The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 2 December 2014

Session 4

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HEALTH AND SPORT COMMITTEE

32nd 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)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Penny Curtis (Scottish Government)
Theresa Fyffe (Royal College of Nursing Scotland)
Dr Ron Gray (NHS Greater Glasgow and Clyde)
Jamie Hepburn (Minister for Sport and Health Improvement)
Dr Anne Mullin (General Practitioners at the Deep End)
Dr Lucy Reynolds (Royal College of Paediatrics and Child Health Scotland)
Dr Charles Saunders (British Medical Association Scotland)
Jayne Sellers (NHS Greater Glasgow and Clyde)
Carol Sibbald (Scottish Government)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 2 December 2014

[The Convener opened the meeting at 09:45]

Interests

The Convener (Duncan McNeil): Good morning and welcome to the 32nd meeting in 2014 of the Health and Sport Committee. I ask everyone in the room to switch off mobile phones, which can interfere with the sound system. The perceptive among you will see that some committee members and officials are using tablet devices, but they are doing so instead of having hard copies of our papers.

We have had some changes in membership, and I give a genuine welcome to Mike MacKenzie and Dennis Robertson as new committee members. Under agenda item 1, I give our new members the opportunity to declare any relevant interests.

Dennis Robertson (Aberdeenshire West) (SNP): I direct members to my entry in the register of members' interests but, as far as health and sport are concerned, I really have nothing to declare.

Mike MacKenzie (Highlands and Islands) (SNP): I have no interests to declare, convener, but I direct members to my entry in the register of members' interests.

The Convener: Thank you very much.

Subordinate Legislation

Public Bodies (Joint Working) (Integration Joint Monitoring Committees) (Scotland) Order 2014 (SSI 2014/281)

09:46

The Convener: Agenda item 2 is consideration of five negative Scottish statutory instruments.

On SSI 2014/281, no motion to annul has been lodged, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to the order as detailed in members' papers. If members have no comments, does the committee agree to make no recommendations on the order?

Members *indicated agreement.*

Public Bodies (Joint Working) (Local Authority Officers) (Scotland) Regulations 2014 (SSI 2014/282)

Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 (SSI 2014/283)

Public Bodies (Joint Working) (Prescribed Days) (Scotland) Regulations 2014 (SSI 2014/284)

The Convener: No motion to annul any of the instruments has been lodged, and the Delegated Powers and Law Reform Committee has made no comments on them. If members have no comments, does the committee agree to make no recommendations?

Members *indicated agreement.*

Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (SSI 2014/285)

The Convener: No motion to annul the order has been lodged, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to it as detailed in members' papers. Do members have any comments?

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have two comments.

First, I am not quite sure what is meant by

> "the proper officer of the integration joint board"

in article 3(1)(e), as opposed to the

> "the chief officer of the integration joint board".

Presumably, as the person in question will come from local government, they will be in addition to the “chief social work officer”.

Secondly, the order mentions representation on the board by two doctors and a nurse, but it does not refer to allied health professionals. Of course, they might be appointed under article 3(8), which says:

> “the integration joint board may appoint such additional members as it sees fit”.

I am slightly disappointed by the fact that there is no specific mention of allied health professionals, who, in my view, will be fundamental to ensuring the success of the integration project.

The Convener: Does the committee agree to forward Dr Simpson’s comments to the appropriate minister for clarification?

Members *indicated agreement.*

The Convener: Despite those comments, does the committee agree to make no recommendations on the order?

Members *indicated agreement.*

The Convener: Thank you.

Mental Health (Scotland) Bill: Stage 1

09:50

The Convener: Agenda item 3 is the final evidence-taking session for our stage 1 consideration of the Mental Health (Scotland) Bill. In this session, we will question the Scottish Government. Welcome to the meeting, minister, and congratulations on your recent promotion. We are pleased that you could make it to the Health and Sport Committee, and we look forward to working with you in your new role.

I formally welcome Jamie Hepburn, the Minister for Sport and Health Improvement, and his Scottish Government officials: Carol Sibbald, Mental Health (Scotland) Bill team leader; Penny Curtis, acting head of the mental health and protection of rights division; and Stephanie Virlo—what is it? [*Interruption*.] The clerk tells me that it is Virlogeux. That is a difficult one for me this morning, I can assure you.

I invite the minister to make an opening statement.

The Minister for Sport and Health Improvement (Jamie Hepburn): Thank you for your welcome, convener. I should tell you that I, too, had to check with Stephanie how to pronounce her surname, so I understand where you are coming from.

First of all, I realise that this evidence session got caught up in the changeover of ministers, and I apologise if that has delayed the committee’s consideration of the bill. That said, I am delighted to be here in my first appearance as Minister for Sport and Health Improvement, and I look forward to working with the committee. The First Minister has stated that she is seeking a consensual approach, and I hope that that will be a hallmark of our work together.

Before I get to the bill, convener, your clerk had asked for a run-down of my responsibilities, and I am happy to provide that to the committee.

The Convener: That will be useful.

Jamie Hepburn: Along with mental health—which will be an absolute priority area for me, and I will be seeking to engage early with stakeholders in the sector—my portfolio covers dementia, restricted patients, autism and learning disability. All of that sits alongside along matters such as continuing the legacy of the Commonwealth games and action on obesity, physical activity and healthier working lives. Policy for carers, self-directed support and older people’s health also sits with me, while my colleague Maureen Watt, the Minister for Public Health, will oversee a wide range of issues, including health protection, alcohol and tobacco, and child and maternal health. I am sure that she, too, is looking forward to discussing her role with the committee.

With regard to the bill, I acknowledge the work that the committee has done thus far in its evidence taking. The evidence has been helpful for me as someone who has come to the issue somewhat late on in stage 1, and I am sure that it will also be helpful for the committee's new members.

The overarching purpose of this amending bill—it amends the Mental Health (Care and Treatment) (Scotland) Act 2003—is to make a number of changes to current practice and procedures to ensure that people with a mental disorder can access effective treatment in good time. In doing so, it seeks to build on the principles of the 2003 act.

However, the bill also proposes the implementation of a victim notification and representation scheme for victims of mentally disordered offenders who are subject to certain orders. The scheme will put such victims on the same footing as victims who are currently eligible to be part of the criminal justice victim notification scheme.

I welcome the high level of stakeholder engagement with the bill. There were more than 100 responses to the Scottish Government's consultation on its proposals for a draft bill, and the committee received nearly 70 written submissions following the stage 1 call for evidence. The committee has also had four evidence sessions, which stimulated some interesting discussions. I acknowledge the continuing stakeholder input. A small working group has already been convened to look at the necessary revisions to forms that will flow from the bill, and a second small working group will be convened shortly to consider any necessary revisions to the code of practice.

I will do my best to answer members' questions, and I look forward to reading your stage 1 report when it is available.

The Convener: Thank you, minister.

Richard Lyle (Central Scotland) (SNP): Good morning, minister. I welcome you to your post and wish you well.

My question concerns two submissions to the committee: the written submission from the Convention of Scottish Local Authorities and a letter from the Finance Committee.

COSLA commented in evidence that

> "MHO reports would be triggered in far more circumstances than the financial memorandum anticipates."—[*Official Report, Health and Sport Committee*, 7 October 2014; c 10.]

In its written submission, COSLA states that it is

> "concerned that the scope of new duties on MHOs is unclear at this stage … However, it is clear that the additional cost set out in the financial memorandum is an underestimation of the costs associated with the measures contained in the actual Bill".

In a letter to the committee, the Finance Committee highlights the fact that COSLA

> "suggested that the total number of hearings requiring a report could be in the region of"

more than 500

> "as opposed to 20 and 40 as stated in the FM. As the FM estimates a cost of £475 per report this suggests an overall annual cost to local authorities of over £281,000 instead of the £18,000 noted in the FM."

What is your view on those two submissions?

Jamie Hepburn: Given that I was a member of the Finance Committee when that letter was written, you might think that I have created a rod for my own back. We have looked into the matter and—in a nutshell—COSLA's analysis is correct. I should clarify that I have been advised that there is a discrepancy between the bill and the accompanying documentation, which has resulted in understandable confusion and concern about the number of reports that mental health officers will be required to complete. I accept that COSLA is correct in its assessment of the difference between the policy memorandum and the financial memorandum.

The policy intention is that a mental health officer will be required to produce a report when the tribunal is required to review a responsible medical officer's determination to extend a compulsory treatment order or a compulsion order in two specific situations, not the three specific situations that are described in the explanatory notes accompanying the bill. The two specific situations are when there is a difference between the type of mental disorder that the patient has now and that which was recorded in the original compulsory treatment order or compulsion order; and when the mental health officer disagrees with the responsible medical officer's determination to extend the compulsory treatment order or compulsion order. A third situation was included erroneously.

We accept that COSLA's analysis is correct but, on a practical level going forward, we estimate, on the basis of the most recent hearing figures from the Mental Welfare Commission, that a mental health officer is likely to be required to produce a report as a result of the proposals in fewer than 15 cases a year—that is the total for Scotland as a whole. If we go with the £475 cost per report to which you referred, we can see that the global cost—based on the most recent year—would be £7,125 spread across all local authorities.

I apologise to the committee and to COSLA for the understandable confusion that the error caused.

Richard Lyle: To be clear, can you remind the committee how many hearings there were last year?

Jamie Hepburn: This is a slight revision to what was set out in the financial memorandum, as the figure at that time was slightly higher. In the past year, there were 15 cases.

10:00

Dr Simpson: My first question is on the same point. The minister has helpfully clarified that there will be only a modest increase in work for MHOs. However, last year, in the Greater Glasgow and Clyde area, there was no MHO report for about 60 per cent or more of detention orders. The annual monitoring report from the Mental Welfare Commission for Scotland indicates concern that, in relation to detention in Scotland as a whole, an MHO report is provided in only about 55 or 56 per cent of cases; I think that that is the figure—it is somewhere in the mid-50s anyway. Clearly, MHOs are already under enormous pressure. Although the increase in work will be modest, I hope that the minister and his team will consider closely whether the funding is adequate to ensure that MHO reports are provided.

My question is about the generality of the bill. It is a fairly narrow bill that is focused on the McManus report, but we heard evidence, both from Steve Robertson from the learning disability group People First (Scotland) and at last week's round-table session, that, because of new information on and knowledge of neurodevelopmental disorders, we should consider a more extensive review of the Adults with Incapacity (Scotland) Act 2000 and the mental health legislation. Have the minister and his team seen that evidence? Does the minister have any comment on whether a broader review is necessary or whether we should tackle the issue by amending the bill to broaden its scope?

Jamie Hepburn: On a longer-term review of incapacity legislation, the committee will be aware that the Scottish Law Commission has recently reported on adults with incapacity. The Government is actively considering that report and we are thinking about how we can look more broadly at issues of restriction of liberty and capacity, and about the best way to deal with that against the background of what is a complex operational landscape. Work is on-going on that, so I cannot say much more on the issue now, but I accept that it is important. We will of course come back to the committee with details of the Government's consideration in due course. I am acutely aware of the views of many people with learning disabilities and autistic spectrum disorders that their specific conditions are not dealt with in the bill.

If the bill removed those conditions from the scope of the 2003 act, protective legislation would of course still be required, as Dr Simpson has acknowledged. That could be argued to add another layer of complexity to what could be felt to be an already complex legislative landscape. Indeed, it could result in some people with such conditions finding their care impacted on by up to four pieces of legislation—mental health legislation, incapacity legislation, adult support and protection legislation and whatever new legislation would have to be put in place.

I said that I want to have an open dialogue with the mental health sector but, equally, I want to have on-going dialogue with the representative organisations for people with those conditions. Indeed, tomorrow, I will attend the autism conference in Glasgow. I say to those organisations and the committee that my door is always open and that we are happy to consider those matters. However, to be absolutely clear, we have no current plans to remove people with learning disabilities or autistic spectrum disorders from the scope of the 2003 act.

Dr Simpson: Thank you—that is helpful.

I move on to a more specific point, which is the proposed extension of the period for the confirmation of orders from five to 10 days. When McManus proposed that, the number of mental health tribunals that had to be postponed or repeated was much higher than it is today. I pay tribute to the current president of the tribunal, who has reorganised the administrative approach in such a way that the number has dropped substantially and will, we hope, continue to drop.

Is the extension from five to 10 days still an appropriate measure, or might it have the unintended effect that many more applications from RMOs or MHOs will be automatically delayed and, therefore, the period of detention would be extended? The bill says that any additional time would be taken off the next order, but that is no compensation for someone who feels that their order is inappropriate in the first place.

I appreciate that the number of emergency detention orders under the 2003 act has been reduced by two thirds, which is extremely welcome, and the number of short-term detention orders does not seem to have increased. We appear to have got it relatively right, but do we really need the extension now? If we do, should the power not be exercised under the specific condition that the applicant from the mental health side or the individual to whom the order is intended to apply or who will appear in front of the tribunal for a new order seeks to have an extension for a specific purpose? In other words, will regulations define absolutely and clearly the terms of the power so that we do not get the unintended consequence that I described?

Jamie Hepburn: We do not want any unintended consequences with any aspect of the bill. We might want to touch on this later, but the regulations will come before the committee, so the committee will be able to consider them.

I am looking through my notes because I have a summary of the evidence that the committee has taken and I know that the matter was touched on. Like you, I welcome the fact that the number of repeat, delayed and rearranged tribunals has dropped but I am aware that tribunals can still be repeated, delayed or rearranged. We want to minimise that because it always has an impact on the person who appears before the tribunal. Therefore, we still think that section 1 is an effective provision.

I understand that, for good clinical reasons—which can vary from case to case because we are talking about clinical judgments in specific circumstances—applications for compulsory treatment orders might not reach the tribunal until late on. That can create quite a tight notification period for the tribunal and service users—there might not be sufficient time to arrange notification and named persons might have difficulty arranging time off work at short notice. That is what leads to hearings being adjourned, which we want to avoid, because additional hearings can exacerbate the circumstances and the stress for service users.

In the round, we think that section 1 is still an effective provision but, if the committee cares to offer comment on it, we will examine that closely.

To go back to first principles, of course we want to avoid any unintended consequence arising from regulations. The committee will have a crucial role in assessing and providing feedback on the regulations.

Dr Simpson: I accept that it is a fine balance. We do not want to put the person to whom the order applies in the position of having unnecessary repeat, rearranged or delayed tribunals. However, it would be helpful to the committee if we could get further information and up-to-date figures on the matter and an indication of the precise reasons for current delayed, rearranged and repeat tribunals. That would inform us as to whether the balance is still right, given that McManus reported five or six years ago. If that is possible, it would be extremely helpful to us in coming to a conclusion in our stage 1 report.

Jamie Hepburn: Absolutely, Dr Simpson. I see that the officials either side of me are assiduously scribbling, so they have already taken note of that. We will, of course, get that information to the committee.

Dr Simpson: Thank you.

Bob Doris (Glasgow) (SNP): A number of MSPs wish to make points in relation to the matter raised by Dr Simpson. I point out that the Mental Welfare Commission and the Mental Health Tribunal for Scotland both supported the increase in the extension from five to 10 working days. They said that, in a good week or a good month, about 20 per cent of hearings still went to repeat hearings or multiple hearings because reports were not prepared, for a variety of reasons. We have to drill down to find the reasons for that.

We should do anything we can do to avoid multiple hearings. It could be a case of not getting the views of the named person, and I am conscious that there are reforms to the named person process under the bill, which could create a knock-on effect, so I would be keen for you to take cognisance of that if you continue with the increase in the extension from five to 10 working days.

My question is twofold. First, I am content that, as long as the increase in the extension from five to 10 days is not just seen as an administrative convenience but is viewed as meaningful to those under short-term detention, it is a balanced and proportionate step for the Government to take. I would like some reassurance that the Government will monitor the reasons for the five to 10 working days being deployed by relevant professionals, so that the extension is to the benefit of the person under short-term detention, rather than being for the administrative convenience of professionals. If I could be reassured on that first point, I would be content.

Secondly, concerns were raised at last week’s meeting about compliance with the European convention on human rights. I made the mistake of asking two lawyers for their opinions on the matter, and I got 17 different views—which was quite helpful. That is perhaps slightly unfair. I should point out that the lawyers were witnesses at the committee and were not giving it legal advice.

One of the lawyers said that the new arrangements will potentially be less compliant; the other was content that they will still be compliant. The situation was as clear as mud at the end of that discussion. There seemed, however, to be a general feeling about it. The concern that was voiced last week was that the extension could be used inappropriately or used uniformly across the board. I am determined to ensure that we get this right not just with regard to the administration of the system but also with regard to the human rights of all our constituents who could be subject to detention orders.

Information on both those aspects would be welcome.

Jamie Hepburn: Thank you for those questions, Mr Doris. I note your point that both the Mental Welfare Commission and the Mental Health Tribunal support the measure, which I think is for the same reasons that the Government wishes to pursue it. It is not about administrative convenience; it is about ensuring the best provision of service for those who appear before them.

I return to my earlier point. Although there are fewer rearranged hearings, there are still some, and we wish to minimise them, as they are stressful for service users. That is the primary motivation when it comes to giving service users and their named persons the chance to prepare for any hearing properly; I repeat that the motivation is not about administrative convenience.

You also asked about monitoring. I can assure committee members that the bill team will discuss with the tribunals service the type of markers that can be put in place to monitor the throughput of cases as a result of the proposed change. We of course have to monitor any legislative provisions that we put in place to see whether they are effective.

On the second issue, ECHR compliance, I think that getting only 17 views from two lawyers is arguably a pretty good job. We are convinced that the provision is ECHR compliant, and I think that that is fundamentally important. I used to be the convener of the cross-party group on human rights and I care deeply about human rights issues. I note the comment from the Faculty of Advocates on compliance with the convention, which centres around whether the change is proportionate. The intention behind the provision is, as I have said, to benefit the service user, so on that basis we think that it is a proportionate change. We consider that all the provisions of the bill, including this one, achieve the end of being compliant with the ECHR across the board.

10:15

The Convener: The general point was that the provision could be challenged because, although the current arrangement is compliant, we are going into an area where there could be challenge. That is what I took from last week's evidence, which raised some interesting issues for discussion. If the officials who are with us today have not had time to read last week's evidence, it is worth considering how practitioners think the process works, what time people currently spend in the system, and whether it can be improved or diminished.

Jamie Hepburn: Let me make it absolutely clear that we will look carefully at every bit of evidence that the committee has gathered, particularly with reference to your stage 1 report. On your point about the feeling that the provision could be subject to challenge, I would say that any legislation that the Parliament passes could be subject to challenge. The question, of course, is whether such a challenge would be upheld in the courts, but that is the nature of the Parliament's competence.

We consider that the provision is compliant with article 5 of the ECHR. I think that I am right in saying that article 5 does not definitively set out a time period for which a person can be detained, so we think that the extra five days, given the safeguards that we have put in, will not fall foul of ECHR requirements. Of course, we will look at every bit of available evidence, because we want to get it right.

The Convener: I have a couple of bids from members who wish to ask questions.

Dennis Robertson: From what you are saying, minister, I take it that we are looking at the extension as an exception, rather than the rule. If particular conditions were to arise, would the flexibility of the extension allow factors such as the geography of remote rural areas of Scotland or inclement weather to be taken into consideration?

Jamie Hepburn: Accessibility for rural areas is not really the motivation for the change.

Dennis Robertson: I am not saying that it is the motivation. I am asking whether the change would give you the ability to be flexible. We are not discriminating against people who live in remote and rural areas—far from it—but I am suggesting that factors such as inclement weather could make the extension necessary. In some cases, it could happen that a person cannot return home not because of mental health issues but because of other factors.

Jamie Hepburn: I suppose that we cannot rule out any possibility. Although I recognise that it takes longer to get to more remote and rural areas, the increase in the extension from five to 10 days is not intended to address such factors. I repeat that the change is driven by efforts to improve the experience for service users by giving them time to get ready for their appearance before any tribunal. That is the motivation. We might well explore other areas in which the issue of accessibility for rural and remote areas is more pertinent than in this case.

Dennis Robertson: You are primarily saying that it is the exception rather than the rule.

Jamie Hepburn: I will bring in my officials in a minute. It is the rule in the sense that the period is automatically extended by 10 days. Of course, we always hope that these matters can be expedited as quickly as possible.

Carol Sibbald (Scottish Government): As Dr Morrow said in his evidence, the tribunal will always work at holding the hearings as quickly as possible. As the minister has said, the main point is to assist service users and named persons at what can be a stressful time by ensuring that their case can be determined at the one hearing.

On the points that have been made about setting conditions, the committee might want to consider that the timescale is relatively short and that we can sometimes overcomplicate things. I saw in some written evidence that people might like certain specific circumstances to be set out, but that means having to define those circumstances and decide whether that has to be set out in legislation. It is not that those conditions could not be considered but, in the timescale involved, what we are proposing is a reasonable alternative. As the minister has indicated, should section 1 pass through the parliamentary process, we will monitor its usage. We will also beef up the text of things such as the code of practice, which is under revision, in relation to responsible medical and mental health officers submitting applications at the earliest opportunity.

Jamie Hepburn: Carol Sibbald made an important point. We do not want to overcomplicate the system. Mr Robertson asked whether we are talking about the exception rather than the rule and I am aware that the committee took evidence about this. In fact, I think that it was Mr Doris who asked whether section 1 could be an exceptional provision. I understand the intention behind that point, but Carol Sibbald has set out why that could be seen to be overcomplicating matters.

I make no apologies for making this point again. I want to make sure that we give service users an improved experience and minimise the stress that the system can cause. Let us face it: the system is going to place people under some duress and we want to minimise that as far as we can. If we add another layer of exceptional circumstances, that might make the service user or the named person wonder whether it is something else for which they need to apply. We want to keep the provision as straightforward as possible, but if the committee makes any comments on that, we will look closely at the evidence.

Nanette Milne (North East Scotland) (Con): The bill is silent on the issue of advocacy, which was raised in all the evidence sessions and is clearly important to all the witnesses. Many of them highlighted how advocacy provision across Scotland is quite patchy. The Mental Welfare Commission felt that the 2003 act is quite strong on advocacy rights, but it questioned whether it is being properly implemented across the country. It suggested that

> "The Government might commit to proper auditing of the availability of advocacy and the performance of local authorities and health services."

Do you have any comments on that? I have another question to ask afterwards.

Jamie Hepburn: Let me say at the outset that I am a strong supporter of advocacy, which I think empowers people. I have worked locally with independent advocacy organisations, albeit probably in a different context from the one that we have discussed today—although it occurs to me that the organisation concerned may well interact with the framework that we have put in place to help people with a mental disorder. I am a strong supporter of advocacy.

Forgive me if I am wrong, but I think that the committee was considering the matter in relation to the position of carers in particular, if I remember correctly. Preliminary discussions have taken place between officials and the Care Inspectorate, which is the independent scrutiny and improvement body for care services in Scotland, regarding the possibility of the inspectorate's programme of audit including a review of how well local authorities are meeting their duty to provide advocacy.

That is something that we take seriously, and the work is on-going. If the committee feels that that is too narrow, we can reconsider the matter, but let me assure you that I, too, think that this is a very important matter.

Nanette Milne: My second question was going to be on carers, in fact. There was quite a strong feeling on the part of organisations such as the Scottish Association for Mental Health that there is nothing in the bill to strengthen advocacy.

Jamie Hepburn: I return to an earlier point. The bill before us is an amending bill. It is not a matter of starting afresh; the bill amends the 2003 act. The point that those organisations are making is that the 2003 act is pretty strong in this area. The question is whether the provisions of the 2003 act are being fully met. We will consider that. I do not know whether there is necessarily a requirement for legislative provision at this stage.

There is a general point across all our discussions today. No matter what aspect of this area the committee comments on in its stage 1 report, we will examine it very closely.

Nanette Milne: I appreciate that—thank you.

Mike MacKenzie: In doing my homework for this meeting, I was pleased to note that a lot of the witnesses had placed a high emphasis on the importance of advocacy. I will pick up on that theme. How far could the accountability mechanism for the provision of advocacy be directed towards an examination of the special challenges of geography that we experience in the Highlands and Islands?

The Arbuthnott formula for health funding contains a provision for rurality, as has the grant-aided expenditure formula for local authority funding. Therefore, it seems reasonable that rural authorities ought to make provision for rurality in deciding what resources they make available for advocacy organisations. I am interested to hear from the minister—in pursuing the accountability mechanism or in considering accountability—to what extent there is proper provision of advocacy and how far rurality can be taken into consideration.

Secondly, we all agree that it is absolutely important to increase provision of and access to independent advocacy if at all possible, but to what extent is it possible to say that advocacy is genuinely independent? Advocates and advocacy agencies are very conscious of the fact that funding may well come from the very agencies that they sometimes have to challenge.

Jamie Hepburn: Mr MacKenzie is not the only one who has been doing his homework at the weekend, after coming to the bill a little later than might have been felt to be ideal.

In the legislative framework, those are clearly matters for local authorities. I have already pointed out that there are on-going discussions about how we can look at how well local authorities are fulfilling their legislative duties. I suppose that we can try to factor in issues of rurality. As with most things in life, it is just that little bit more difficult in rural areas. It is certainly something that we can reflect on.

10:30

On the question of how independent the advocacy agencies are, that is in the eye of the beholder, as with anything. In my experience, despite it often being the case that such agencies require core funding from the very bodies to which they may be making representations on behalf of their client base, they are assiduously clear about the need to be independent of those organisations, and they take that responsibility seriously. Of course, we are talking about a huge range of different organisations and no one situation will be precisely the same as any other.

Mike MacKenzie: Do you agree that the constructive criticism and analysis that advocacy agencies can provide on common issues can be extremely useful for the authorities that they engage with? I am aware that some authorities appreciate the value of that feedback mechanism, while others do not. Is there anything that you as a minister can do to encourage that positive feedback loop?

Jamie Hepburn: Criticism can sometimes be difficult to take, but if it comes your way you have to reflect on what has been said, and if there are areas that you need to improve on, you need to look at them. It is difficult to make a general comment about that. I do not know whether there is a specific situation that Mr MacKenzie has in mind, and even if there is I am not sure that I will be able to comment on it, but I certainly think that the process of constructive feedback can allow organisations to continue to improve their work. That is an issue not just for local authorities but for the bodies that are relevant to the bill—the commission and tribunal—and for the Government, because we also need to hear what is said.

The Convener: The minister said earlier that we should not expect any increased capacity in advocacy as a result of any part of the bill. Members have mentioned, and it is reflected in the evidence, that the bill complements all the Government’s legislation in relation to delivering advocacy on the ground, particularly as good advice is available on avoiding delays. Has the Scottish Government audited or evaluated advocacy services? Whether it is true or whether it is a perception, people feel that provision in rural areas is likely to be patchy. In urban areas, there is more availability, but the problem may be access. There is a question about whether the Government’s objectives and policies are working effectively for the people for whom we want them to work, and advocacy is a key aspect of that. Is there any recent work that suggests that there is a problem, or has there been an audit of the services? Are health boards meeting their responsibilities?

Jamie Hepburn: I say first that the answer depends on what kind of advocacy organisations we are talking about. There are some organisations that relate specifically to the bill, and I have referred to some of the on-going work, but I am aware that they will interact with elements of the public sector on a wider basis than just the area of the health service that we are discussing. I reiterate that there is, of course, dialogue with the Care Inspectorate on assessing how well local authorities meet their advocacy duties under the 2003 act.

The Government is working to produce guidance on advocacy for carers, with the aim of launching it early next year. The guidance will be a useful tool in making people more aware of their right to advocacy and the existence of advocacy organisations.

The Convener: I am looking also to your officials. Has there been an evaluation of advocacy services and where they are effective, sparse, properly funded and so on?

Jamie Hepburn: I have to tell you that I need to look to my officials on that, too.

Penny Curtis (Scottish Government): I am not aware that there has been such an evaluation. The minister talked about our work with the Care Inspectorate, which is at an early stage and very much reflects some of the views that have been expressed in evidence on the bill. We will look at the Care Inspectorate’s work programme to ascertain whether we can accommodate the matter within it. We absolutely want to reflect on what people are saying.

Jamie Hepburn: If the convener is proposing a review of advocacy organisations, we need to be clear about what we would be asking about. If the issue is the provisions in the 2003 act, work is going on in that regard, but if the issue is wider aspects of advocacy we might need to discuss that with colleagues elsewhere in the Government.

The Convener: I was asking mainly about advocacy support for mental health patients under the various acts—the bill tidies up the 2003 act. Practitioners have talked to us about the issue. I am not proposing a review; I was picking up Mike MacKenzie’s point about the perception that expert advocacy is not always available or funded. It has been claimed, at least, that the service is patchy across the country, and I think that the committee and the Government want to establish whether that is the position. That is what I was driving at. As we all recognise, we can legislate, but there might also be practical steps that we could take to address the evidence that we have heard and to make the legislation meet its objectives more effectively.

Bob Doris: The committee is scrutinising a bill in which advocacy does not come up. We often talk about advocacy in general terms, rather than thinking about what it means in the context of the provisions in the bill, so I was considering that while I was listening to the minister’s discussion with the convener. You raised the issue yourself, minister.

We have from time to time had fairly lengthy discussions about extension by five days of the 28-day short-term detention order, and about whether the extension should be for 10 days. I do not expect the minister to have the answer at his fingertips, but it would be good to know whether sometimes extensions are needed because service users or their families have not had appropriate advocacy that would have enabled them to engage with services and prepare reports. If that is so, greater access to advocacy might mean that an extension of 10 working days would not be needed and might avoid the need for multiple reports and hearings. That is a concrete example of an area in which advocacy could have an impact.

There are other such areas in the bill, such as the provisions on appeal against being held in conditions of excessive security, appeal against transfer from one hospital to another and the preparation of advance statements.

There are pinch points in the system, for which the bill makes provision and in relation to which the Government might consider how advocacy should be used and whether there should be additional advocacy responsibilities. For me, that would be more meaningful than a general review of advocacy across the board. Will the Government consider that?

The Convener: I was not calling for an overall review, but I was addressing the evidence that we have heard and the points that have been made suggesting that advocacy is not necessary in some specialist areas in which there is very much a legal process and there are services to provide that. I was also thinking about people being encouraged to nominate a named person and being more aware of how the service works at a lower level that complements the bill and the Government’s objective. I do not want to labour the point too much. After the minister’s response, enough has probably been said on the issue.

Jamie Hepburn: I do not think that you are labouring the point at all, convener. The committee is absolutely right to consider the area seriously. As I said, the provision of advocacy is important. We will look closely at any recommendations that are made and we will look again at your evidence. I am inclined to agree with the points that have been made by the deputy convener about advocacy playing a crucial role in improving the experience of service users at pinch points. That is a fair way of looking at it. I have said that the 2003 act already sets out the right to advocacy, and I presume—I will invite Carol Sibbald to comment in a moment—that that provision will still allow for the interaction of advocacy agencies at those pinch points, as Mr Doris described them.

I agree that we need to ensure that service users are aware of the function of the named person. I am conscious that some campaigning bodies and stakeholders have talked about having awareness-raising campaigns; they can be good for a short time, but once a campaign is over and done with its impact could be short lived. We need to look at how we can raise awareness from grass-roots level and build upwards from there. A number of organisations, including the national health service, local authorities and the Government, have crucial roles to play in promoting use of named persons. Of course, advocacy bodies themselves will want to tell people that they have a right to a named person. If the committee has a view on how we can better make people aware of the named person provision, we would be happy to look at your suggestions.

Carol Sibbald will comment on the 2003 act's provisions on advocacy.

Carol Sibbald: I would like to pick up on the comments about pinch points, which were absolutely correct. It is crucial that people have access to advice. Part of the role of mental health officer is to make individuals aware of their right to advocacy and to help to put them in touch with advocacy agencies. We often find that nursing staff are familiar with the good work that is done by advocacy agencies, so assistance can be given to individuals in the hospital setting in accessing advocacy services.

Rhoda Grant (Highlands and Islands) (Lab): The bill includes a provision to nominate a named person and a provision not to nominate a named person. However, if the person has done neither, the situation will revert to provisions under the 2003 act, and the next of kin would be put in the named person role. We have taken evidence from service users and carers, and they do not like the reversion back to the 2003 act's provisions, because the next of kin may not be willing to take on the role, or the service user may not wish the next of kin to have access to their medical records. Have you given any thought to changing that by amendment at stage 2?

10:45

Jamie Hepburn: I recognise that this is a sensitive area, and I understand the strong view that has been expressed by stakeholders who have engaged with the committee that service users should have a named person only if they want one. The Government is generally very supportive of that. Provision has been made for service users to opt out of having a named person.

You are correct to identify that if an individual has neither nominated a named person nor chosen to opt out, the role reverts back to the person's primary carer or nearest relative. You have made the point already: there could be many reasons why an individual—the carer, the next of kin or the service user—would not wish that to be the case. The Government wishes to retain the provision in the best interests of service users, as a form of protection for people who lack capacity. To be fair, however, and having reflected on what has been said to the committee, we have perhaps not struck the right balance, so we will be happy to reconsider the matter.

Rhoda Grant: Carers and next of kin have also expressed the wish to be able to refuse to be the named person if they are nominated but feel that they are not best equipped to carry out the role.

There has also been some discussion around what the role of the carer or next of kin would be. It was suggested that they should perhaps have a separate role to that of the named person, such that they might be consulted and would be able to speak, but without having the powers that are given to the named person. They could play a role in their own right that they felt comfortable with and able to fulfil without encroaching on the rights of the service user and without having to take on the full role of a named person. That would give different people different roles, but it might be in the best interests of the service user to have those different roles in place.

Jamie Hepburn: That is the flipside of the point that I have just made. As I reflect on the matter further, it could equally be the case that a carer or next of kin will not wish to take on the role, as you have said. We will reflect on that specific point, too. Unless there are exceptional circumstances in which a carer or next of kin should not be involved, it would be understandable if they wished to continue to play a role in relation to the service user.

The tribunal can hear from persons of interest, which would include a carer or next of kin. If it is felt that that does not cover the point that Rhoda Grant is making, we could consider the matter further, but the essential point is that such people can continue to play a role in the process without being the named person.

Dennis Robertson: I wonder whether there might sometimes be some conflict. For instance, if the relationship between the consultant psychiatrist and the members of the family is not good, and the named person is the next of kin, but the consultant feels that that arrangement is not in the best interests of the patient if they are going to proceed towards a better outcome, where do we stand? Do we go with the views of the consultant in saying that the main barrier to achieving a positive outcome is that named person? Do you have a view on that, minister?

Jamie Hepburn: I will bring in Carol Sibbald on that point in a minute. I do not want to say something that might be incorrect. Having read the notes, I think that there is provision for the removal of named persons, although I could be wrong about that.

In such circumstances, when there is a disagreement between the qualified medical professional and the carer or next of kin, that is very unfortunate. If the disagreement relates to the interaction with the tribunal, the tribunal will consider the matter and will come to a decision. Under the bill, there is an increased role for mental health officers by way of the provision of reports to tribunals when that is applicable. That would be another point of view. It is for the tribunal to rule, taking into account all the evidence that is placed before it.

I invite Carol Sibbald to comment.

Carol Sibbald: The minister has covered the main points. Any disagreements between both parties will be fully explored at the tribunal hearing. The tribunal will then reach a determination on the basis of the evidence that has been presented to it.

In relation to the removal of a named person, the minister is probably thinking of the provision that we have for children under the age of 16. If they currently have a named person but it is felt that that named person is not acting in their best interests or is not carrying out the role, there is provision for the tribunal, on the basis of the evidence that is presented to it, to remove that named person and appoint a more appropriate person. That will involve discussions with the mental health officer and others.

Under the new provisions, someone will have a named person only if they wish to have one, and the person who is nominated to be the named person must sign to say that they are content to take that role. In our view, there will be less opportunity, and therefore less need, for the tribunal to step in and remove a named person.

Jamie Hepburn: That is, indeed, the provision that I was thinking of.

Perhaps I should have made this point earlier. We hope that, in such circumstances, any disagreement or problems between the medical practitioner and the carer, next of kin or wider family will be resolved amicably before things reach that stage. Nevertheless, there must be provision for such circumstances.

Colin Keir (Edinburgh Western) (SNP): Good morning, minister, and congratulations on your promotion.

My question is on the aspect of the bill that deals with people under the age of 16. Was any consideration given to the inclusion of McManus recommendation 4.16? It states:

> "A young person under the age of 16 who has adequate understanding of the consequences of appointing a named person should be able to do so."

Jamie Hepburn: I think that Mr Keir is congratulating me on my promotion because we used to share an office and he has finally got rid of me after three years.

That matter has, indeed, been raised. Although it is important to allow a young person to express a view on matters that will directly impact on them, it is equally important to protect those who are most vulnerable, and it could be felt that young people are particularly vulnerable in that regard. An overwhelming majority of respondents to the Scottish Government's consultation on the bill did not say anything in relation to the matter. If Mr Keir or other members wish to make recommendations or comments on the issue in the committee's stage 1 report, we will consider them in detail.

Colin Keir: It is just that that particular issue about those aged 16 and under was brought up in another context, so I thought that I would ask about it.

I have one more question. I do not know whether you addressed this point earlier—perhaps you did and I missed it because I am bit cloth-eared this morning. I gather that the chair of the mental health nursing forum Scotland said, in effect, that the proposal to extend the nurse's holding power would not work. Can you comment on that?

Jamie Hepburn: Sure. Mr Keir can rest easy—we have not explored the issue thus far.

I will need to look again at that particular comment, but I do not think that the person in question went as far as to say that the provision would not work; the question was whether it was felt to be necessary. I recognise that there could be concerns that the changes to the nurse's holding power could result in the restriction of a service user's liberty, but the Government has made it very clear that the provision refers to a time period of up to three hours. The code of practice that we will put in place will strongly emphasise that the nurse must take all reasonable steps to contact a doctor and a mental health officer right at the start of the period and, equally, that hospital managers should impress upon their medical staff the need to make themselves available to examine the patient as soon as possible.

We would expect the detention to last only for as long as was required for the examination; in other words, the full three hours should be used only if that length of time is required. I also point out that, under existing powers, the current two-hour period can be extended by an hour, which means that, if the extension is put into effect right at the end of the two hours, the period can be more or less three hours already. Several stakeholders have recognised in their responses to the Government's consultation that the change should allow sufficient time for a medical examination to take place. They hope that it might reduce the number of occasions on which doctors have to apply for what could be an unnecessary 72-hour emergency detention certificate in order to complete a medical examination, given that such a move would have significantly more impact than the three-hour period.

The provision is driven by a desire to improve the experience for service users and should provide clarity for service users on the maximum period of time for which they can be detained under the nurse's holding power. At the moment, the period is two hours but it can be extended to three hours. It should also, I hope, make it clear to service users that they are being detained to enable a medical examination to be carried out.

Colin Keir: I apologise for having misquoted in my previous remarks. My memory is obviously not as good as the minister's. He is perfectly right—the chair of the mental health nursing forum Scotland said that there would be no advantage to such an extension.

The Convener: Indeed. He said that there would be no advantage to such a move, that it was not based on evidence, that it would impact on nurses' workload and that the idea had not come from nurses. The Mental Welfare Commission, too, opposes the move. It is certainly an issue that the committee should look at.

Colin Keir: It is my fault for not phrasing the point properly.

The Convener: No—you are right, Colin.

Is your question on this specific theme, Dr Simpson?

11:00

Dr Simpson: Yes, convener. The Mental Welfare Commission has reported that a nurse's order has been used on 177 occasions and that on no occasion did a doctor attend within the prescribed time. However, the two most interesting points in its submission are, first, that there is massive variation in the use of the orders—a quarter of them were made at the Royal Edinburgh hospital, which suggests that there is something not right about the way in which they are being applied—and, secondly, that there might be underreporting with regard to the NUR 1 form. We need further detail and some proper research done on what is actually happening. We also need to see what will happen as a result of the Mental Welfare Commission's response to its own report, which was to issue new guidance on the use of the nurse detention system.

Given the evidence that has been highlighted by Colin Keir and quoted by the convener, I am minded to suggest that we recommend in our stage 1 report that the change should not be made unless the Government can produce convincing evidence of the number of occasions on which, as the minister has just suggested, an emergency detention order has been employed because of delays. Given that the number of such orders has dropped from more than 3,000 to 1,000, I would need to see evidence of the number of occasions on which that has occurred before I would be prepared to support the change. After all, we are talking about a further small but nevertheless possible period of detention.

Jamie Hepburn: I take on board Dr Simpson's points, but I can tell him that, in its recent guidance, the Mental Welfare Commission says that the numbers involved will be reviewed. Moreover, the fact that the number of emergency detention certificates has dropped and there might not have been any recently does not mean that there is no possibility of utilising such certificates any more.

The proposal is to change the period in question from two to three hours; we are not proposing anything as drastic as an extension from two to 24 hours. I make the point again that, right now, nurses have the power to detain someone for two hours and that period can be extended by another hour. If that happens towards the end of the initial two-hour period, we might already be talking about a three-hour period.

The most important point—I am sure that Dr Simpson will accept this—is that the period in question should be up to three hours, as we want to ensure that such matters are dealt with as quickly as possible. We have already discussed issues of accessibility in rural areas and so on. When I said, in response to Mr Robertson's question on the extension from five to 10 days in another section of the bill, that there might be other areas of the bill in which such a move might be more about accessibility, I was thinking of this as an area in which such a change might make things easier in rural areas.

Nevertheless, we will consider the points that Dr Simpson has made. We do not want to do anything that is felt to be disproportionate or absolutely unnecessary, but we feel that there could be some advantage in formalising the three-hour period instead of retaining the possibility of the two-hour period being extended to three hours. As I have said, such a possibility might not be entirely clear to a service user, who might turn up in the expectation that the period will last only two hours and suddenly find that—bang!—it has been extended to three hours. If we make the change, the person will be clear from the outset that the period could last up to three hours.

The Convener: Richard Lyle has a question on the same subject.

Richard Lyle: It is on another subject, convener.

The Convener: That is good—we are moving on.

Richard Lyle: I want to ask about something that we have not yet covered: the wider review of mental health and incapacity legislation. Minister, you said that you are going to attend a conference on autism tomorrow. At a recent party conference, I had a discussion with Autism Rights. Autism Rights and Psychiatric Rights Scotland have called for the removal of people with learning disabilities and autistic spectrum disorders from mental health law. Inclusion Scotland has also commented that people with learning difficulties are concerned that they will be subject to compulsory treatment as a result of their learning disability alone. What consideration have you given to removing people with learning disabilities and autistic spectrum disorders from the scope of mental health legislation?

Jamie Hepburn: I touched on this earlier when I made it clear that I recognise that people out there hold such a view. We do not have plans to remove people with learning disabilities or autistic spectrum disorders from the scope of the 2003 act at this stage. I made the point earlier that, even if they were no longer covered by that legislation on the basis of their having a learning disability or an autistic spectrum disorder, the bill, incapacity legislation, adult support and protection legislation and new legislation would still encompass them. It could be felt that that would complicate matters, although that in itself is not necessarily an argument against such a move. As I said earlier, I will be happy to maintain an open and on-going dialogue with the representative bodies.

I suspect that you are talking about a party conference that I attended, and I confess that I did not have a conversation on the issue then. However, the First Minister has made the point that she wants this to be an accessible Government, so I will certainly be looking to play my part in relation to my portfolio, and I will be happy to speak with the representative bodies on that issue.

Richard Lyle: I am sure that the organisations that spoke to me will be happy with those comments.

Jamie Hepburn: I am sure that they will, and I look forward to meeting them in due course.

Dr Simpson: I have a question on the degree of security. The extension of the right of appeal to a medium-secure unit is welcome, but some of the evidence that we have heard suggests that it should be extended to low-secure units as well. Does the minister have any comment on that and on the extension of the right of appeal to civil orders?

Jamie Hepburn: It is an area in which we have to legislate because of the provisions of the 2003 act. It was the clear intent of Parliament that there would be a right of appeal. As it was framed at the time, the 2003 act addressed the need for someone to be transferred to another hospital, but, as I am sure Dr Simpson will appreciate, that does not reflect reality. In some settings, a person can be transferred from one part of a hospital to another part, which I hope the committee agrees is a lot better for the service user. However, the subordinate legislation that we would have liked to put in place was not possible under the scope of the primary legislation as it was worded in 2003.

There has, of course, been a ruling by the Supreme Court that emphasises the need for us to act swiftly. As I want to be as transparent as possible with the committee, I should also say that there is now a petition before the Court of Session on these matters. However, that is as much as I can say in relation to the issue for two reasons: first, that is about as much detail as I have at this stage; and, secondly, I do not want to fall foul of the Presiding Officer in terms of what is sub judice.

We have to get it right this time, and we are determined to do that. I am also aware that, as these are affirmative instruments, the committee will want to be able to assess their efficacy, so another good reason for getting them in place early is to allow the committee time to properly scrutinise the provisions.

The Scottish Government does not consider that there is necessarily a problem with patients being held in low-secure settings. The provisions relate to patients being held in “conditions of excessive security”, and we are not convinced that low-secure settings fall under the definition of “excessive security”, particularly since the next step in progressing patients in low-secure settings is getting them back into the community and it is open to the tribunal to order that as part of its on-going review of procedures, which is covered elsewhere in the 2003 act.

We are not convinced that there is a need to extend the right of appeal—beyond what we are doing in relation to people in medium-secure settings—to include people in low-secure settings. However, I make no apology for saying again that

I am keen to hear what the committee has to say, and if the committee makes recommendations on the matter we will look closely at them.

The Convener: The test of that will be your response to our recommendations.

Jamie Hepburn: I am aware of that. I could be making a rod for my own back.

The Convener: That will be a test for you as a new minister.

If members have no more questions, I will ask about registration of advance statements, which is provided for in section 21. The Mental Welfare Commission welcomed what it described as a

“modest and perfectly sensible provision”.—[*Official Report*, *Health and Sport Committee*, 30 September 2014; c 3.]

However, the commission also highlighted a matter that we heard about in evidence. We all recognise that if someone makes an advance statement when they are well it should improve their experience when they are unwell, but there has been a slow take-up of advance statements and the commission has said that the provision in section 21 will not in itself change that. We have heard that people have a notion that advance statements are not considered or acted on. Is the Government doing any work to promote advance statements? Have you talked to user groups about how we might do better in that area?

Jamie Hepburn: I am new to this, so I do not know what discussions have taken place. As I said, we will always be happy to have dialogue, but we have no plans to undertake research specifically on whether advance statements are underutilised and whether there are barriers to making them.

Advance statements are an important part of the process, and a register of statements, which will be held by the Mental Welfare Commission, will provide data on the number of advance statements that are made in Scotland and their geographic spread by NHS board. That will help us to build up a much better picture of how widely advance statements are being used. If need be, we will be able to respond to circumstances.

The Convener: I am sure that you have ideas for the future. Can the officials say what the historical position has been on how advance statements work and their slow take-up?

Carol Sibbald: It is a difficult issue. The register will help, because we will have everything in one place provided that health boards submit copies. We will then get a better picture. The anecdotal evidence is that take-up is quite good in some areas and perhaps not good in others.

There is the facility to override what is in the advance statement, and some people think, “What’s the point of making a statement if it is going to be overridden?” However, data from the Mental Welfare Commission show that that happens in a very small number of cases. We probably need to get that message out a bit better.

We recognise the good work that an advance statement can do, but an individual who is leaving hospital after a mental health episode probably does not want to start thinking about what they should put in place in case they are ill again—they want to think that they will not be ill again.

As the minister said in the discussion about named persons, it is about trying to raise awareness, from the grassroots up, of the effectiveness of an advance statement as a tool.

Jamie Hepburn: I suppose that one of the aims of the provision is to enable us to monitor the picture much better in the future.

The Convener: I accept that. I note that Carol Sibbald said that that will happen provided that health boards submit copies.

Carol Sibbald: There will be a duty on health boards—

The Convener: A clear duty?

Carol Sibbald: There will be a clear duty on health boards. The provisions in the bill require the health board to place a copy of the advance statement in the patient’s records and, at the same time, to send a copy to the Mental Welfare Commission.

Jamie Hepburn: As I remember from the evidence that the committee heard, the approach can improve the patient experience—I think that the deputy convener made that point. Currently, advance statements are held by the general practitioner and are not held centrally, so there is an issue if someone needs to access a statement quickly but the GP is not available. Again, the approach is driven by the desire to improve the service user’s experience.

The Convener: If you take note of what the deputy convener of the committee says, you will not go far wrong, minister—at least with him.

Bob Doris: That is not what you have said in the past.

The Convener: It was a pleasure to have you here for the first time, minister. We look forward to working constructively with you and your team in the future. I thank you all for your time and your evidence.

11:15

Meeting suspended.

11:21

On resuming—

Health Inequalities: Early Years

The Convener: Item 4 is a return to our early years inquiry, which is a piece of work that the committee is doing under the health inequalities theme.

Today we have a round table of health professionals. As usual, to help promote discussion, we will begin by introducing ourselves. To lay out the rules of engagement, we are interested in hearing from our invited panellists, and on all occasions I will give precedence to the panel over the politicians. Members of the committee will of course have an opportunity to come in and keep the discussion going, but I will look to the panel first.

I am the member of the Scottish Parliament for Greenock and Inverclyde and the convener of the Health and Sport Committee.

Dr Anne Mullin (General Practitioners at the Deep End): I am a GP from Govan in Glasgow and I represent GPs at the deep end.

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

Jayne Sellers (NHS Greater Glasgow and Clyde): I am a nurse team leader in Glasgow, working with homeless families and newly arrived asylum seekers. I am a health visitor by profession.

Dennis Robertson: Good morning. I am the MSP for Aberdeenshire West.

Dr Ron Gray (NHS Greater Glasgow and Clyde): I am a public health doctor in Glasgow and associate professor at the University of Oxford.

Richard Lyle: I am an MSP for Central Scotland.

Dr Charles Saunders (British Medical Association Scotland): In real life, I am a consultant in public health medicine in Fife and I am also the chairman of the British Medical Association Scotland's public health committee.

Colin Keir: Good morning. I am the MSP for Edinburgh Western.

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

Dr Lucy Reynolds (Royal College of Paediatrics and Child Health Scotland): I am also from Glasgow. I am a paediatrician and I work in Possilpark in north Glasgow, but I cover a wide area, including East Dunbartonshire, which is more affluent. I see kids with disability and developmental problems. I worked for 10 years as part of the maternal and child public health team in NHS Greater Glasgow and Clyde. I am here representing the Royal College of Paediatrics and Child Health.

Mike MacKenzie: I am an MSP for the Highlands and Islands.

Rhoda Grant: I am an MSP for the Highlands and Islands.

Theresa Fyffe (Royal College of Nursing Scotland): I am the director of the Royal College of Nursing Scotland.

Dr Simpson: I am an MSP for Mid Scotland and Fife.

The Convener: Thank you, all. To set us all off, the deputy convener, Bob Doris, is going to pose a question and we will see where that takes us.

Bob Doris: The convener informed me about four minutes ago that I was asking the first question, but I am delighted to do so. I have a general question. When I listened to the First Minister's statement last week on the new programme of legislation and policies, one of the things that jumped out at me in relation to health inequalities was the fact that the Government seeks to appoint a new independent adviser on poverty and inequality. That is of great interest.

I am keen to know what progress you think has to be made in promoting policies that tackle health inequalities. We have heard that a lot of the rooted aspects of health inequalities come from income inequality, so there is a variety of policies that are not directly at the coalface of healthcare but have a wider impact on the health and wellbeing of the people we seek to represent.

I am looking for initial comments on how you think the role of the new adviser could fit in with the public policy development that we are all involved in. Do you believe that the poverty impact assessment, which will be on-going under a new Scottish Government initiative, should have a specific reference to health inequalities as well?

Theresa Fyffe: Anything that sets the agenda around poverty and sets out health inequality is a good message. Much of the work that people are trying to do is invisible, so it is not easy to document or assess the impact.

I was very pleased to see the research that came from "Growing Up in Scotland", which talks about a couple of things that have come up in our nursing at the edge campaign. The most important thing is to get as close as possible to the marginalised groups and to be very aware of the impact that we can have on individuals. Too often we look at services as a whole. One of the things that come out of considering inequalities in groups is understanding how individuals react to services and how the focus can be on them.

When we are tackling inequalities for children, it is important to remember that the parents and the family are a big part of that. For example, work that is done with women who are offenders in prison who have children is a crucial part of looking at strategies for the child.

It is hard to look at the impact of other policies, so I would be interested to see what measures the adviser will set out to say whether something has made an impact. It is not easy to do that.

Dr Saunders: From the BMA's point of view, the vast majority of inequalities in health, whether they be in the early years or later on, do not arise from health. Health picks up the consequences of inequalities, which arise from the effects of Government policies, both here and in the south, and also from other Government actions and actions within society. The social determinants of health have far more effect on people's health than the NHS ever will. We are just trying to minimise the adverse consequences on people's health that those inequalities cause.

The Convener: Yes. Given the evidence that we have heard, the committee would accept that point in general, although we would not accept that there is not significant mitigation that can have a positive impact.

Bob Doris: I suppose that I was being deliberately general. It is not for me to predict what witnesses might say in reply to our questions, but there is a cluster of policies on the early years that we could talk about. We could ask Dr Mullin how she thinks the deep-end project and the link worker system help those living in poverty and in deprived communities, or we could talk about family nurse partnerships; the proposals on childcare and the balance between childcare for children's development and childcare as an economic necessity to allow mothers and fathers to go into employment; and the living wage policy of the Scottish Government.

I was trying to give a wrap-around test by which the committee can judge where a policy sits when we are looking at how we tackle health inequalities. I suppose that there is an opportunity for our witnesses to say, "Here's something that we think is working well and we would like to be extended," "Here's something that we would like to be changed," or, "Here's an income maximisation policy that has to be pursued." It is fair to say that the committee thinks that there are lots of good spends out there, but we are trying to work out whether we are getting the best value for money in tackling health inequalities for the spends that we are putting forward.

11:30

Dr Reynolds: I absolutely agree that most of what we are picking up is the consequences of inequalities that then impact on health, rather than health being the cause of the inequalities. However, as health services, the last thing that we want to do is to then exacerbate those inequalities through the way in which we structure our services. The proposed adviser on poverty and inequality should look deeply into resource allocation models for how we fund the services that then pick up the difficulties.

Working as a paediatrician, I am well aware of the barriers that we put up. They often arise from trying to be more efficient. For instance, Anne Mullin will refer patients to specialist services. A lot of them, instead of just sending out an appointment, will send a letter saying, "Please respond to this letter in order to make an appointment." It is as if they are saying, "It's only people who are really motivated and will turn up who will make appointments, and we will not waste all these other appointments." It is the most vulnerable people who are under stress, be it financial stress, lack of sleep, mental health problems or whatever, who will not get round to phoning and making the appointment. It would help if we just sent out the appointment in the first place.

I am sorry to go into a lot of detail on that one example, but it is the kind of thing that we meet again and again, and it involves putting up barriers. We are trying to be more efficient, but we need to consider the truth of how much extra time and effort it takes to engage with people who are more vulnerable, whether that is due to socioeconomic inequalities, disability, ethnic group or whatever. I do not think that our current formulae for calculating resource allocation hit the mark.

Dr Mullin: I agree. Working at the deep end, we have to think about progressive universalism in services, but we cannot really have that unless we have realistic universalism. We all work in areas of high deprivation, and we are aware of the social determinants of ill health. We still need the resource to address the inverse care law, which is prominent where we work. We need the resource to match the needs.

Part of that is to do with making the policies right. Some of the policies are very good, but it comes down to the resource. For example, in our south community health partnership, we are having to lose £500,000 in the next financial year from our children and families budget. We cannot realistically run universalism with that scale of cut. That is one of the very real issues that we face.

Theresa Fyffe: I return to my point about access, which was about exactly that. My colleague who works on homelessness might want to comment as well. The work that we have done on nursing at the edge is about people with chaotic lives, who are unable to fit in with what we put in place as a service, and how they can access services. One thing that we are asking for is that, where services are provided, there is greater authority to reduce some of the bureaucracy and paperwork that means that we may lose the person who has made the contact and made the effort to get there, but who then needs access to services and has to go through a convoluted process. Such people often do not return. One-stop places where people can get those services have worked very well for that reason.

Access is a big word. That is what I meant when I mentioned marginalised groups. It is a question of knowing where they are and who they are and understanding how we can go towards them. The work on women offenders that has been done in Perth has focused on those women and their children in a way that has made them feel that, even though they are not in the community, they are receiving services as part of the community, and similar work has been done in Grampian. It is important to look for such examples.

However, the issue often is—as we will show at our reception tomorrow night—that those projects are funded for the short term and dependent on funding coming from a number of pots and that there is no wish to fund them long enough for them to be able to show the impact of what they do.

Many people we meet talk about waiting for a year to know whether they will be funded for the next year. How do they stay with that? It is risky for health professionals to step out of what is considered to be a good and safe job to go into such a role, but most of them do it because they are really keen to make a difference. However, they more often do it at the end of their careers because they are more confident and feel more able to work within that world.

Those are some of the things that could be measured. If we do not change how we deliver the service, people will always fall between the footstools of what is there for those who know how to access it.

Dr Gray: Bob Doris's original question was about what we should ask the poverty and inequality adviser to do. That is a great question. In my career, I have seen advisers and tsars come and go, but I was never really sure to what effect, particularly if they operated at a national level because, if we want to make change, we have to make it at a local level.

If I were going to employ such an adviser, I would look at the evidence about what makes an effective leader in those circumstances. Al Aynsley-Green is a good example of someone who achieved something in the past, so I would look at what he did to achieve that. I do not know what makes a good commissioner, adviser or tsar, but there must be an evidence base on that. We need to think about the kind of person we want, what they might do and what they would require from us because, unless we listen to them and act on what they do, they will be ineffective and could be sitting in an office achieving nothing. Before employing such an adviser, I would think carefully about what I wanted them to do and how to make them most effective.

Dr Reynolds: My point relates to Theresa Fyffe's. It has probably been said again and again, but it is important that we invest in generic measures such as universal services. There are fabulous things to be learned from projects but, again and again, I see good people from local health visiting services being seconded into projects. The most vulnerable families really benefit from continuity of care—having the same general practitioner and health visitor for years—and, if they are all being broken up into projects, we do not get that continuity.

Dr Mullin: Under the Public Bodies (Joint Working) (Scotland) Act 2014 and the Children and Young People (Scotland) Act 2014, there is great potential for the work that we are talking about to be developed. GPs at the deep end think that the integration agenda is important for this area of work because health and social care really need to work together much more closely. We need to understand each other's language and how we work together. That relationship has been fragmented for a number of years.

We have developed a project that we hope will be funded, because it addresses many of the issues that, as practitioners, we feel are barriers to better access for families, shared understanding, sharing information, addressing the issues and addressing inequalities. That project is unique because it has been built from the ground up; it does not come from a top-down approach. However, it needs research support and we do not have that in general practice. We do not have a lot of well-supported research through the chief scientist's office or core funding that we can keep rolling on.

Short-term funding for projects has been mentioned. That is a real anxiety about all pilots. Where do we get the good evidence and evaluation that has international implications as well as local and national ones? That is something that we would advocate for at the deep end as well.

Dr Gray: I will change the subject slightly but will pick up on that last point.

I have just come back to Glasgow after 12 years away. There have been massive changes in policy and things are an awful lot better in general throughout Scotland than they were 12 years ago, but a culture of evaluation is still lacking. There are so many different pilots on child obesity, parenting and so on. Sometimes, they get started and people ask which ones are effective and how effective they are but, frankly, we do not know, because not enough resource is put into evaluation at the same time as they are commissioned. They need to be longer term in scale and they need to have evaluation built in.

That needs to be part of the set-up as we move into integration. Health and social services could do lots of stuff together on, for example, looked-after children, who are marginalised and go on to form a lot of the prison population and so on. Will they do that? It depends on whether they are prepared to share information so that we can see the outcomes across the piece. That should include education if that is possible. If we do not bring all that together, we can set up all these projects but we will never have any idea whether we are making any difference.

The Convener: I want to test some of that. We are here under the banner of looking at child poverty and every day of the week we see that it has almost become meaningless to people.

Professor Marmot said that being in poverty is defined as having an income of less than 60 per cent of the median income and it is unlikely that a country would have a distribution of zero, which would mean no child poverty. The country with the lowest levels is Norway, which has 10 per cent child poverty because we use the median income measurement.

We have heard evidence that because of that, we are almost hiding very vulnerable groups such as those that are defined by ethnic background or children coming out of care. We are almost blurring the edges and losing the focus because we are dealing with a generality. Governments do it as well. We are all very hot on this point. One question is how we measure child poverty. Should we have a greater focus on what we are tackling? Would that mean a greater chance of dealing with the very vulnerable groups?

The other question is about what the Government is to do. We are all very hot on the idea that the living wage will solve poverty. We are all rushing to support the living wage, but it does not measure household income at all. In some cases, it might not reduce poverty; it might increase the gap between the less well-off and the better-off. There is a lack of clear objectives in Government policies. The well-understood inverse care law can be applied to education, the economy and everything else.

There is a question in there. Do politicians need to understand what they are talking about? Do we need to evaluate it? Do we need to do better in ensuring that the measures that we take do the job that we say they are going to do? At the moment, I do not think that we are achieving our ends when the gap between rich and poor has been growing despite all the well-intentioned policies from all shades of Government right across the board. I throw that in there to see whether we can warm this discussion up. Any takers?

Dr Mullin: Last year, Dr Atkinson, the Children's Commissioner for England, wrote an interesting report—you can all read it; it is online—about the effect of welfare reform on children. She wrote from a children's rights perspective, which is an interesting way of looking at the welfare cuts and how they affect families and cause poor child outcomes. Anything that a Government does that undermines the rights of the child, as set out in what it has signed up to, opens it up to criticism. It is in danger of breaching its own children's rights policies under the international agreement that it signed up to because of the retrogressive nature of its policies, which discriminate against and affect the poorest children.

That is the sort of thing that a Government has to decide how to address. A number of policies are creating inequalities by making the gap wider, and poor children are being disproportionately affected rather than other children.

11:45

Dr Gray: You are right about poverty, but you also have to think about the other side of the equation—wealth. What is really perpetuating the inequalities is not just people staying in poverty but other people getting tremendously wealthy. There has been a lot of literature on the subject—I am sure that you have read the book that Thomas Piketty has written about it—and various other people are talking about the huge increase in wealth among a certain group in society, which is fuelling the inequalities as much as problems at the other end of the scale.

It seems that one of the ways in which the problem is mediated is through a lack of opportunities for education. Although we are talking about health inequalities, education is one of the most important things. We know from figures from Glasgow and elsewhere that poor children are beginning to fall behind by the age of two or three in terms of their early literacy, vocabulary and so on. Even the most well-intentioned early childhood programmes, which are effective and cost effective, do not completely make up for poverty. I read recently that the effect of two years in pre-school might reduce the effects of poverty on various outcomes by about a quarter, but that is all.

To some extent, you need to tackle poverty at its root, but you also need to tackle increasing wealth.

Dr Reynolds: After the publication in 2007 of the UNICEF report on the wellbeing of children in 21 countries in the Organisation for Economic Co-operation and Development, in which the United Kingdom came last, UNICEF UK undertook some research that compared in more detail child wellbeing in the UK with child wellbeing in Spain and Sweden, looking particularly at the impact of inequality and materialism. As Ron Gray says, the fact that there is so much perceived wealth contributes to the inequality, and one of the recommendations of that report was to ban advertising that is directed at children—not just advertising of unhealthy foods, but all advertising that is directed at children.

If I could recommend one change to improve the health and wellbeing of children, it would be to reduce the stresses on parents. There are already stresses of poverty, poor housing, the need to maintain a job, childcare and so on, but materialistic advertising puts additional stresses on parents. The research in the UK found that the more affluent parents who are time poor because they work hard feel guilty that they are not spending enough time with their kids and buy them expensive things to compensate, whereas the poorer parents feel stressed because they think that their children will be bullied if they do not have Nike trainers. I have had patients fail to turn up for their appointments because of that. One mum did not bring her child for an appointment, and when I phoned her on her mobile she was Christmas shopping. She thought that the child getting some flashy piece of plastic was more important than their seeing the paediatrician. We have a culture in which people queue overnight to get the latest electronic gadget, and a factor in the inequality is the perceived wealth. It sounds terribly patronising, but the people who are not wealthy feel pressure to get those things for their children instead of spending their money on things that would be more appropriate.

I do not know whether advertising that is directed at children could be banned. Our borders are so porous that, even if we did that in Scotland, it would be accessed in other ways, although it would send a good message that we are a child-centred nation and we care about our children. It is important that we build resilience so that people do not feel so impacted on by the inequality and the materialism.

The Convener: Some of that touches on what we heard from Harry Burns.

Dr Reynolds: I am glad that he and I agree.

The Convener: He talked about the difference between the situations in Glasgow and down south, and he highlighted the lack of compassion in our society now. For instance, people in Glasgow are less likely to trust their neighbour.

Going back to my original question, if we are generalising the problem, how we measure and communicate the problem in order to have some effect is important. Health is the only portfolio area where we measure inequalities—for example, in terms of smoking, birth weight and mortality rates. I am not saying that that is the only way to measure inequalities, but no other portfolio area has a measure.

I suppose the question is whether using health statistics is the right way to measure inequalities. Are there other measurements that could be applied in other portfolios that would communicate the nature of the problem more effectively?

Dr Reynolds: To me, it is much easier to pull down data to illustrate inequalities in, for example, what we deliver or outcomes for children—we can use the Scottish index of multiple deprivation to show areas of deprivation by postcode—than it is to demonstrate that by any other method. There could be other ways of measuring inequalities, but at least we have a measure and we can report.

There is clustering of risk for so many families. For example, childhood disability is more common in the more deprived populations and if there is childhood disability in the family there is more likely to be adult disability as well; ethnic minorities and asylum seekers are more likely to be poor; and there are issues around looked-after and accommodated children, which we have touched on.

However, we cannot pull down any data on our routine delivery of services according to a child’s disability status and we do not even know how to record that status—we have not even decided on a definition of disability. We are not recording ethnicity well, either. At least I can use gender, age and the Scottish index of multiple deprivation to measure poverty. However, we are not measuring other risks that cluster in certain families.

Dr Saunders: We have known for decades that a number of generalisable areas need to be measured, but we have not addressed that. As we said earlier, factors include parental employment and parental income; nutrition for a woman before she becomes pregnant, while she is pregnant and after pregnancy; and nutrition for the family. We know exactly what food we would like people to eat but, by and large, many of the most deprived people do not get to eat that food because it is too expensive or not available, or because people know that if they bought such food to feed their family but they did not eat it, they would not have the money to replace it. Another factor is the socialisation of children, which we significantly fail to achieve. Particularly in very deprived areas, it is not even feasible for children to play outside safely.

Large parts of Scotland are very rural, but the deprivation data does not show rural deprivation terribly well. It is quite easy for pockets of rural deprivation to be hidden among relatively less deprived areas and to not appear in the statistics. One of my colleagues at work has a particular interest in that issue and has spent a large amount of time showing to his own and others' satisfaction that the data that we collect misses a lot of people in rural areas who are deprived. There is no simple way to get round that and dig out such data.

We need action across Government portfolios to try to bring everybody up out of deprivation while also focusing on those who are the most deprived. Some of the initiatives that have been set up in that regard are working very well. For example, there is the childsmile initiative on dental health, which I am sure the committee is aware of, through which the numbers of decayed, missing and filled teeth in children in all categories, but particularly the most deprived, are being addressed and dealt with, and the children's dental health has improved immeasurably.

Other programmes that are working particularly well include the family nurse partnership, but that service is restricted to women under 20—women over 20 who need it do not get it. There are other programmes that have time-limited funding. Some of them are due to finish next year because of that and we have no idea yet whether their funding will be continued.

A lot of joined-up thinking is needed for the more generalisable things that will help all children whatever their degree of relative deprivation. The specific programmes concerning the most deprived need long-term funding in order to work well. Childsmile has long-term funding and I would say that its future is pretty well established, but there are a lot of other programmes that need that sort of certainty in order to achieve the same things.

Theresa Fyffe: The common theme that has been coming through in what people have said is that we are not very good at knowing what data we have and how to use it. Furthermore, there is a gap in the research evidence, which is why I mentioned that the growing up in Scotland research was good to see. There is no body of research, however, that would enable people to know what the best impact would be. That is why I made the point earlier about how we measure impact. We need an evidence base that helps us to understand what the efficacy is and what we can do.

I support what Charles Saunders said about the childsmile programme, which really has demonstrated a significant drop. What has gone right with that programme? Why did it get long-term funding? What did it do to succeed while other projects got short-term funding and were not secure? I do not believe that enough is done at the very beginning about evaluation.

The family nurse partnership has been shown to work through the evidence base. Right now, however, in my position at the Royal College of Nursing, I want to see the impact of that very focused and expensive work on a targeted group, leaving others out. Does supporting the partnership really achieve things and make the difference?

We have been looking into instances where health visitors wish to provide more specialised services on top of what they do in their ordinary day. That is hard to do, and it is a hard case to make. The work that was done in Grampian on prisons came from a wish by the teams up there to do something different. It did not come from having a particular goal.

Returning to the point about what the adviser needs to do, it is to have some clear goals that cross all Government portfolios and that hold people to account. When the Children and Young People (Scotland) Bill was out for consultation, we were one of the groups that felt that there should have been more about the rights-based approach to children, and the Children and Young People (Scotland) Act 2014 does contain a duty on ministers to demonstrate how they are going to adopt such an approach. I refer here to Anne Mullin's point about how they will be challenged. What activity are ministers undertaking to demonstrate that they have taken a more rights-based approach?

As an organisation, we believed that that approach should have been more embedded in the 2014 act, thereby requiring such activities to be taken across Government through a more constant approach. We have already highlighted the importance of continuity in who is providing the care and a constant approach to services.

We know that it will take years to make the difference. It will not take a couple of years; we know that it will take a long time. If you want an intergenerational shift, you will have to work at it for quite some time. In the end, what difference will it have made or not made? What more can you do?

Dennis Robertson: I will pick up on that point—and this is a point that Dr Saunders and Dr Gray have made, too. Some of the foundations have been laid. Dr Gray mentioned education. Do you think that some of the initiatives that are in place, including getting it right for every child and curriculum for excellence, are the foundations for moving in the right direction, but do you also think—I refer to the point that Theresa Fyffe has just made—that we require a behavioural and cultural change, which will take a number of years?

There has been a tremendous change in the role of school nurses, for instance. Is it school nurses that we need, or is it perhaps health visitors within schools and initiatives like that? Are we getting the foundations right, despite taking a while to start building on them?

Dr Gray: We know quite a lot of the things that we should do. Michael Marmot has listed a number of the interventions. They start off in the antenatal period, including those concerning alcohol, drugs, smoking during pregnancy and stress, and then go on to breastfeeding, weaning, parenting, early education and so on. We know about all those things.

12:00

The issue for me is that the approach is rarely joined up. Although we have evidence on a number of those things, we often do not see local evidence of effectiveness. We need to know a number of things. We need to know not just whether the measures work but how well they work and what size of effect we get from them. We need to know whether the people who need them are really getting them—if you like, the reach of the intervention and whether it is getting to the right people. Then, we need to know whether those things are actually being implemented properly on the ground, because sometimes they are not. Sometimes, with the best will in the world, people do not implement things properly and they therefore have no effect.

For a lot of interventions, we just do not know that kind of detail, and we can get it only by having a data system so that we can look at a broad series of outcomes across health, education and social care. That would perhaps also allow us to look at positive outcomes as well as negative ones, which the convener alluded to. We might want to look at happiness, aspiration and quality of life for children. For example, we could consider aspiration among those in the most deprived quintile compared with those in the least deprived quintile. That would give us information that we could start to act on, and it would allow us to begin to see whether we are being effective.

The Convener: Dr Reynolds, do you want to comment? Oh—sorry, Dr Mullin. You are too polite to nudge me in the ribs and I am always looking straight ahead, rather than to my side.

Dr Mullin: Dr Gray is right that we need to know what we are measuring, how we are going to measure it and what evidence we want. Particularly in primary care, we lack a research base that cuts across all the disciplines and allows us to see what we are doing.

Despite the strategies and so on, the work goes on at the front line and we deal with the consequences of the pressures on budgets and a lack of resource—we somehow have to muddle our way through all that. General practitioners are universally accessible and we provide an unconditionally accessible service, so we are useful contributors to the debate, yet only 3 per cent of our contract is to do with child health. In some respects, it is given very little attention, yet we do a lot of general paediatrics in general practice. Our relationship with health visiting is extremely important in the early years.

There are some very good things in education, such as the nurturing corners in nurseries, but the two programmes that have an unassailable evidence base are the family nurse partnership and the Incredible Years. The other programmes have some promise, although the positive parenting programme, or triple P, has been slightly controversial. We do not have much to go on.

At the front line, we are asking for realistic universalism so that we can have progressive universalism. There is no point in having specialist services for vulnerable children and families if we cannot get the rest of it right. That is the problem that we have.

The Convener: We have heard before about universalism plus or realistic universalism. What is your definition of realistic universalism?

Dr Mullin: From the point of view of a GP working at the deep end, we need more time to provide the service. Stewart Mercer's work in the care plus study involved estimating how much more time GPs need. Obviously, I am not here to talk only about general practice, and other services are under the same pressures. However, we need realistic times in which to see people and deal with their problems, which is what the Govan project is trying to address. The links project is another aspect of that work. That is a good project and it will be properly evaluated, but we need that time. There is room for flexibility, but unless we have that time we will not do the work that is needed. There is unmet need all the time.

The Convener: Is there not a point of debate with Dr Saunders, who says that everybody needs to move up? In my humble opinion, one of the problems that we have is that, if everybody moves up, we do not address the gap—the gap is frozen. Despite everything that we add on, none of it reduces the gap.

Dr Mullin: Danny Dorling talks about the top 1 per cent and the inequalities gap there, which is massive. That needs to be sorted out, but that is an international agenda and we would have to do something with capitalism to deal with it. Meanwhile, we can work with other inequalities and do positive things about them.

The Convener: I will let Jayne Sellers comment and will then give Dr Saunders a chance to come back on that.

Jayne Sellers: From a practical point of view, to a health visitor on the ground universalism means that every single child has a health visitor who is accessible to them and who uses their professional judgment about how much time a family needs. Some families will need less time at some points and others will need considerably more time. Health visitors need to be able to facilitate access to specialist services that might be necessary. We must accept that every child in an area, no matter who they are or where they sit in the socioeconomic spectrum, should have a health visitor—that is what I mean by universalism. It is about allowing health visitors to make a professional judgment about who they see and how they do that.

Mr Robertson raised a point about school nursing. We have very few school nurses, particularly in Glasgow, and we need to look at the broader aspects of health and wellbeing for school-age children aside from the education and pastoral care that children get in school. The capacity for school nurses to do that work is absolutely minimal. Once they have delivered the immunisation programmes and other such things, they have absolutely no capacity to do any other work.

We need health visitors to specialise in that aspect of health and development in the pre-school years, and we need school nurses to be able to do not only the immunisation but the wider support work for families during the school-age years.

Dennis Robertson: Do you see a role for health visitors in schools as well as in communities?

Jayne Sellers: Not necessarily, because school nurses as a profession are well able to deliver what health visitors deliver in the pre-school years.

The Convener: That aspiration prevents us from dealing with the issue of transfer of resources. The better off, the better educated and the more articulate get a disproportionate amount of the health budget. Maybe it is a fair amount but, in comparison to poorer people, they get a bigger share of the health budget and the education budget, and they get a better share of the jobs and better pensions. Is it time to tackle some of those issues? Dr Saunders talked about everybody moving up, but the challenge is that that means that the gap does not get any narrower.

Dr Saunders: Everybody needs to move up; it is just that some people need to move up slightly more than others. Everybody in Scottish society, including children, needs to improve their health. Some people have a more desperate need to improve their health than others, but everybody needs to move up.

I take on board what my colleague Jayne Sellers said about school nursing. In recent years, the school nursing service has been largely subsumed into delivering immunisation in schools and there is very little time left over for anything else.

The directors of public health at the health board level have the responsibility to take a population perspective. A large part of their job is to raise with the health boards the issues of population health, inequalities in health and deprivation. However, in the future, those who are appointed directors of public health will not be executive directors of NHS boards and will lose a great deal of authority in the boards. Directors of public health will have no formal role in the health and social care partnerships. Although, intuitively, it seems a good idea to put together health and social care, it does not seem sensible to take out the directors of public health—I am not one—who historically have had responsibility for population health, when we are aware that health inequalities in Scotland are increasing, particularly in the early years.

Theresa Fyffe: I return to my point about a universal service and the need to understand how to respond to deprivation. Health visitors are trying out a new tool that might at least assess the workload and take into account social deprivation. Before that tool came along, there was no means of doing that, so, in some parts, a case load could be high and extremely demanding because of increased deprivation. Health visitors in some parts of Scotland had different case loads from other health visitors just down the road from them because of deprivation, so we are trying to find a measure that at least tells us what we need in response to that deprivation. Without that, there is no doubt that, whatever an individual practitioner may do, the demand will come from those who make the most demands, who require more and who are most articulate, which means that a practitioner might miss the very people they are trying to get near.

The situation with school nursing is unfortunate, because the service has been hijacked by a need for immunisation. Do not get me wrong—there is a need for immunisation, and when that need arose everyone agreed that it was something that school nurses could do, but they forgot that they were meant to have other functions, which have been reduced in some areas. Even though there has been an emphasis on that in schools, school nurses have not increased in number—in fact, in some areas of Scotland they have decreased in number. That is another measure to consider.

I return to a point that others have mentioned. If we do not find a way of joining up all the policies and being clear about them, we risk having lots of policies but not knowing what impact they are meant to have for children or truly understanding whether those policies connect.

I have a further point to make about the integration of health and social care. As you know, we have been here to give evidence on the move to integrate those services. We support that move, but we are going to have to keep a close eye on how the partnerships work. As they look at what they believe the services to be, we need to ensure that they provide continuity. In some areas, there will be several partnerships. Glasgow, for example, will have a number of partnerships, so you will need to consider how you can ensure a cross-Glasgow approach to issues. It is not impossible to do that, but it will be challenging. In the next couple of years, you will need to keep an eye on the very things that we have been talking about, because they are more expensive and they demand a different type of resource. My concern is that we could be short changed during that period.

Dr Reynolds: On universalism, I agree with what has been said about how crucial health visitors are in being proactive and going out to seek patients. GPs are also highly important, but they are not going into people’s homes to find families. In identifying the increased level of need, health visitors are absolutely crucial to those people who do not necessarily present themselves. I therefore welcome the increased investment in health visiting and the ability of health visitors to be the named person.

I work with school nurses a lot and wish that there were more of them. We must remember that, under GIRFEC, once a child is in school it is the education service that provides the named person role, so we need to think about how we support the people who perform that role. It is not a question of recreating health visitors for schools because, once children are in school every day, the people who provide their education will have a much better idea about them and will, we hope, form relationships with their families as well.

The SHANARRI indicators—safe, healthy, achieving, nurtured, active, respected, responsible and included—are pretty much from the United Nations Convention on the Rights of the Child, and people in all other parts of the UK will be working towards similar outcomes. We should ask what we are doing to make our children safe, healthy, achieving and so on, not just on an individual basis but at a population level, and health visitors and professionals in the local area should be able to build that up using initiatives such as the bottom-up initiative in Govan to which Anne Mullin referred. There are also initiatives such as the responsive, intersectoral-interdisciplinary, child-community, health, education and research initiative—the RICHER project—in Vancouver, where additional resource is put in to areas that, at a population scale, are more needy according to early development index scores, to make services more accessible.

12:15

As I said at the beginning, the more complex the circumstances are, the more time the professionals will require to undertake assessments of need and support families. Overall, building up the population view is all about raising the status of children and supporting GPs and health visitors on the front line while providing easily accessible services. Specialist services—those that are provided by paediatricians, for example—must be more accessible for consultation and advocacy at the population level in addition to working with individual children.

Sorry—I have so many things to say that I get them all rather jumbled up together.

The Convener: Absolutely—good for you.

Dr Reynolds: I am better on paper.

The Convener: That is okay; your passion came through.

If no other panel members wish to respond, I invite Nanette Milne to ask another question.

Nanette Milne: I want to follow up on a comment from Jayne Sellers, who mentioned health visitors specialising. I had some experience in my husband’s former practice, which was a mixed practice: there was some deprivation, but that was not the entire picture.

I remember from years back the real efficacy of practice-based health visitors. When they took on more of a community role, they were not so effective. What are your comments on that? Is it better to have health visitors based in practices or groups of practices? What do you see as the best way forward?

Jayne Sellers: Prior to my current role in dealing with homelessness, I always worked as a health visitor attached to a practice, and I think that it is a very reasonable way for health visitors to work. It promotes a really good relationship with GPs, and it is a good way to identify people in the local area.

When there was an attempt a number of years ago to introduce more of a public health agenda for health visiting, we lost some of the ability to make direct contact with families. Nothing can come close to home visits with families on a regular basis. That system allows health visitors to build a relationship with a family and see how they live their lives, and to support them in the best way so that they—particularly the children—can live the lives that they want to live. It also allows us to facilitate access to the GPs and the other services that are located in a GP practice hub. It is an ideal way for health visitors to work.

Nanette Milne: Would many more health visitors be required in order to carry out that system?

Jayne Sellers: I am not sure whether it would require many more health visitors. Perhaps it would, because in order to make it work the health visitors, particularly those working in cities and areas of high deprivation, need to have smaller case loads.

I have never worked in a rural area but presumably in rural areas the issue is less about numbers and more about spread and time.

Dennis Robertson: Travel time.

Jayne Sellers: Yes—travel time and things like that. I have never had that experience; I worked in Liverpool, as you might be able to tell, and now I work in Glasgow.

In order for health visitors to manage their case loads, to offer home visits—not only to the articulate people who demand them but to the more vulnerable people, as they all have needs—and to be able to get involved with some of the community work with very localised groups so that we can offer services to people on the ground, we need smaller case loads.

Theresa Fyffe: I understand the desire to look back at the attached model and say that it might work, but our world has changed and so has the way in which services are provided. We would use the word “aligned”: we have to have the team model working, but I have never agreed with the idea that everyone has to be in the same place with the same filing cabinets and processes.

Given the way in which services are run now and will be run in the future, one could never fit them into a GP practice, but they should absolutely be aligned and should work together to share good practice. E-health and improved technology can enable people to do that.

Some places have done something very different in their community by using a building or hospital that they have turned into something bigger. They have been able to have everybody together because they have had the premises to do that. However, I spoke to the providers in my local area, and they said that they could not fit in anyone else. We need to be careful in talking about how well the previous model worked.

We need to be absolutely clear that teams are working together—obviously, this is not just about health visitors—and we need to share the working and intelligence. That can be achieved without everybody believing that they have to be in the same place. I used to think that that model was right, but I have seen lots of places—not just involving health visitors—where people are good at team working, and that is what we should be promoting.

Jayne Sellers: I agree. In years gone by, we had health visitors working in cupboards in GP services and so on, but we have moved on considerably from that. What I meant is what Theresa Fyffe alluded to—it is a matter of having relationships and hubs, and wherever the hub is, that is where the health visitor should be.

Nanette Milne: I probably meant that, too. I agree with you about team working.

Dr Reynolds: Health visitors form relationships with many people, and not just GPs. Jayne Sellers or one of her team might phone me about a child from a homeless family who has developed mental problems or a disability. I am based in Possilpark, where there are also a load of GPs and various health visitors, and they will email me about cases that we share.

I was at a child protection case discussion on Friday with a health visitor who is not based in the same building as me but who had been emailing me in preparation for the discussion and for me seeing the child. Thank goodness for that health visitor, who has stuck at her job for years, because the family had about five different social workers attached to it in a period of two or three years. The health visitor was the person who really held the discussion together because she is the one person who has seen the family through a variety of different changes. There was a 35-page chronology that nobody was able to read through in five minutes, but the health visitor had it all in her head.

Dr Mullin: I agree. Alignment is not a toxic word. We do work as teams, but our practice still has the relationship with our health visitor. She works in the team within the health centre, and that is working absolutely fine. We just need more of her.

Theresa Fyffe: The question was whether we need more health visitors, and that is the issue. We are thrilled with the investment in health visiting, but we now have to train those people. It took a long time to get round to it, so they will not appear on the stocks straight away, and we have to get the case loads right.

I return to the point that I made about freeing up people. We have too many bureaucratic processes. Sometimes, people can see that they could do something for vulnerable families but they have to go back through the routes, which loses the moment when they might have worked with the family and been near the point of getting agreement that something would be a good step. By the time they go back, knowing that they can access it, they have lost the moment. People who are working in that kind of world know that. Anything that we can do to reduce bureaucracy and make measures more accessible to them at the time would be a good thing.

The Convener: We hear about best practice when we are sitting here as a committee, but there will not always be good practice. Recently we visited a project in Edinburgh—I cannot remember its name—and we asked about family nurse partnerships. The project deals with older and younger women and children, and on the scant evidence we had it seemed that there was no integration. There are projects such as family nurse partnerships and there is a lot of resource, but do you agree that the system is sometimes not working to the best effect?

Theresa Fyffe: That relates to a point that my colleague Lucy Reynolds made. We end up with too many projects. I have been part of pilots for years and they are important, but we can get too many pilots and not enough clarity about what is working. We need to give things time to work and to produce the efficacy. If we do that, we can make a difference, but we tend to move on to the next thing that people think it is important to do.

I agree with your point, convener. Recently, I went out to visit a team that was not connecting across the area. It was almost like its pilot was more important. That was because it had short-term funding and the people who were involved thought, “If we focus on this, we might get the funding,” rather than looking at providing the whole service in a different way.

I wish that we could get a better way of setting up projects and getting them on to more sustainable funding.

The Convener: Sometimes, as we have heard in the committee, it is not the new projects that are the problem; the problem is letting go of the old ones. People want to keep the old project, which is not as effective as the new project. There is an inability to discuss funding issues and agree on priorities and on what works.

Dr Reynolds: The two things that have happened in the past five or six years that have most helped me to co-ordinate the care of vulnerable children and families were not things that were introduced for that purpose.

The first thing is secure email. I can email colleagues, health visitors, GPs and consultants in the hospital, and there is now even secure email between us and the council, so I can email social workers and teachers and so on. The other thing is the clinical portal, which is an information technology system. Now, rather than having to write to people at Yorkhill hospital to find out what they are doing, I can look at their information on the portal.

We are always thinking of a project that is going to do this or a project that is going to do that. I am not saying that we should not do projects, as they can be great; I am saying that we should do projects, evaluate them and then try to mainstream the stuff that works well. However, sometimes generic things are happening that we have never thought about evaluating, yet they are the most valuable things that we are doing.

If we were better at looking at our routine data, perhaps we would be able to build up more of an evidence base on some of the things that we have been doing for ages or that we have started doing for another reason—not because they have been mandated through a project that is going on.

The Convener: That is an important point.

Jayne Sellers: I agree with Dr Reynolds. We are a centralised, citywide service, so we used to have constantly to make phone calls to everybody; secure email has made things considerably easier for us.

Dr Reynolds: You could be playing telephone tennis for weeks, could you not?

Jayne Sellers: Absolutely. You would keep missing people.

The Convener: Are those things available to—or necessary for—GP practices? Do GP practices need the portal and so on to get information?

Dr Mullin: It is available but it does not help with everything.

The Govan project is trying to recreate a relationship that existed when I first started in general practice, which was the relationship with the attached social worker in the health centre. That made a massive difference to how we worked. Part of that approach was about building up professional relationships but it was also about someone being available to discuss cases.

The Govan project is trying to recreate that. We have no evidence to say that it works but all the GPs who remember working like that think that it was a much better way of working. It was easier to sort out patients' issues if that social work attachment was in place.

The Convener: Richard Simpson and Dennis Robertson want to ask questions, but I am not letting in members before panellists, so Dr Reynolds is first.

Dr Reynolds: We used to have a social work resource worker in our child development centre—we did in each of the centres in Glasgow. The service that those workers provided was never evaluated in any way and eventually, in 2008, the money went from social work. Social work thresholds have just gone up and up, and that service was pulled.

Then the healthier, wealthier children project came into Glasgow. The project is fantastic and I refer to income maximisers all the time. However, when I was sitting listening to the project presentation and the people said, "Look, we have increased the income of these families—particularly when someone has a disability, as we have used the disability living allowance. We have brought in all this money," part of me was thinking, "That is what the resource worker used to do."

We lost our resource worker, who used to do what that project does and a lot more. However, healthier, wealthier children was a project, so it was evaluated. I listen to the project people saying, "Oh, isn't it fantastic?" and it is—I do not want to take anything away from that project—but the resource workers were fantastic too. They used to do all that work, but nobody ever noticed.

The Convener: As no other panellists want to comment at this stage, Dr Simpson has a question.

Dr Simpson: I have been sitting here feeling that it is groundhog day. In 1975, Sir John Brotherston did his report on widening health inequalities; in 1980, there was the Black report; in 1998, there was the Acheson report. We have been through this so often. The point about recreating things is important. It keeps happening.

What I find astonishing is the fact that, when we had a situation in which health visitors and social workers were attached, they were the key people managing the children; as a GP, my input was all about the background to the family and the historical situation, because we had experience of that within the practice.

12:30

It seems to me that, whatever system we have, we need continuity. Theresa Fyffe mentioned the move to a geographical organisation. When social work moved to a geographical basis, the relationship collapsed because we did not have a named person. Whatever system we have, surely—although the panellists might not agree with this—we need two things. First, we need continuity so that we do not have a different person dealing with the family and cases being opened and closed. That is something that never happens in general practice—a family is often registered with a practice for life, sometimes for generations. In contrast, social workers open and close cases. If health visitors opened and closed cases, that would be really problematic. How do we get the continuity?

Secondly, everyone on the panel is medical, or in a related profession, but the fundamental issue that we are talking about in terms of the integration of health and social care goes beyond just the family and the family's downstream problems; rather, it is about the upstream problems. What do we do about traffic calming measures, separation of pedestrians and vehicles, child-resistant containers, the installation of smoke alarms, affordable heat and damp houses? I have taken those examples from just one section of the Macintyre report of 2007.

As medically oriented and trained individuals, what input do you have to the upstream aspect of health inequalities? Do you want some input and what are the barriers to that? Do we need it? Are we going to solve those problems without public health being based in local authorities, as it used to be, where it can influence all those things? Are we really aligning health visitors and social workers adequately within the new geographic teams?

I am sorry for rambling on, but I have been round this issue so often in the past 35 or 40 years.

Jayne Sellers: I do not think that health visitors ever close cases in the same way as social workers do. We do a different kind of work. Once a health visitor is allocated, as Lucy Reynolds said, the ideal situation would be for a family to have the same health visitor from before a baby is born. I am thinking of how the family nurse partnership works and how we worked when I started health visiting, when the GP would give us a list of the women who were pregnant and we would make sure that we went out and touched base with them.

Dr Simpson: Does that still happen?

Jayne Sellers: Not routinely.

Dr Simpson: So we have to create the family nurse partnership because we have lost that.

Jayne Sellers: I know that the family nurse partnership has had 30 years of evaluation in the United States and is apparently very successful, but there is a little bit of me that has reservations. I applied for a post within the family nurse partnership and I have read quite a lot about the issue because I was very interested in it, but to my mind it mimics what health visiting should be, and to some extent what we used to do.

Dr Saunders: I agree with Richard Simpson. It is slightly outside my brief, but many decades ago I was a GP in a deprived rural area. We had attached health visitors and social workers, and they were invaluable in helping us to help the most deprived members of the practice population. They were very good.

Putting public health into local authorities has been done in England and it has been an abject failure, with local authorities trousering the budget—or, to use a different term, using the budget for different things—which has led to the public health workforce disappearing at a rate of knots. It has not worked well.

Dr Reynolds: I was working as part of the public health team when we had community health and care partnerships in Glasgow city. That was when the health visiting review was held and our health visitors were being managed by social work managers.

I occasionally prescribe the odd melatonin, laxative or whatever, but I am mostly a very social—not just sociable—paediatrician. I am forever writing letters in support of rehousing and asylum claims and for people who want social work-type support that is not really there.

When social work managers managed health visitors, I felt that such an approach was not successful because the social work managers did not have a background in universalism. Their concept of isolated episodes is partly the reason why our health visiting review was pretty unsuccessful; it went the wrong way, and the direction that it sought to take us in has been reversed.

According to the sure start evaluations, some of the most successful projects have been led by health. I love social workers and I love working with them—and I heard what has been said about Al Aynsley-Green, who is a paediatrician, as a leader—but the fact is that people in general practice or health visiting, for example, understand universalism. Although I welcome certain aspects of integration, I simply point out that getting non-health people to manage universal stuff when they have no experience of it has been unsuccessful in the past.

Theresa Fyffe: To return to my earlier point about the difference between attachment and alignment, I note that RONIC—the review of nursing in the community—led to an inordinate break-up of the way in which health visitors worked in some areas. For a start, some areas proceeded with it faster than others. Since the review stopped we have without question come back to the idea that health visitors should work as part of a team, aligned with general practices and others, given the multi-agency world that we are now in. That approach would bring about what has been suggested, because it would allow health visitors to understand better what they see so they could make a difference. When the social worker resource was taken away, the relationship was not seen as being aligned any more; instead, their work became something that existed elsewhere.

That brings me back to my point about integration. If the intention is to bring things together, we need to bring those relationships and ways of working back into alignment. The principal difference, however, is that health is about need, but as far as local authority funding is concerned the issue is sometimes more about the resources that are available. That is a very different view, and we talked about that a lot when we discussed the changeover. At the moment, the health service would say, “We must respond to need, and universal services are core to that.” For other services, that would not necessarily be the case. That is what I mean when I talk about how things should come together. To tell people, “You have to close your cases,” “That person no longer needs you,” or “We don’t have enough resources,” was not a success, so we must find a way to measure the workload, understand need and demand, and find the best approach to take.

Evidence has shown that when health visitors were attached, the resource was found to be elsewhere when it was needed in areas of greater deprivation. It was really hard to say to an area, “Please give us back that resource, because we need it here.” I would never want to go back to that system, because it should be all about having aligned relationships, and about knowing, understanding and being able to measure need and allocate teams accordingly. However, we need a multi-agency approach, because that is the best way of getting a broad understanding of families in certain situations.

Dr Simpson: I support Theresa Fyffe's remarks. The inverse care law is absolutely critical, but the fact is that we need to apply the resources. We are very lucky in Scotland in that every patient has access to a GP; that has not been the case in England, and they have faced real problems. However, the problem here is that distribution is equal and is not based on need, so we need to develop a system in which need and resource are aligned. Anne Mullin might want to comment on that, but I think that, with the resources that are given to general practices in deprived areas, even the link workers are just at the edges.

Dr Mullin: I am obviously speaking as a GP. The deep-end general practices are becoming stretched, partly because of the demographic of the population that we are serving now. Members know about the complexity of the care that is required. The assumption that those complex patients can somehow always be managed in the community with limited resources is not realistic any more. General practice needs more resources—more GPs and more GP time. I do not believe that we can get away from that.

Stewart Mercer's work has shown the benefits of extra resources. People do not get better because they are given more GP time, but it delays their getting worse and a lot of what we are trying to do is to delay people having to go to hospital constantly and becoming sicker earlier. If we are to do the job that we are supposed to be doing, we need more GPs and more GP time. The job is becoming impossible; I have worked in general practice for 20-odd years, and recently for the first time a district nurse told me that they could not see a patient because they did not have time. That is what is happening at the front line. All that happens when services do not meet service users' needs is that the problem comes back to the general practice to be sorted out—we are the fallback for just about every other service. The deep-end practices have made it very clear what we need.

Child health inequalities are part of the issue; the GP contract could be more robust around child health. It is great that there is more investment in health visitors—that is very welcome—but it will take a bit of time for them to bed in. The Govan project is trying to rationalise, under severe budget cuts, how we can work better with social work services. We realise that that relationship has been missing for quite a long time and that we could do more around that. For the day job, however, we need more GP time and more GPs. Those things are expensive, but that is the reality.

Dr Gray: I agree with everything that has been said about targeting resources at deprived areas and the need to improve universal services. You asked whether, although we might be moving everything up, we are making a difference. I read the evidence from the centre for excellence for looked-after children in Scotland, which points out that there are 16,000 looked-after children in Scotland, and 4,000 in Glasgow alone. For years, I worked in prisons, and most of the people I saw there had been looked after at some stage in their childhood. Their suicide rate was something like 100 times the suicide rate in the general population. People say that we should mind the gradient as well as the gap, but I think that we can identify that group fairly easily, although getting routine data on it is another matter.

There is now a shared agenda around integration, whereby social work and health are meant to work together. Maybe it would be possible to target some resources at that group to try to make a real difference, such as has been achieved in Scandinavian countries, where there is now little difference between the outcomes of looked-after children and the outcomes of children who are not looked after. We need to aim for something like that.

To go back to the initial question about what the new adviser could do, I stick by what I said: you should go by the evidence. However, if you were to ask me what one thing I would do, I would say that we should concentrate on looked-after children and try to improve things for them. That is especially important because we are corporate parents to them, so there is expectation. We should do a lot better by that group than we do.

The Convener: We are going into the last five or 10 minutes of this evidence session. Given that social work services have been bashed about a wee bit—

Dr Reynolds: No—we love them.

The Convener: Dennis Robertson is bracing himself. He is a former social worker and has been sitting patiently for about 15 minutes, waiting to ask a question. After he has done so, we will come back to the panellists to tell us one thing each—Dr Gray has given us a useful steer—that they would like to place on the record today. That will be useful in rounding up our discussion. What one thing—or two, three, four or five things—do the witnesses want to put on record today? First, let me bring in Dennis Robertson, former Inverclyde social worker.

12:45

Dennis Robertson: I am glad that it is on the public record that someone loves social workers. I was a social worker for more than 30 years. As the convener said, I started out in Glasgow and Inverclyde, which was a wonderful experience.

I endorse the multi-agency approach, in which an appropriate key worker is identified, and I have a great deal of sympathy with Richard Simpson, who said that we have been round the issue several times. We have indeed—in many ways and forms.

Dr Gray talked about localisation. Do we need to focus more on local solutions for local problems, without pointing the finger and talking about a postcode lottery, which is a dreadful term? Sometimes a local solution is important. We need a framework, but have we moved away from localisation?

Theresa Fyffe: That is a good question, but it takes me back to my point about short-term funding. A lot of local projects stem from local activity and people saying, “That’s a good idea, let’s do it,” but many projects do not get funded and mainstreamed in a way that would help people. Localisation is a big part of the integration agenda. It is intended to get us close to communities and to support activity.

The Convener: The committee heard earlier this year from Professor Marmot, who told us that in Birmingham and, I think, Tower Hamlets—one of those inner city areas—people had adopted his principles. He had initially been sceptical, but he was impressed by how people had delivered and made a difference. Does anyone know about that, in the context of Dennis Robertson’s point about local initiatives?

Dr Saunders: I would not like to speak about those particular areas, but I will say that although local action will help a number of people, it also lets Governments off the hook. Many of the problems that people face arise from Government policy. Local action helps to mitigate the effects of Government policy.

As I said, we need to improve the lot of all children in Scotland, and that of some children more than others. In lifting everyone up, we lift up the people at the bottom who most desperately need help. They need additional help, but if the approach is universal, as a number of benefits in the benefits system have been, it is much easier for people on the margins to access support, it is much less socially stigmatising for people to receive support and it makes life easier in general.

As we have said, the people who are most deprived need additional help, but we will reach most of those people if we give stuff to all the people. If we focus just on the tiny number of people whom we might call the deserving poor, a number of people whom we might call the undeserving poor will miss out. We should go for a “let’s improve everybody” approach, with a bit extra for some.

Dr Reynolds: An issue with things being local is that when we start talking about localities we start talking about boundaries. I am a specialist, so I have to cover a lot of localities; we cannot have one community paediatrician for Possilpark, another for Springburn and another for Ruchill. I have to cover a large area because I am a specialist. A superspecialist at a children’s hospital will cover an even wider area. If policies are implemented only within a specific locality, what about the people who are just over the border? How do we co-ordinate the local thing here with the local thing there? It makes sense for different things to be done at different levels. It makes sense to do some things locally, but some things must be done at national level so that universalism can be achieved.

Dennis Robertson: Is the multi-agency approach the solution to the problems, regardless of the wider community?

Dr Mullin: I am going to talk about the Govan project again, although it has not even been funded yet. Our idea is that, if you work in a locality with a cluster of GPs and a reasonably sized population of about 30,000, you can start to determine the needs of that population. You have to do the super-epidemiology stuff, but you also have to do the localised epidemiology. We look at our population needs, what third-sector agencies are in that locality and what specific issues we have in Govan. With a large asylum-seeking population, people’s needs are various, but we need to respond where there are no services attached. That local level links into national policy, and we need to understand where the links are.

In embedding all of that, long-term professional relationships are important if interagency working is to succeed.

Dr Reynolds: If that does not happen, I could find myself asking whether a patient lives in East Dunbartonshire or in Glasgow, and if they are in Glasgow whether they in north-west Glasgow or north-east Glasgow, before I decide who I need to liaise with or what my patient might be entitled to.

The Convener: As Richard Simpson has said, we have been dealing with the issue since he was a boy.

Dennis Robertson: Surely not that long.

The Convener: Maybe not quite as long as that.

The committee struggles with many of the issues that have been raised. We would all argue that we should defend health spending and protect it from cuts, but we recognise that delivering on that agenda is not just about funding hospitals. The health service is protected and local government is not, so that is a problem right away when it comes to our ambition to deliver more services in the community. Nevertheless, it has been an interesting discussion.

Do not feel under any particular pressure to respond, but if anyone wants to leave us with one single thought about their top priority—I am looking at Theresa Fyffe and her colleagues—now is your chance. Do not wait until you are on the bus going home thinking, “I wish I’d said that.”

Theresa Fyffe: I come back to what I have said a couple of times. It is about evidence, data and evaluation. If we can grapple with that, we might know better what we are trying to achieve and what is working; a point was made about understanding the work that has been done. I saw a television programme that described what people were doing and it sounded great, but do we know whether it was sustained?

I was here for part of the committee’s evidence session on communities working together and what community empowerment looks like. We sometimes forget that power. Lots of things happen in healthcare that happen because of community support by individuals or by groups. If we can harness that, we have a better chance of tackling the problems together, without there being divisions based on who has which bit of the resource.

Dr Reynolds: For me, the overriding thing that would improve the wellbeing of children and tackle inequalities in child wellbeing is a reduction in the stresses on parents, and a reduction in the unequal spread of stresses on parents, because the stresses cluster. Some of that happens at societal level, so a society that is more financially equitable would help, and some of it happens at individual level, so health visitors, GPs and other professionals are key in finding out what those stresses are and in advocating for them to be dealt with. For all the programmes that we bring in, if the parents are under too much stress to actually do them, they will not work.

Dr Saunders: At the risk of repeating myself more than once, there is a great need for a healthy public policy, and that will have to come from the Government. People who can be helped—through equality in education and in opportunity—need public policy that creates an environment in which choices that will help parents’ health and their children’s health are made easier rather than more difficult, so that the healthy option is not the more difficult one, as it currently is for too many things.

The Convener: Dr Gray, you have had your say, but would you like to add anything?

Dr Gray: I would just combine points that have been made by saying that I also like the emphasis on evidence, data and evaluation, which should be used to improve outcomes.

Jayne Sellers: From a professional point of view, I know that health visitors are well placed to deliver the best outcomes for children. Dr Gray talked about looked-after children. I know anecdotally and from experience of working at the base 75 project for women who are involved in street prostitution that a huge number of women in prostitution have come through the care system. I have also worked with homeless families, and many homeless individuals are ex-prisoners who have been through the care system. That is an area of deprivation that needs to be taken into account.

Dr Mullin: I would like to say two things. First, GPs need more time. Secondly, we need to imagine things from a child rights perspective, because that is an interesting approach that focuses people’s minds on the impact of policies.

The Convener: Thank you all for your valuable time and your evidence.

12:56

Meeting continued in private until 13:45.

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