoda Grant asked about inequalities and a lower starting point. I understand that Sir Harry Burns will come to speak to the committee at some point—he has been instrumental in the work that we have done around the early years collaborative and is a huge supporter of what we are doing. I fully recognise everything that Rhoda Grant said from the conversations that I have had with him. It is important to recognise that there is a longer journey in getting children who are in the most difficult circumstances and situations up to the mark. That is where the small-scale tests and the data for improvement, as opposed to the national data, come into their own. We can start to see the small steps and changes that are being made and their impacts, whereas if we looked only at national statistics, some of that richness and the power of the interventions would be lost.

As we touched on earlier, we really need to have the stickability factor. We need to bear with it. We will not change the world overnight. The early years framework, which set out aspirations over a 10-year period, is a great document, but when I started to look at it quite critically with my improvement hat on, I thought, "What's the method? How will we ensure that it happens?" We now have a method, but it takes time to gear it up and get it moving, and to start to get the data to answer the questions. However, having data at the local level helps in identifying the interventions that are really impactful for the most vulnerable children and the things that really make a difference.

I do not know whether that helps in any way. I will hand over the Judith Ainsley to speak about the national partners.

Judith Ainsley: I shall finish the point on inequalities first of all. The 20 per cent of children who are not given a 27 to 30 month check are really important. We are asking questions about that. It is not up to us to decide how they are followed up, but we are asking what is being done to reach those children. It is not just about them getting a check; it is about what happens as a result of that if a need is identified. The idea is that all children should get that check, so that things that are spotted can be followed up and services can be provided. It is not enough just to identify that something is needed; it must be delivered. That is how we should be able to pick up the children with inequalities better.

It is not just a question of mapping the services in an area. At a programme managers' meeting last week, I spoke to a manager who had mapped the services that a particular family accessed in order to streamline all the interventions, which involved more than 20 different services and individuals, all from the same area. That is a slightly different point, but it is related to what we have been discussing.

We have set up a group called the national partnership, which is made up of lots of third sector organisations. Members are self-selecting, but they are third sector organisations that have come forward and said, "We deliver services to children," or, "We have research," or, "We have resources that can be used," and they want to know how they can best become part of the collaborative and get involved. There are also third sector partners on the early years task force, so there is huge engagement with the third sector, and with the inspection agencies.

Dr Simpson: My second question is about the workforce. Obviously, there is a statutory workforce for the NHS, local authorities and the third sector, but we know that the family nurse partnership will utilise 350 individuals when it is eventually rolled out. Half of those people will be from health visitor backgrounds and half will be from other backgrounds.

As a result of the Children and Young People (Scotland) Act 2014, we know that substantial numbers of health visitors will become named persons, in addition to their other work, and the Royal College of Nursing estimates that that will involve another 450 health visitors. However, the planning relating to health visitors is still handled by individual health boards, not by the local authority. The health board decides how many health visitors it will train.

Looking just at that one area, I do not see how there is any possibility of maintaining universal checks, even on a proportionate universality basis—that was Marmot's phrase—or on the basis of universality plus focus, as Bob Doris mentioned. I do not know how we can maintain that and the family nurse partnership and the early years collaborative, with all the additional stuff that is involved in that, without effective workforce planning.

My question is really about workforce planning and training, because if you are going to have a collaborative you need conjoint training across the third sector, local authorities and health. It is a two-part question about the workforce.

Shirley Laing: I will do my best to answer that, although I do not have policy responsibility for workforce planning or health visitors, so please forgive me if I cannot answer on those points.

The early years collaborative learning sessions are exactly that—they are learning sessions and training and development events that bring together multi-agency professionals from across the piece for joint training.

In terms of capacity building, we are investing in folks from across the CPPs to turn them into improvement advisers, so that they are better at gathering the sorts of data that we need. We are putting 15 people through that. We also do training through the programme manager events that Judith Ainsley mentioned and our practice development team goes out and works in localities with teams to train and support them on the quality improvement side of things. There is support around the early years collaborative methodology and approach, to train and build capacity and to support folks in localities.

Forgive me, because I am conscious that I am not directly addressing your workforce planning question. I am not in a position to do that, but we know from the feedback that we have had over the past year that people find the method hugely empowering. Nobody works in public service unless they want to do good things for people; it is a tough area to work in. People now know that when they go into work of a morning they have an approach and a framework through which they can look at things in the system that have been frustrating them, with a view to making changes to improve outcomes for children and families. That gives those people job satisfaction and makes them feel that they are really doing the job that they went into the sector to do. We are getting lots of positive feedback.

At the outset, when we spoke to every chief executive in the country and said, "We think this method might help, although it is up to you whether it will," we viewed it very much as one tool

in the toolbox. It is not the answer; it is an approach, and it is not an additional burden. For us, the early years collaborative provides a method to put into action getting it right for every child; it is about putting the child and the family at the centre and it is not additional to or in conflict with GIRFEC. The named person provision, which has come in through the 2014 act, has been part of the GIRFEC methodology for a number of years. The early years collaborative is not about new burdens; it provides a tool that we hope will assist practitioners in doing their day job and, at the same time, improve outcomes for children and families.

Dr Simpson: Does Ms Ainsley wish to contribute?

Judith Ainsley: I have more examples of what we are doing to build capacity. We have a thing called a boot camp, which is quite interesting; it is a data and measurement boot camp. People in each CPP can come along for two days of intensive training on, for example, how to do data and measurement properly. In addition, we are in the process of recruiting national improvement advisers, whom we will link with our pioneer sites, to give support from the centre.

Dr Simpson: I am sure that the redesign that you are talking about—refocusing work by reducing the medical part and increasing the social part of the model—is absolutely critical on delivery, but at some point we will need more information on the workforce planning side. Perhaps we can come back to that.

Richard Lyle: I am impressed with your enthusiasm, ladies. Some of my colleagues strayed into the area that I was going to ask you about, but I will try to retrieve what I really want to know.

You say that the early years collaborative is

"the world's first national multi-agency quality improvement programme"

and that you have 16 CPPs, 32 councils and 40 pioneer sites. There is a myriad of programmes and everybody is doing everything differently, so how are we keeping a handle on it? How do we know what will work and what will not? What is the timescale? You said that it would be between three and 10 years. In my previous experience, people shared information. The best place to do that was at a conference or through different programmes that were brought together.

You gave a great example of a nursery in Edinburgh. I always used to have the view that a flavour of the month programme happened in various councils, which was then dumped.

There are hundreds of programmes in which everybody is doing their own thing. You are not dictating what people do, so how are you keeping a handle on it so that it does not get into a mess?

Shirley Laing: The first year has been messy, and we have acknowledged that, but that is part of the process. Year 1 was very much about CPPs getting to grips with the method, understanding quality improvement and giving it a go.

A number of things are different with the early years collaborative, but the difference between the early years collaborative and the Scottish patient safety programme—from which we drew a lot of learning, because of the great things that it had achieved—is that with the Scottish patient safety programme, people knew what bundle of things they needed to do to make a difference. I am not a medic, so forgive me if I get it wrong, but I am referring to things like having the bed at 30 degrees and taking the ventilator tube out once an hour and cleaning it, or whatever. There was a range of things that everybody said they were doing but, as Judith Ainsley mentioned, when we tracked activity we saw that they were not doing them. However, they knew the bundle and they knew that once those things were done reliably, it would lead to the great results that we have had.

11:00

When we decided to move forward with the early years collaborative, we had the benefit that, of the multi-agency partners around the table, health partners knew the method. They had been sceptical when they first started on the Scottish patient safety journey, but over time they had seen the impact of it, so they were advocating for it. Other partners around the room were looking for tools, methods and things to try in the challenging circumstances in which they found themselves and said that they were up for giving it a go. We did not have the bundle; I do not know the five things that we could do to give every child the best attachment.

Year 1 of the collaborative was about people understanding the method, giving it a go and starting to test things out, building on the good stuff that they do locally. If there is a gem out there that the rest of us can learn from, I want to know about it. People can share examples at the learning sessions by bringing their story boards, sharing ideas and chatting.

By the end of year 1, we recognised that it was fine to let 1,000 flowers bloom but we needed to identify the five, six, eight or 10 things on which we needed to focus collectively, so that the chief executive of the health board or local authority could say, "My team are busy focusing on X. Because of all the things that we've tested, that's the area where we're really seeing potential for a step change to move things on."

Last November, we held a number of sessions with folks from across the CPPs—smaller sessions than our 800-strong learning sessions. Through those, we developed the key changes, which we launched in January. There are key themes. There are areas where we think that if we can come up with the right bundle, we will see that step change in improvement.

This is where the numbers come in. We have all of Scotland on board; all 32 CPPs are signed up to the early years collaborative. We have our stretch aims and our ambition to make Scotland the best place in the world to grow up in. Those are set in tablets of stone, if you like.

Folk have been testing locally. We have now started to drill down and say, "These are the areas that we think you need to be focusing on. As 32 community planning partnerships, you'll want to consider all the testing that's going on in your area and identify how it fits or identify other things that you're doing that you think fit into the work streams." In addition, we have said, "If there is work that you are doing that you can see has real potential to make that step change and it fits into one of these key areas, would you like to be a pioneer site?" If an area wants to be a pioneer site, the team from the centre—the national improvement advisers that Judith Ainsley mentioned—will work with them and a wee bit more support will go into those areas so that we can learn more quickly and start to pull forward that information and share it with others at our future learning sessions.

We anticipate that over time there will be a convergence of the things that we should be doing and the right ways to make improvements to bits of the system. It is very much a grass-roots-up approach; it is not top down. It does feel messy and I am the first to admit that we do not have control over all of it, but we are already starting to focus down.

To give one example from the Scottish patient safety programme, there is now one surgical checklist for the whole of Scotland. There was not always just one for the whole of Scotland; when the Scottish patient safety programme started, I think that there were 20-odd versions of it around the country. Over time, through going to the learning sessions and chatting to each other, folk started to say, "Oh, I quite like that bit of what they're doing over there. I'm going to change to doing that." There was a convergence, but it is about convergence by mutual agreement. The point was made earlier that if people are told what to do, they will say no; this is about people learning for themselves what is right and what has the maximum impact on improvement.

Yes, it is messy and we do not have national level data yet, but we are only 14 or 15 months into a process that is making a difference.

Richard Lyle: There are many questions that I would like to ask, but we do not have time. What is the timescale for evaluating the collaborative?

Judith Ainsley: We are kicking off the evaluation process in earnest just now. We give people questionnaires after the learning sessions, so we have gathered that sort of stuff. We are kicking off the process of evaluating the overall package to see how it is working. We will probably have something to come back to you with by the autumn.

Richard Lyle: I will run all my questions together, because there are several points that I want to make. Is there a danger that the collaborative might be discontinued at any time? You went on about the nursery in Edinburgh. Are we sharing that example across the country?

My daughter recently had a baby. The health visitor came yesterday—they came to our house, because my grandson unfortunately has chicken pox and he was at his house.

You spoke about vouchers. Going back to the olden days, in the same vein as Richard Simpson—not that Richard is old—I remember that there used to be a milk programme for new mothers and newborn babies. How are the vouchers given out? Do people apply for them, or is it based on need and so on?

Judith Ainsley: I do not know a huge amount about it, but I believe that not everyone can get them and that there are eligibility criteria. The vouchers need to be applied for. A form needs to be filled in—the test has involved a health professional helping with that so that the vouchers can be accessed.

Richard Lyle: Basically, we are targeting the sections of our community that require that help in order to improve their children's health.

Judith Ainsley: Yes.

Richard Lyle: That is all I wanted to know—thank you.

Judith Ainsley: May I add something regarding pioneer sites and the messiness that was mentioned? To be a pioneer site, there is a requirement to report monthly and to take part in a set number of WebExes. Are you familiar with those? Basically, people meet using the phone and the computer at the same time to share their learning. There are requirements on pioneer sites so that things are a bit less messy. We will get a structured form of data back from the pioneer sites, which we can learn from. We can then scale

that up across the country with the things that are working.

Richard Lyle: We will soon get to know the things that are working and the things that are not working.

Judith Ainsley: We have examples of that now, which we could give you.

Aileen McLeod (South Scotland) (SNP): We have been talking a lot about the learning and sharing of best practice through the collaborative. My question is about the extent to which international good practice in child health and wellbeing programmes can be used to inform the work of the collaborative. For example, we know that there are higher levels of equality in child wellbeing, as measured in terms of educational, maternal and health outcomes, in Denmark, Finland, Sweden and the Netherlands as compared with other Organisation for Economic Co-operation and Development countries.

Shirley Laing: We are open to learning from wherever. If we want to make Scotland the best place in the world to grow up, we need to learn from others who are doing good things. Decisions on the programmes that are used locally are for CPPs to make at local level. As I mentioned earlier, where the CPPs assess that there is a need for a programme, we would encourage them to use evidence-based programmes rather than creating something from scratch.

We look at international examples, and international colleagues look at us. People from Denmark attend our learning sessions, which they see as an innovative way to work from which they can learn. It is not often that we hear that.

Judith Ainsley: At the forum that I attended, we came across exactly that kind of thing: we could all learn from each other. The example that was being presented on the stage was of something that had not worked; it was part of an obesity programme that had been running for a number of years in the country concerned. We can learn as much from that sort of example as we can from things that have been successful. We look at wider practice.

Bob Doris: I also sit on the Public Audit Committee, and I seem to spend half my time on that committee asking health-related questions, for example about the quantity of audit reports that come out. I have an audit-related question. At some point, all of this will be audited. That is about determining what targets are and what outcomes are. What can be monitored nationally? What is local discretion? It becomes incredibly difficult to monitor the whole thing. At some point, this committee, auditors and others will ask whether it is possible to make sense of local discretion, with people going their own way and with no national baseline data. Auditors tend not to like that kind of thing—when people do their own thing because they think that it is working and they then roll it out. How are you, at the centre, keeping tabs on what is or is not working?

I will not say, "Give me the 10 targets." What I will ask you is how you will make sense of the vast swathes of data that will come to you over the next few months. How will you report back to this committee and, I suppose, to auditors, because they have to do what they do? What will we look at as a reporting exercise? How can we ensure that the public pound that is being used to drive service improvement is being used wisely? At the end of the day, that question will be asked and it is an incredibly difficult one to answer. I would draw attention to the change fund for older people and how that is being managed. There is lots of good practice out there. However, it can be quite challenging to monitor, to audit and to follow the public pound.

Judith Ainsley: It is very challenging. I spoke about the general way in which we will do evaluation, which will bring in the driver diagram method, because what we will have, mostly, is the stuff down at this end. We have met Audit Scotland to talk about it. It is the causality that is difficult to show. Audit Scotland is more accepting of that than I am. I want to see stuff that shows me numbers, figures and what goes on. That is not always possible, but it is what we are striving for. We are speaking to the right people and we are aware of that issue. We are also pulling together a national measurement plan to try to make sense of all the small pieces of data that are coming forward and to build that data up. Does that answer your question?

Bob Doris: I think so. I suppose that I was just putting on the record that I know how challenging it can be. At some point, those difficult questions will be asked, either by this committee or by the Public Audit Committee.

Judith Ainsley: We are asking those questions already. We will not be able to answer all the questions because we cannot always show the causal link. We sometimes have to accept that there have been lots of changes and that something has changed up here that may have caused it.

Bob Doris: I know that this is the Health and Sport Committee, but it is encouraging that you are in early talks with Audit Scotland about the best way to manage that.

Judith Ainsley: Yes. Two people from Audit Scotland are coming to the next learning session. The committee is welcome to send two representatives to that session.

Bob Doris: I see my fellow Public Audit Committee member, Colin Keir, sitting there desperate to ask a follow-up question. He might have to resist.

The Convener: Richard Lyle has beaten him to it.

Richard Lyle: There was one question that I meant to ask that slipped my mind. Children are seen by health visitors up to about age three and then move on to the education side. Should we not have a straight line that follows how children develop over the years, rather than moving children from one agency to another?

Shirley Laing: That is part of the beauty of the early years collaborative. When we were designing the collaborative, there was no template. It has never been used on a multi-agency basis. Judith Ainsley has already touched on the fact that some families have 20-odd agencies working with them. My colleagues and I felt that the most straightforward way of looking at this complex environment was to do it on the basis of age and stage. That is why it is broken down into minus nine months to a year, a year to 30 months and so on. We could have done it in a variety of ways.

At the outset, most practitioners could identify closely with one of the workstreams—for example midwives and health visitors see workstreams 1 and 2 as theirs, and educationists see their interests coming in from workstream 3, which is the pre-school area—but by bringing all the practitioners together as a multi-agency team at the learning sessions, this method starts to build knowledge and understanding of the educational things that are happening in the very earliest years. We know all about brain development and so on from zero to three. Health practitioners then start to feed their knowledge into what is happening upstream. We get a blend of skills.

Social work can be involved at any point, because this starts on the basis of a universal approach, with targeting as needed. Depending on the particular vulnerabilities of a child or family, they may have a social worker assigned to them from very early on. This approach and method should break down some of the artificial barriers between practitioners, while still recognising and valuing the professional skills and expertise that each group of practitioners brings to the table.

The Convener: Aileen McLeod mentioned international comparisons. Evidence that we have had on inequalities stresses the importance of economic equality and why all this matters—or indeed whether it matters. I am getting to my question. Shirley Laing mentioned Harry Burns, who retweeted something that was published in an article by the Harvard school of public health. The opening line of that article is:

> "If you want to narrow health inequities, be bold. The most practical action you can take is not narrow incrementalism".

Tell me what is bold about the early years collaborative.

11:15

Shirley Laing: It has never been done anywhere in the world before, and the world is watching what we are doing.

On another level, it is bold because it brings together in the one place everyone who works with children and families to learn with and from one another and to challenge one another. That is done in a safe place and with a framework in which, for each point, we ask, "What is the aim? What are we trying to do? What is the change that we think we can make that will lead to that improvement, and where is the data that demonstrates that?" Without data, we have only a theory. When we bring data to the table, the theory becomes powerful and everyone will take on board what is being said and will look at their practices and think about how to improve them. The improvements start on a small scale and can be incremental.

I have just remembered a point that was made earlier that I want to come back to. Civil servants often put out policies, strategies and new ways of doing things, and we often pilot stuff and evaluate it. For me, the different thing about the early years collaborative is that it operates in real time, so the minute we know that something is not working, we stop doing it, change it and do something else. However, when we know that something is working and we can prove that it not only works for one child and family but can be scaled up and will continue to give that improvement, we embed it into practice and then move on to the next thing. That is what is bold and different.

Judith Ainsley: From the point of view of the practitioner, they are required to accept that not everything that they have done so far has been the best it could be, and that they could change some things. That is really difficult for people—change is really difficult for people. People are required to say when they have tried something that has not worked, and they need to be bold to do that, too.

The Convener: That is a good point. My impression from this morning—it is only a personal one, as the committee has not discussed the matter—is that much of the effort is targeted at the professionals to create change. We are early in the process, but at this stage I do not see the connection to and impact on the 20 or 30 per cent

of children who are not being reached. I am anxious that we need to get to them sooner than we plan. Anyway, that is the job that we have in this short inquiry.

On behalf of the committee, I thank the witnesses for attending and for their patience and the evidence that they have given.

Petition

Speech and Language Therapy (PE1384)

11:18

The Convener: Item 3 is petition PE1384. As members will have noted from their papers, the suggestion is that, as we have probably done as much as we can on the issue, we move towards closure of the petition. However, if members are minded to do so, there is the option of taking evidence from the Minister for Public Health before we close the petition. Do members have any comments?

Bob Doris: We have had a detailed reply from the Minister for Public Health. I was going to suggest closing the petition, but I have changed my mind, because I think that it is only right that we give the petitioners the opportunity to respond to the information from the minister.

I know that we usually discuss our work programme in private, but I suspect that it will provide the opportunity for some petitioners to come to the committee to talk about a variety of issues. I suggest that we keep the petition open and seek an opportunity in the general course of the committee's work at which the petitioners can respond to the minister's reply. Rather than close the petition, we should keep it open and give the petitioners a formal opportunity to respond at a later date.

The Convener: Does the committee agree to keep the petition open and seek an opportunity in our work programme to give completion to the petition?

Members *indicated agreement.*

The Convener: We previously agreed to take item 4 in private.

11:20

Meeting continued in private until 12:05.

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