The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 9 December 2014

Session 4

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HEALTH AND SPORT COMMITTEE
33rd 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:

Dr Daniel Beckett (NHS Forth Valley)
Aileen Campbell (Minister for Children and Young People)
Graeme Dey (Angus South) (SNP) (Committee Substitute)
Geoff Huggins (Scottish Government)
Alan Hunter (Scottish Government)
Dr Fergus Millan (Scottish Government)
Shirley Rogers (Scottish Government)
Maureen Watt (Minister for Public Health)
Carolyn Wilson (Scottish Government)
Alex Young (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Health and Sport Committee

Tuesday 9 December 2014

[The Convener opened the meeting at 09:46]

Interests

The Convener (Duncan McNeil): Good morning and welcome to the 33rd meeting in 2014 of the Health and Sport Committee. As usual, I ask everyone to switch off mobile phones, as they can interfere with the sound system. Some members are using tablet devices instead of hard copies of the papers.

We have apologies from Dennis Robertson. I welcome to his first meeting of the committee Graeme Dey, who is here as the Scottish National Party's substitute, and invite him to declare any relevant interests.

Graeme Dey (Angus South) (SNP): Thank you for your welcome, convener. I am not aware of anything that I should declare.

Decision on Taking Business in Private

09:47

The Convener: Agenda item 2 is a decision on whether to take in private item 6, which is our approach to a legislative consent memorandum. Does the committee agree to take item 6 in private?

Members *indicated agreement.*

Subordinate Legislation

Public Bodies (Joint Working) (Health Professionals and Social Care Professionals) (Scotland) Regulations 2014 (SSI 2014/307)

Public Bodies (Joint Working) (Membership of Strategic Planning Group) (Scotland) Regulations 2014 (SSI 2014/308)

Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 (SSI 2014/326)

09:48

The Convener: Agenda item 3 is subordinate legislation. We have five negative Scottish statutory instruments before us.

In relation to SSIs 2014/307, 2014/308 and 2014/326, no motions to annul have been lodged, and the Delegated Powers and Law Reform Committee has not made any comments on them. As there are no comments from members, does the committee agree to make no recommendations?

Members *indicated agreement.*

Products Containing Meat etc (Scotland) Regulations 2014 (SSI 2014/289)

The Convener: Again, no motion to annul has been lodged on the regulations, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to them as detailed in our papers. Do members have any comments?

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have just one comment. The products that are not for sale include, I think, brains, lungs and feet, but unless I have misread the summary of the policy document that we received, there is no mention of spinal cord. Is that really the case? I realise that I will not get an answer to that question today, but perhaps the clerks can check for me. Spinal cord products were one of the things involved in BSE, and I wonder why they have been omitted here.

The Convener: We have not asked anyone to come along and speak to the regulations, but we can certainly ask that your comments be noted.

Dr Simpson: Our paper talks about products that include

"parts ... such as brains, feet or lungs".

The actual order might refer to spinal cord, but I could not see any mention of it.

The Convener: We can communicate that.

Mike MacKenzie (Highlands and Islands) (SNP): I think that I am correct in saying that the Government has given a commitment to correct the points that the Delegated Powers and Law Reform Committee has raised, and we should welcome that.

The Convener: Okay. Noting those comments, does the committee agree to make no recommendation?

Members *indicated agreement.*

Food Information (Scotland) Regulations 2014 (SSI 2014/312)

The Convener: No motion to annul has been lodged on the regulations, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to them as detailed in our papers. If members have no comments, does the committee agree to make no recommendation?

Members *indicated agreement.*

Health Inequalities: Early Years

09:52

The Convener: Under agenda item 4, we return to our early years inquiry, this time to discuss the theme of health inequalities. For our final evidence-taking session, we are joined by two Scottish ministers. I give a special welcome to Maureen Watt, who appears before us for the first time as Minister for Public Health. We also welcome Aileen Campbell, the Minister for Children and Young People, whom we have met before at committee, and the following Scottish Government officials: Alex Young, team leader, tackling poverty; Dr Fergus Millan, head of creating health team, public health division; Anncris Roberts, early years collaborative team leader; and Carolyn Wilson, operational policy manager, child and maternal health division, early years.

I believe that we are going to have a short opening statement from the ministers, and I presume that they have agreed between themselves who will lead off first. Is that right, Maureen?

The Minister for Public Health (Maureen Watt): Thank you, convener, and thank you for your special welcome. If you do not mind, we would both like to make some brief opening remarks.

I thank the committee for this opportunity, and I look forward to working with you all in my new role. I will seek to set the broader context for this morning's discussions, and my colleague the Minister for Children and Young People will give the committee more detail about the policies that fall within her portfolio. I have been trying to get up to speed with my new portfolio, but I want to say that I and my colleague feel very strongly about the inquiry's subject and remit.

Scotland's health is improving across the piece, and people are generally living longer and healthier lives. However, I am acutely aware that, despite the significant efforts of this and previous Administrations to tackle health inequalities, they remain a blight on our society.

The committee has previously acknowledged the complexities of resolving Scotland's health inequalities and developing policy solutions that can minimise the impact of the differences in power, wealth and resource that underlie the inequalities in health in our society. Committee members will know that the First Minister has made tackling inequalities one of our stated objectives and we remain determined to address the gap in rates of chronic ill health and premature

death that impact on communities throughout the country.

The committee has focused on health inequalities in the early years because that is where society can make the most difference in long-term outcomes. We know that getting it right in the early years—and even pre-birth—can have a positive effect on the health and wellbeing of the child and the family. Prevention and early intervention should drive our work and that of our partners.

That is why the Government has had a strong focus on early years right from when it first came into government in 2007. We expect community planning partnerships to have a focus on the early years in their single outcome agreements. Addressing health inequalities in the early years is not a job for the national health service alone; we need all statutory agencies and partners to work with the strength, skill and assets of communities.

We have also focused on developing strong evidence-based policies in the early years that deliver a proportionate or progressive universalism, which we believe will make a difference.

For example, in our work on antenatal inequalities, we have taken on the messages about the need for a universal approach to ensure that we reach all those who are in need of services by focusing on improving access to maternity services. We have developed a robust framework to support maternal and infant nutrition, including breastfeeding, in recognition of the importance of nutrition pre and post birth. We have implemented the family nurse partnership but recognise that it reaches only a specific segment of the population, albeit one that comprises those who are at higher risk of poor outcomes.

There was a clear message from the evidence-taking session with the general practitioners at the deep end group and others that continuity of care and consistency of approach are crucial to reducing health inequalities. All our early years policies strive to achieve that. That is why we have invested significantly in strengthening universal services by increasing the number of health visitors to ensure that all families can access the services that they need through that universal gateway of provision.

However, we also need to be clear that health inequalities cannot be reduced by health interventions and policies alone. They are linked to and derive from the wider inequalities agenda of socioeconomic and welfare policies. As the committee knows, the Government does not yet have all the levers to address those comprehensively and coherently, but that does not mean that we can do nothing, and we must do all we can to address that social imperative.

The Minister for Children and Young People (Aileen Campbell): Good morning, committee. I thank you for allowing me the opportunity to make an opening statement.

It is significant that you have me and Maureen Watt in front of you today. In fact, you could probably have invited a number of our fellow ministers as well because health inequalities in the early years cross all portfolios, as well as agencies beyond the Government, as Maureen Watt said.

I welcome the opportunity to be here because early years policies and issues surrounding the early years are close to my heart—in more ways than one, given the imminent arrival of my bump at the end of the month. The Government wants to make sure that Scotland is the best place in the world for all children to grow up in and has a number of policies that are aimed at doing that. Maureen Watt has already mentioned some of them, and I add the getting it right for every child approach, the Children and Young People (Scotland) Act 2014, our play, talk, read campaign, our commitment to high-quality early learning and childcare and our national parenting strategy, which is the only one in the United Kingdom. All those policies have in common the perspective of prevention and early intervention.

I was pleased that the United Kingdom-wide social mobility and child poverty commission's "State of the Nation 2014" report commended Scotland's early years task force and the early years collaborative for their continued focus on prevention and early intervention.

10:00

I know that the committee had an evidence session on the early years collaborative, which is a vehicle and method to deliver our evidence-based policies and has the overall ambition of making Scotland the best place in the world to grow up in, by reducing inequalities and giving every child the very best start in life. It empowers practitioners and those who work on the front line to use their expertise to test different approaches for different children and families, initially on a very small scale before scaling them up. Is the venue difficult for some families? Is the form too complicated for someone who cannot read very well? Are we making assumptions about our services meeting people's needs? Those are the questions that we are encouraging practitioners to ask when they approach their job.

The collaborative is also about co-production: working with parents and children to build on the assets that are available in families and communities. We are proud that the collaborative

is world leading. We are the first to use this methodology in a complex, multi-agency environment, and there is a regular flow of requests from around the world to visit or receive further information about what we are doing in Scotland.

Far more important is the fact that we are now beginning to see the small tests of change bearing fruit and delivering for children and families. For example, at one site, the breastfeeding rate among a small group of vulnerable mothers has increased to 86 per cent. According to the Information Services Division, the local average is 25.5 per cent. Work is also going on at some sites to reduce the time that it takes to place a child in a permanent care setting.

At another site, parents are being encouraged to read their children a bedtime story. That scheme started with two parents in one nursery and is now working with 150 parents across six nurseries. Staff continuously evaluate the effectiveness of interventions and have witnessed outcomes that have exceeded their expectations, including increased numbers of parents sharing books at bedtime with their children. In one setting, parents have read 148 books to their children in the past year. The scheme has improved children's speech and language, which means that they have needed less support in class, and it has established bedtime routines, which has resulted in better behaviour in class. As well as improving concentration and behaviour, it has improved attachment and bonding between parents and their children. Parents have reported improvements in their own reading and confidence, their understanding of child development—and their essential role in that—and their own wellbeing and self-esteem, as they witness their actions making a positive difference for their child and themselves. Other sites are using the model to assess whether they are targeting their resources at the correct place, with some surprising results.

Of course, we still have progress to make and culture can be slow to change, but the enthusiasm and commitment that we see from the 700 practitioners from all across Scotland who attend the learning sessions that are held in the Scottish Exhibition and Conference Centre every few months make us optimistic that progress is on its way and is continually changing our culture.

Thank you for allowing us to make our opening statements, convener. I look forward to answering the committee's questions.

The Convener: Thank you both for your opening statements. Our first question is from Mike MacKenzie.

Mike MacKenzie: It is interesting that you both said that the early years is an issue that crosses portfolios and should involve all statutory partners. In that vein, do you welcome Sir Harry Burns's appointment to the Council of Economic Advisers? Does that perhaps signal a greater focus on health inequalities in the early years?

Maureen Watt: I think that it is an inspiring choice. Much of our work is based on equally well, which I was involved with as the Minister for Schools and Skills from 2007 to 2009. Harry Burns was a key member of the task force, which was where I first learned about how early health and the mother's health pre birth can impact on children's early years, and how regular feeding and nurturing are so important to the development of children's brains.

Aileen Campbell: The appointment sends a clear signal about the desire to align inequality with efforts to improve the economy and keep them closely interlinked. Harry Burns has been instrumental in the development of the early years collaborative. When he was the chief medical officer, he was one of the co-chairs of the early years task force. He has been an early years evangelist for some time, making the case around the country and beyond about the importance of effective intervention in the early years and the policies that we need to adopt to improve brain development.

Harry Burns has continued to be involved in the early years collaborative and has brought about some of the changes that we are seeking to make because of that approach. His appointment to the Council of Economic Advisers is a good move that links social policy and economic policy across the Government much more firmly.

Mike MacKenzie: At last week's meeting we took evidence from a number of witnesses who commented that some of the early years pilots are a bit short lived and that data and evidence that would give an understanding of their effectiveness are not collected. Do you feel that the appointment of Harry Burns will help to ensure that we have an approach that is based on the gathering of evidence and data so that we can understand what the best and most effective interventions are?

Aileen Campbell: I again mention the early years collaborative, which is strongly focused on data collection to ensure that we have the knowledge and the confidence to scale up interventions. It was not designed to be a short-term pilot. The approach of the early years collaborative does not fit neatly into the electoral cycle of the Scottish Parliament or local authorities; it is about ensuring that we make the right interventions at the right time. It involves

taking a longer-term view rather than the short-term pilot approach that you describe.

Pilots are important and have their uses, but the thrust of the early years collaborative is about collecting data and ensuring that it is robust so that we can check that what we do is working. If a pilot does not produce the outcomes that we expect, we need to have the confidence to use it as a learning opportunity and to not continue with that approach. It is a case of bringing about change and doing that using the data that is necessary to ensure that we are making the improvements that we all seek. The early years collaborative approach certainly addresses some of the points that you make.

Maureen Watt: You highlight a problem with pilots. People get upset if they think that a pilot has been working and we stop it because evaluation has shown that it has not delivered what was expected. That has been a problem across Governments.

Therefore, it is important that evaluation is built into pilots. Where feasible, that could be done in house or it might involve bodies such as universities undertaking self-evaluation. We are trying to improve on the methodology all the time to ensure that we are getting the right data so that we can find out whether pilots work. We also want the people who come to the sessions that we run across the country every now and again to share data and experiences, because that is extremely valuable.

Mike MacKenzie: Thank you.

Dr Simpson: I want to pursue the point about research. Is the chief scientist consulted on all the pilots to determine what the baseline data should be before they start? I think that, over both Administrations, the evaluations have been more process driven and have tended to involve self-evaluation instead of being driven by outcomes. Outcomes should be given careful consideration.

We know that the outcomes of the family nurse partnership may well be very long term. Everyone is signed up to that and recognises that that is the case, but it would be good to have a list of the intermediate outcomes of all projects at the beginning. The family nurse partnership programme is expensive, but the committee has been and continues to be generally very supportive of it.

However, I have a couple of questions. When someone drops out from the programme, they are not replaced. Each practitioner has a heavy workload with a small number of families but, overall, other health visitors see the workload as being fairly generous—I will put it as mildly as that. When people drop out, we are told that they cannot be replaced because the protocol does not allow it or because they might come back. There could therefore be a drop-out rate of 10, 15 or 20 per cent and that would mean that the workload would go down. Will the ministers comment on that?

Some families are not eligible for the programme, which has a strict protocol. How do we support such groups? Fife had a programme for families, including those that are now family nurse partnership families, but it is under considerable financial pressure. If someone presents after 28 weeks, for example, they do not get into the FNP programme. If they are over 21 but are very vulnerable, they do not get into the FNP programme. If they have a second child, they do not get back into the FNP programme. Those are three examples. How are we concentrating on them?

That is my first question. I also have a very short one, if I may, convener.

The Convener: There were a couple of questions in there, albeit important ones.

Aileen Campbell: I agree that the family nurse partnership is impressive. I have been out on some visits, and I believe that the committee has visited some of the health boards that are further down the line with implementing the programme. Some of the indicators for the short term are delays before someone has their next child, and more confidence when they have their next child about the approaches that they want to take to attachment and bonding. In general, there is more confidence from some of the mothers and the fathers. At some of the examples that I went to see in Fife, I was impressed with the fathers who were being more supportive of the family.

The member asked about people dropping out of the programme and not being replaced. Carolyn Wilson might want to comment on that. The approach is strict and the rules have to be adhered to. However, we also have the parenting strategy, which was the first in the UK. Scotland was first to have a national parenting strategy that speaks to all parents beyond those who are eligible to go on to the family nurse partnership scheme. We want to ensure that we help and support parents beyond those groups.

On top of the family nurse partnership approach, we have endorsed a number of interventions through the early years task force, such as triple P—the positive parenting programme—and incredible years. We also support a number of third sector organisations through third sector strategic intervention funding or strategic partnerships. For example, Families Outside uses effective interventions to support families who are affected by imprisonment to do the best that they can.

We also take a collaborative approach to target families who are in a bit more need by empowering health visitors and midwives so that they know where to direct families to money matters services so that they can increase their household budgets, or when to give support with nurture and attachment issues. Bedtime stories is a perfect example. More children than ever before are now being read bedtime stories as a result of that collaborative approach. On the face of it, that might not have the weightiness of the politics that we are used to but it is crucial to a child's development and their long-term outcomes so that they can flourish as an individual.

Carolyn Wilson might want to comment on the specifics of family nurse partnerships.

Carolyn Wilson (Scottish Government): Dr Simpson asked about filling gaps that come about in case loads when someone drops out of the programme. That depends on where they are in the cycle of starting the programme. There are opportunities for recruiting to empty spaces in case loads over time, but that depends on how far into the cycle of the programme delivery the teams are. I do not want to go into every single scenario just now but we can provide more detail.

Dr Simpson is right when he says that initially case loads can be lower than anticipated because people might drop out. However, the number of people who drop out is very small at less than 10 per cent overall for the whole programme. You are right that some drop out, but the numbers are a lot smaller than in other programmes.

10:15

Maureen Watt: An evaluation strategy is being developed and will be implemented in 2015. We are aware of the randomised control trials in family nurse partnerships in England, which are primarily investigating birth weight; smoking during pregnancy; child emergency hospital admissions within two years of families being on the programme; and—as you mentioned—the number of subsequent pregnancies. Those elements, and a number of secondary outcomes, will be evaluated during the programme.

Dr Simpson: It would be good to get a list of those outcomes when they are available.

Aileen Campbell: Another useful resource is the "Growing Up in Scotland" study, which is longitudinal and gives us some rich information. We can also point to further resources that provide the type of baseline data in which Dr Simpson is interested.

Dr Simpson: My other question is on quite a different area, but members may want to come in on that issue—

The Convener: A number of members want to ask questions, so there will be an opportunity at the end to sweep up any issues. Bob Doris can go next.

Bob Doris (Glasgow) (SNP): I am interested to know how the role of the independent adviser on poverty and inequality that the Government has just announced it will appoint will fit in with on-going Government policies. I am thinking about programmes such as family nurse partnerships and the national parenting strategy, and recently announced initiatives such as the new literacy and numeracy drive and attainment officers for primary 1 to primary 3 in each local authority. All those things fit together as part of the early years strategy, but where will the independent adviser on poverty and inequality fit in? Is the adviser's role to challenge Government when it has not got something quite right, or to suggest changes in how policies are progressed?

There are a variety of strategies, many of which the committee supports. We are seeking an independent expert to look at the thread that runs through all the policies, and to endorse strategies that the Government has got right and point to areas in which policy might be redirected. The committee will scrutinise each individual initiative, of course, but I am keen to know where the independent adviser on poverty and inequality will fit in the early years framework.

Aileen Campbell: The role and remit of the poverty adviser are being developed, but it would be right and proper for that person to challenge Government, as that is where such appointments are most useful.

I used to attend the ministerial advisory group on child poverty, which the former Deputy First Minister—now the First Minister—chaired, alongside Margaret Burgess. That forum allowed us to be challenged on the policies that we wanted to progress, and ensured that we could bring to bear expertise from wider civic society beyond Parliament and Government to enable us to tackle inequality, and child poverty in particular.

More directly, as part of my portfolio, we have the early years task force. One of our most recent appointments is Professor Jim McCormick from the Joseph Rowntree Foundation, who has just agreed to take a role in the task force. The task force sends a signal across Government portfolios and different disciplines that we want to ensure that there is a common approach that enables us to be challenged robustly.

From my experience on the task force, I know that bringing together people such as Scotland's Commissioner for Children and Young People, John Carnochan and now Jim McCormick means that we are challenged. That ensures that we

approach our policies robustly and that they do what we want them to do.

I welcome the proposed appointment of a poverty adviser, and I hope that they will be robust in their challenge to Government, because we cannot afford simply to wear rose-tinted glasses and have nice conversations. There is a real problem affecting families now, and we need to ensure that we are challenged as strongly as possible in order that we are directed to the areas on which we need to focus.

Bob Doris: I meant that the adviser would challenge things constructively, of course, but I am interested to know what priorities they will have. I suppose that, as they are independent, they will set their own priorities, but I would be keen for them to start on early years and early intervention, given that the Scottish Government has been focusing on those themes for a number of years.

Perhaps you cannot answer my question, but you could feed the issues that I raise into Government. My follow-up question is on childcare. We have an increasingly qualified early years workforce. However, the remuneration does not particularly reflect the workers' skill set, so they are quite often low paid. The Scottish Government has planned a huge expansion of provision running through to 2020. We need to ensure that childcare is in the right setting not just for the child, but for the parents who are in work or hoping to get into work. In that regard, there is a relationship with partnership nurseries, too.

There is also a UK layer with the tax credit system, for example, and the need to support people into work, and the minimum wage and living wage have to be at a correct level. Do you see your role, or that of the independent adviser on poverty and inequality, working across different Governments to look at the bigger picture? If the adviser looks only at Scottish Government policies they will miss a trick, because the issue is much more complicated than that.

Aileen Campbell: There is a lot of merit in what you say. I do not want to second-guess the adviser's remit, but to be helpful to the committee I suggest that, once it is finalised, we will make sure that you are kept up to speed with what that looks like.

We can also keep the committee informed on childcare. We have commissioned Professor Siraj, who is an academic with a childcare speciality, to look at the workforce. You are right to say that the workforce is increasingly knowledgeable and people have qualifications in a way that they did not have before.

One of the drivers for expanding childcare, alongside the economic reasons, is quality. If we want to achieve the outcomes that we expect for children we need a good-quality setting, otherwise the initiative's effectiveness will not flourish beyond the 600 hours of provided childcare.

Professor Siraj is researching the workforce and what more we as a Government need to do to help with the quality. She is looking at the feminisation of the workforce, pay and a host of other issues. She is due to report back to us in spring next year. We will make sure that the committee is kept abreast of the work.

You mentioned partnership nurseries in relation to the provision of the 600 hours of childcare. We have a mixed bag of different providers. There is a mixed economy—the statutory entitlement is provided not just by the local authorities, but by the private sector, third sector and childminders.

We took the first step towards the 600 hours expansion to increase flexibility. We know that families need that flexibility and the ability to access quality childcare. We are not there yet, but the Children and Young People (Scotland) Act 2014 implemented an expansion that was the first step towards the transformational change that we are seeking. It is frustrating that we do not have competency over tax credits, because that is very much interlinked with childcare and its funding. However, we are embarking on a change that, we hope, will deliver for families, for parents and, importantly, for children. The first step towards that was the expansion that we announced through the 2014 act.

Bob Doris: Given the questions that you have been asked, it would be fair if you thought that you were sitting in an education committee rather than a health committee. However, the committee is quite clear—and has been for some time—that the early years are important for lifelong health outcomes. Getting it right in the early years is critical, and that includes childcare, the employability of parents, and good-quality parenting and workplace experiences.

Aileen Campbell: The expansion of quality childcare for two-year-olds is critical, because we need to ensure that those very young children get the best start in life. There are sound economic reasons for expanding childcare, but the quality of that childcare is essential.

As the Minister for Children and Young People, I would add that effective and early intervention is not the same as early years. We can effectively intervene in a child's life beyond the early years, too. I know that the committee is concentrating on early years, but I make that point because we do not want to write off children just because they are beyond the age of eight.

Bob Doris: Absolutely. Thank you very much, minister.

The Convener: This might just be part of the journey, but my head is in a spin with the number of initiatives, projects, groups and experts involved. There is a comfort in that, because we have heard it in evidence throughout our work on this committee and, indeed, the work that Bob Doris and I did in the previous Local Government and Communities Committee. How do we make sense of it all?

We all enjoy the moments that we have on a Monday or a Friday when we see good projects and come away feeling great. What are the stark figures on breastfeeding among certain groups, and on smoking and drug and alcohol consumption while pregnant? Are the rates improving? Are they static? Where are the indicators? What have we learned from single outcome agreements? How many local authorities have child poverty as a priority in those agreements?

Maureen Watt: You and Bob Doris make valid points, convener. This will come more to the fore as budgets are challenged. We have to make sure that people do not duplicate work and that best practice is rolled out across local authorities. As you say, we all visit good projects in particular local authority areas, but we need to make sure that where such projects are proven to work, they are rolled out in other areas. We have to make best use of the workforce and ensure that we do not duplicate work or perhaps misuse resources.

I think that that is happening through the coming together of all the lead people in these projects through the early years collaborative. We are seeing good practice rolled out. The leaders who come to the meetings are very keen to make sure that they learn from others and roll out best practice.

Aileen Campbell: The 2014 act sought to embed the consistency that I think we need. We had 32 different levels of progress across Scotland in implementing getting it right for every child. We all understand that the Highland model was furthest along, through the pathfinder. In one of the most recent members' business debates, in which Dr Simpson took part as well, we recognised that the approach goes beyond party politics—it started with the Labour Administration and we have continued it because it is the right thing to do. However, it has lacked national consistency, which is why we drove forward with the legislation that we passed in the spring.

One of the wellbeing indicators is whether children feel included. The ministerial working group has discussed how we make that meaningful in relation to children who face deprivation and poverty. There is method in driving forward the legislation and linking it into the groups that we are talking about, whether through the ministerial working group or the early years task force. It is important to note that the poverty strategy also now includes an outcomes framework to include more robust indicators on how we are making progress on the issues that you sought assurance on.

The Convener: We deal with some of the frustration and we have taken evidence over years on some of those issues. That goes across political parties and across Governments. I mentioned single outcome agreements because they have been in place for some considerable time, whereas family nurse partnerships will need to be evaluated further down the line.

Given the importance of local government in delivering many policy initiatives on the ground, what does the single outcome agreement show us at this point, some seven years in, or do we not know?

10:30

Aileen Campbell: All local authorities have single outcome agreements that commit them to reducing inequalities. As Maureen Watt said in her opening statement, we are making progress, and we have ways of monitoring that. However, we realise that we always need to do more, which is why the child poverty strategy now has an outcomes framework. It is not just a case of launching the strategy, which is all great; we also have an effective way of monitoring its progress.

We are working with the early years collaborative. That work is about effective collection of data, which has perhaps not been done in the past, as the convener described. It is about ensuring that we have the confidence to develop policies that will deliver the results that we require.

The Convener: I am not questioning the ambition of the current Scottish Government, or that of Scottish Governments over the piece. What I am saying is that there is policy coming out of our ears, and there are experts and discussion groups. What difference have the single outcome agreements made to the most vulnerable children in Scotland?

Aileen Campbell: As I said, all local authorities have a focus on inequalities. They have all committed, through the early years task force and the early years collaborative, to focusing on tackling child poverty and inequality, and to ensuring that they make progress. We have ways in which we monitor that. For instance, we have to do a sweep to ensure that the task force is approaching the change agenda in the way that we would expect, given the money that has been put in.

The Convener: We know—you have pointed it out to us, minister—the importance of the connection between children and parents. It is about more than just reading a book: you referred to 700 children who are now reading books with their parents.

The single outcome agreements have been in place for a considerable time. We set up the policy with the ambition of making life different for the most vulnerable people in Scotland. What was the starting point? I am looking at the officials here. What was the ambition? Have we made progress in addressing some of the issues that the policy was developed to address? What improvements have been made?

Aileen Campbell: Child poverty rates have come down considerably since devolution, so there is a clear indication—

The Convener: Is that as a result of the single outcome agreements and Government policy? That is what we are trying to get at.

Aileen Campbell: There is a mixture of policies and approaches. You cannot have the same approach across 32 local authorities.

Maureen Watt: I do not think that you can lay responsibility for the approach solely at the door of local authorities; the approach is integrated with healthcare. NHS boards have local delivery plans, which are now being linked to the community planning partnerships. We tend to think of health and social care integration more in terms of older people, but it will also be rolled out to younger people.

The Convener: I am not attempting to blame anybody. In health we at least have a list of indicators. That is perhaps the challenge for other Government departments. Whether or not the indicators in health are correct, they are there and we use them to find out whether we are making progress on birth weight, smoking prevalence, mortality and so on. We can measure that up and down. I am looking for other types of measurement that would be available to us, as a committee this morning, so that we can say, "That is where the challenges are."

Dr Fergus Millan (Scottish Government): You are right about the indicators that we use to identify progress on tackling health inequalities, which are just a handful of the hundreds that we could have used, but they are not specifically applicable only to what the NHS is doing; they show what we are doing across all organisations to contribute to shifting the indicators. Unfortunately, the indicators are not going to change rapidly because although we have broken them down into short-term, intermediate-term and long-term indicators, we do not get quick results.

I will go back to the point about what the SOAs are doing and what difference they are making: they are getting people together to talk about things in partnership. That makes people think about how they might do things more coherently than in the past. When "Equally Well: Report of the Ministerial Task Force on Inequalities" was published in 2008, it set out quite clearly that the CPPs would be critical in delivering on health equality. However, CPPs had not found their feet in that respect until the time of the Christie commission report, and since then they have started to think more clearly about what they have to do and how they work in partnership.

The Government has been quite specific about the priorities that we want to see being reflected in the SOAs. Maureen Watt was absolutely right to say that health boards have their own local development plans; only in the past two or three years have we asked them to say specifically how they contribute to the SOAs and how everything merges together.

We are asking enormously complex organisations in an enormously complex area to try to work together. It is a process, and we want to know that there is confidence among the organisations that are starting to talk and to create among themselves the structures to deliver on policy aims. We are seeing that confidence in a variety of areas; some of the work that has been done around health and social care integration shows that organisations can work together. It is difficult—all such things are—but we sense that progress is being made and that organisations are working towards the priorities that the Government has agreed.

The Convener: The jury is still out.

Dr Millan: We are trying to bring about a shift in the way that complex organisations do business and engage with one another. Bear it in mind that CPPs do not involve just health boards and local authorities; they involve the police and other agencies, all of which have important roles to play. That is also reflected in Government in the way in which officials work across policy areas to identify opportunities to work synergistically—not just in name, but genuinely working with colleagues to join things up. It is a huge challenge and an enormously complex process, but we are making progress.

Rhoda Grant (Highlands and Islands) (Lab): My questions are on a similar theme to the convener's questions, but they may be easier to answer. What tests does Government carry out when it is developing policies to deal with health inequalities—in particular, policies for early years provision? We know that that is a cross-cutting issue that does not sit only with health or with education, but goes across all departments.

Aileen Campbell: As I said to Bob Doris, we have relationships with a number of key professionals, stakeholders and third-sector organisations—we do not make Government policy in isolation. We have to ensure that what we are doing will have the impacts that we expect for the child, and that the outcomes will be achieved. The early years task force is a key collaboration of effort from across the third sector, the private sector, the health service, local authorities and others who contribute to what we need to do as a Government. The ministerial advisory group on child poverty is also cross cutting.

Rhoda Grant: Who sits on that?

Aileen Campbell: That group includes Jim McCormick, who has already agreed to be part of the early years task force, and there is representation from CPAG by John Dickie. I am struggling to remember all the names. Alex Young may be able to list them.

Alex Young (Scottish Government): The other people on the group are from Barnardo's Scotland and from One Parent Families Scotland, and we have the Scottish commissioner from the United Kingdom social mobility and child poverty commission. We also have Linda de Caestecker from NHS Greater Glasgow and Clyde and Jane Wood from Scottish Business in the Community.

Aileen Campbell: Jane Wood now sits on the early years task force as well, to ensure that we are bringing to bear all the expertise that we have.

There are other opportunities, as well. For example, the parenting strategy that we have taken forward was developed in consultation with parents, and we engaged with those parents through organisations such as Children 1st and Families Outside, which already have networks of contact with parents, to ensure that what we are doing as a Government is what parents tell us they require. The work is never done in isolation. That is why I pointed to the collaborative. The approaches that we describe are not just about Government, but are about bringing together all the players that can offer input and have a direct influence on the success of the policies that we want to take forward.

Rhoda Grant: How do stakeholders interact with Government when it is developing policies on, say, the budget, the environment and all the other issues that impact on poverty?

Aileen Campbell: Again, it is about making sure that we have, as a Government, the discipline of being cross-cutting. As I said in my opening statement, the committee could have asked one of a number of different ministers to come here to talk about tackling inequalities. I have described some of the ways in which we ensure that we have people coming from all areas and all sectors to influence the policy directions that we take.

Rhoda Grant: I guess that I am looking for the mechanisms by which those people influence the Government. Do they sit at the Cabinet table? Do they look at legislation?

Aileen Campbell: We have set up the ministerial working group on child poverty, and the early years task force. There is also the raising attainment for all initiative, which is the collaborative beyond the early years that is looking towards raising attainment. Key players sit on that in a national sense and in a very local sense. There are a number of initiatives that are not just about Government officials and ministers sitting down and deciding on policy, but are about—I reiterate—bringing together people who have key expertise and influence in areas on which we think we need a sharper focus.

Rhoda Grant: How do those people influence other areas? That is what I am driving at.

Dr Millan: Policies are put through equality impact assessments, but there are also, since about 2010, health inequalities impact assessments, which NHS Health Scotland carries out. I do not have the briefing in front of me, but it has done about 30 since 2010, and it put out guidance on the assessment in about 2011. It assesses policies on whether they take into account a range of things that impact on inequalities. I do not have the detail with me, but those assessments are a specific way of looking at a new policy initiative to determine its likely impact. It might be that, when the impact has been determined, the Government will still go ahead, but at least it has information that might influence what it does to make a policy have a less negative impact.

Rhoda Grant: Does that happen with all policy development?

Dr Millan: NHS Health Scotland has done about 30 of the assessments—I am trying to remember. There is a list on its website and it looks as though there have been 30 or more since 2010. It has done five or six this year. I do not know whether it is a question of capacity, but an assessment is not done in every case, but will be done on certain policies. Many have been done in the NHS and some have been done within the Scottish Government.

Maureen Watt: There are a couple of relevant publications. "Long Term Monitoring of Health Inequalities: Headline Indicators—October 2014" shows that progress is being made but that inequalities persist in some areas. There is also Audit Scotland's report "Health inequalities in Scotland". A number of publications influence and

determine Scottish Government policy as we go forward.

Aileen Campbell: We are also developing a child's rights impact assessment tool to ensure that we make good on the pledge that we set out in the Children and Young People (Scotland) Act 2014 and that all areas of policy—beyond just education, social work and health—recognise their role in delivering more for children in terms of their rights.

Rhoda Grant: Okay, but that is not going on at the moment. I am trying to find out what happens—

Aileen Campbell: That is part of the new legislation; it follows the legislation that we passed fairly recently.

Rhoda Grant: Will that assessment focus on childhood inequalities?

Aileen Campbell: We are adding the child's rights impact assessment to complement other parts of the Government's influence in terms of inequalities. Children have inalienable rights, which include being able to participate in society, so that will have an impact on what Rhoda Grant asked about in her question. We will let you know how that develops further down the line.

Rhoda Grant: I get the impression that health, social work and education all kind of look at this, but we all know it goes much wider than that.

Aileen Campbell: Of course.

Rhoda Grant: At the moment, we seem only to be considering the very narrow area that deals with the symptoms, but not the causes. What tests are carried out on all Government policy to ensure that the causes, and not just the symptoms, are dealt with?

10:45

Aileen Campbell: In addition to the children's rights element of the Children and Young People (Scotland) Act 2014, getting it right for every child requires a broader approach to ensure that we get it right for each and every child. That requires local authorities, health boards and other partners to ensure that everyone is doing what they can. That goes beyond housing, social work and education. We are therefore about to go to consultation on the guidance that will accompany the 2014 act so that local authorities recognise the role that they must all play to get it right for every child across the country and to make good on the legislation and the legislative changes that we have just taken forward. That is one way in which we can ensure that the influence of those changes goes beyond health and education.

The Convener: Much of what is going on has been described by the ministers and officials in terms of how the Government is attempting to tackle the issues. The committee is considering health and the various indicators, but we do not see them reflected in all other areas. I think that I am hearing from Dr Millan and ministers that genuine attempts are being made to start that work or to push it on. That is positive. It would be useful to hear more.

On a wider point, a paper was recently produced by Professor David Bell. He gave us evidence on the budget and made the point that Governments can make policy that can unintentionally, almost like the inverse care law, not help—if I can put it in less pejorative terms—in achieving climate change targets, because it puts up fuel bills, which also increases the burden on the poorest people. We are looking for information on that, and for indications that the Government is taking those issues on board. It seems that the Government is starting that process, which is a good thing—that is what we want to hear—but rather than labouring the point and going on as I am doing this morning, perhaps we could be supplied with some further information.

Aileen Campbell: We can certainly get back to you with a list. In addition to what we have all said, the First Minister announced in her programme for government that a poverty impact assessment is to be introduced. All those things can be tied together to provide you with a broader sense of how we are knitting together the actions of Government so that we are not working in silos, and so that everything is pointing towards making improvements to the economy while also making inroads into tackling inequality.

The Convener: That is where the committee is: having heard the evidence so far, we want to hear more about that and we want to encourage that sort of activity. That is how Government has operated for a long time—not just the Government at this point.

We need to push on.

Graeme Dey: I wish to consider an aspect of delivery of support. Can the Minister for Public Health update us on progress on deployment of the additional 500 health visitors over four years, which I think was announced six months ago? Can she confirm that they will operate across rural areas as well as urban areas? I ask that as an MSP for a rural area that is not viewed as having significant deprivation, but the existing health visitors are having to deliver classes in basic parenting skills for young people. To what extent does the minister accept the need to ensure that there is appropriate geographical deployment of the new health visitors, taking account of areas more rural than the one that I represent, in order to

ensure support for all families across Scotland who require it?

Maureen Watt: Graeme Dey has made a very valid point. In June this year, the Scottish Government announced that it would provide £2 million of funding in this year and a total of £41.6 million over the next few years for additional health visitors, with the goal of growing the workforce by 500 by 2018. That is to ensure that funding helps all the health boards to ensure that there are enough health visitors to provide universal visits and development checks for children—for example, the 27 to 30-months review—and to meet the obligations under the Children and Young People (Scotland) Act 2014 to provide named persons. That extra money is going in, and since 2007 health visitor numbers have increased by about 22 per cent.

We are committed to ensuring that that the covers all the health boards, and it is up to the health boards themselves to ensure that that happens. There is a tendency to think that inequalities exist in particular pockets in our society, but we must ensure that individuals who live in poverty, especially in rural areas, have access to services.

Graeme Dey: I welcome that commitment, but how will the Government ensure that that takes place across the health boards? Perhaps there is a risk that they will take those additional resources and target the easiest targets, for want of a better expression—they could be focused on major cities, where it appears that there would be the best return. There are obvious challenges in particular rural areas—the bigger ones—in deploying resources effectively. What guidance will be given to health boards to ensure that we get that right?

Maureen Watt: I will refer to my notes. We have recommended that NHS boards use a validated case-load working tool to support consistency in determining health visitor numbers across Scotland. That tool, which is based on population data and allows for local variation, would be used in conjunction with nursing and midwifery workforce workload planning tools. That sounds technical, but that explains it.

Graeme Dey: Obviously, the issue is something that you are mindful of.

Maureen Watt: Yes.

The Convener: Nanette Milne wants to ask questions on a similar subject.

Aileen Campbell: I can follow up on that—I will be very brief.

There is in Angus a collaborative test pioneer site to support parents who have children in the early years in tackling substance misuse. That will give comfort that there is a focus not just on urban areas; local authorities and health boards are taking very seriously the impact of rurality and so on in helping parents. I can pass on to the committee information about the improved attachment and child development work in Angus. Angus Council also has, as a local authority, a good case to make on its approach to getting it right for every child in general.

Nanette Milne (North East Scotland) (Con): I very much welcome the promised extra 500 health visitors, as health visitors play an absolutely crucial role not only in the early years, but as children develop and in picking out families that need help.

I am a great fan of primary care-based health visitors, having grown up with that approach when my husband was in practice. They really have an insight into local families who face difficulties. I raised the issue last week, when the deep end practitioner agreed with me that, in that sort of practice, a practice-based health visitor would be really useful. However, Theresa Fyffe of the Royal College of Nursing Scotland indicated that things have moved on, and she was not quite so enthusiastic. I would welcome comments on that issue.

Some of the most experienced health visitors have gone into family nurse partnerships, and I am sure that they are doing a tremendous job there, but given the named person role, will 500 additional health visitors be enough? I know that that is a lot, given the standing point just now, but in the fullness of time, will that number be enough to cover needs? I am not convinced that it will be.

Maureen Watt: We will continue to monitor to see whether it is enough. You are absolutely right that the health visitor will be the named person for the majority of children under five, so we must ensure that there are enough of them.

Theresa Fyffe has said:

"Health visitors make a critical difference to the health and wellbeing of the future lives of children and families."

She recognises their importance, and has welcomed the increase in investment in that respect. We must ensure that they are fully resourced, but I think that Aileen Campbell is more versed in the named person issue.

Aileen Campbell: I should sound a note of caution, because there is an on-going legal issue about that element of the Children and Young People (Scotland) Act 2014. However, I can say that not every family will need their named person. As a well-known practitioner who has an existing relationship with the family, they will be an important first point of contact but, as I have said, not every family will need theirs.

I also point out that the money that accompanied the expansion of health visitors will be used to increase capacity as well as their training and knowledge of some of the new requirements in the legislation. This is about not just recruiting health visitors, but ensuring that there is quality behind all of that and taking cognisance of the legislative changes that have been made.

Nanette Milne: Will it involve increasing recruitment in the nursing profession? After all, health visitors need to train as nurses first, and I am not sure whether there are enough trained nurses who are ready to take on the role.

Carolyn Wilson: The modelling took account of workforce demographics and the number of health visitors who would naturally be going through the system and then looked at the workforce overall. The situation is being monitored very closely, and it will be down to the health boards to decide what resource they need and where it might come from. We are talking about a four-year cycle; graduates with nursing degrees will be coming out every year, and the hope is that a gap in other nursing services will not arise as a result of people moving into health visiting.

What is very clear is that a lot more nurses are looking to choose health visiting as a profession. For the past couple of years, that has not been as strong, but we now feel quite positive about being able to build on the commitment that we made.

Aileen Campbell: The GIRFEC or named person approach is about embedding the best practice that many health visitors and teachers already do, in the relationships that they have with families and in the help and support that they give children and parents. Given that the statutory requirement for the named person and the GIRFEC element of the 2014 act will not come into force until 2016, things are not going to start immediately. Indeed, we are about to consult on the statutory guidance that will accompany the legislation, and that will provide another opportunity to reflect on the situation and ensure that we have in place everything that we require.

Nanette Milne: Are things being monitored very carefully? Given the previous cut in the intake of nursing students, it is important to look at the whole situation and to plan well ahead to ensure that people are coming through the system.

Maureen Watt: The need for new posts is reflected in the budget lines. For example, funding for new posts is to rise from £6.8 million in 2015-16 to £20 million in 2017-18.

Dr Simpson: Minister, can you pick up the point about the cut in the number of nursing students? I know that it was partly restored, but the fact is that the cut of 20 per cent—or 10 per cent in each of two years—has not been restored fully. The 40 per cent cut in the midwifery intake, too, has been only partly restored; the numbers fell from 180 to 100 and then went back up to 160. The Royal College of Nursing has heavily criticised those two cuts, and they are particularly pertinent in view of the very welcome decision to increase the number of health visitors. If people want to take up the postgraduate training for health visiting, they must have trained as a nurse first. If an increased number of students are not coming through, how will you augment the number of health visitors by 500? I do not follow the logic.

11:00

Maureen Watt: The cuts in numbers are being reversed so that we are recruiting more and taking the need for health visitors into account.

Dr Simpson: So the full nursing complement from three years ago, before the cuts, will be restored. Is that what you are saying?

Maureen Watt: I cannot guarantee that those are the numbers but I can get back to you on that.

Richard Lyle (Central Scotland) (SNP): Most of the questions that I was going to ask have been answered, but I have two quick ones.

The Scottish Government has increased investment in childcare provision. Most parents require it and we all know how good it is for the child. What impact will it have on early years health inequalities?

Aileen Campbell: As we have said in response to other questions, the increased provision is about giving children the best start in life. We have also increased the skills of the workforce through the requirement to have the BA in childhood practice and more qualifications in other areas. We are trying to improve the quality to ensure that the children who have those 600 hours of childcare get a quality experience.

The expansion of provision to two-year-olds—15 per cent this year and 27 per cent next year—is about taking on board what everyone has been talking about: that if we intervene effectively in the early years, we can improve outcomes in later life. The expansion of provision to two, three and four-year-olds is about not only supporting the child but ensuring that we build proper relationships with families—it is about providing support to the families and increasing their capacity as well, so that not only does the child get a nurturing experience in the 600 hours, but there is increased capacity to ensure that they get the nurturing that they require when they go home.

That is not the end point. The 600 hours of child care will do a lot to reduce the impact on household budgets. Our modelling has suggested

that families will make a saving of £700 per child per year. We want to build on that expansion by increasing the flexibility and increasing the hours further. However, we need to do that at a pace that allows us to get the adequate number of people in place to achieve our targets and deliver the quality.

Richard Lyle: I welcome that. My grandson is now attending nursery; my granddaughter is only months old.

Recently, there was a press report about a lady in a famous hotel in London being asked to leave or cover up because she was breastfeeding. Earlier, you mentioned the rates of breastfeeding in Scotland. The Parliament passed a law on breastfeeding. What action is the Scottish Government taking to ensure that firms and the public know that new mothers are allowed to breastfeed in public?

Aileen Campbell: I guess that it does not help that we have certain politicians making certain claims in public about breastfeeding, but I will leave that for Mr Farage to explain away.

Richard Lyle: I totally deplore his comments.

Aileen Campbell: Absolutely.

As I said, some of the tests of change from an early years collaborative point of view have been about increasing the prevalence of breastfeeding and providing the support that mums might need. At that point, they are vulnerable. They have just had a baby and are getting bombarded with lots of information, so they do not need to be made to feel guilty. We are ensuring that the support is available for mothers who need the extra bit of help. We are doing that to increase the prevalence of breastfeeding because it offers the best start in life to children.

The legislation to which you referred was passed in 2005. There are a number of initiatives on baby-friendly or breastfeeding-friendly status. We are promoting it through a number of different avenues. UNICEF is developing a number of bits of work to provide accreditation for premises to be breastfeeding friendly.

Maureen Watt might want to talk some more about some of those measures. However, the result of the collaborative example that I mentioned is that 86 per cent of the mothers with whom the services are working now breastfeed. I acknowledge that the sample is small, but the outcome shows that if we work effectively with a group of mothers, we can quite quickly turn things around and get more positive results than we might have seen in the past. The overall result for Fife was 25 per cent, which highlights the difference that can be made through the approach that the collaborative brings to bear.

It is incredibly important—not least because I am about to have a child myself—that we have in Scotland a culture in which the benefits of breastfeeding are accepted and in which mothers feel that there is acceptance around it.

Maureen Watt: To go back to the point about increased provision of childcare, our aim is to increase not only the provision but the quality of childcare and children's experience of it. For example, they may learn how to read, play and interact, and they may get better nutrition, which all feeds back to the families.

I heard a discussion about breastfeeding on the radio the other morning and the people involved were praising the Scottish approach. We have Elaine Smith to thank for the Breastfeeding etc (Scotland) Act 2005, which was the first legislation of its type in the UK, and one of only a few pieces of legislation in the world that make it an offence to stop a person breastfeeding. Perhaps Claridge's and other outlets and organisations ought to be aware of that.

Aileen Campbell mentioned the UNICEF UK baby friendly awards. Scotland has increasingly been at the top of the list in those awards, in comparison with every other region of the UK, and we should be proud of what has happened here in relation to breastfeeding.

Aileen Campbell: In my constituency office, I have a notice up that says that if a mother wants to feed her baby there, she can do so. All mothers need is somewhere that is quite calm and has appropriate seating and water. We could all take a lead in that respect and ensure that our constituency offices offer that facility.

Richard Lyle: We will take your point.

The Convener: I am sure that Richard Lyle's grandson or granddaughter might find that helpful.

Richard Lyle: On the first day that my grandson went to nursery, he took his jacket off and said, "Bye, Mum" and ran straight in to play, so I welcome the increased hours of childcare, and I also support Elaine Smith's legislation to promote breastfeeding.

Aileen Campbell: For the key developmental milestones beyond the early years, such as adolescence and the transition from primary to secondary school, it is important to get it right in the early years; it all often points back to a good experience in early years settings.

The Convener: I do not want to be a pain, and I do not necessarily require an answer, but it would be useful to get some feedback on our earlier discussions about what our objectives are for childcare policy and how we evaluate them.

The concept of proportionate universalism has been mentioned by the minister and other members, and by Professor Michael Marmot, who gave evidence in a previous session. Given that it is a relatively new childcare initiative, it would be interesting to evaluate how it helps with inequalities and to ensure that an inverse situation is not operating. How do we look after very vulnerable children within the whole spectrum of that initiative? Does applying the concept widen or narrow the gap between the poorest and the better off? What evaluation has been done?

Aileen Campbell: Sorry—I am struggling on your question. Are you referring specifically to childcare?

The Convener: What evaluation has been done of the childcare policy that you have described? How is it poverty proofed? How do we ensure that existing inequalities are alleviated by the policy? What evaluation has taken place?

Maureen Watt: The document "Equally Well: Report of the Ministerial Task Force on Inequalities" sets out clearly that departments should ensure that they do not build inequalities into anything that they do. For example, and as you know, we encourage cross-departmental approaches. The last task force report mentioned the link up project, which was run by Inspiring Scotland and received funding from both justice and health. It looked to enable asset-poor communities to develop and grow. All departments are well aware that they should ensure that they do not build inequalities into their work.

What has been said today and by the panel that gave evidence to you last week is that a lot of inequalities are a result of things that are not in the Scottish Government's control.

We have noticed that when people receive the living wage, it has helped to reduce inequalities.

The Convener: Not to go on about it—maybe I am communicating poorly—but if you implement a universal policy that applies to everyone, rich or poor, how do you ensure that the measure tackles inequality? What evaluation took place to ensure that it would narrow the gap between rich and poor? How does it do it? Why is it an inequality measure?

Aileen Campbell: Going back to childcare—

The Convener: The 600 hours, the flexibility—why is that an inequality measure?

Aileen Campbell: There is a high take-up of childcare—about 90 per cent—so already we have a good base with which we can compare and contrast. The growing up in Scotland longitudinal study has key data about the improvements that childcare measures can make and the reduction in inequalities that they can bring about. However, those things are dependent on childcare being of high quality. We are not just talking about the economic drivers; the policy is about ensuring that children get quality provision.

We know that the benefits of high-quality childcare early on continue at the age of 14 and may particularly benefit children from deprived backgrounds. We see improved cognitive development and speech and language development in five-year-olds. Key milestones point back to the importance of the expansion of childcare. The more hours we give and the better the quality of those hours, the better able we are to begin to tackle some of the inequalities in attainment in later years.

The Convener: All children will benefit from the policy, including children who are in an advanced position in terms of inequalities. How does the policy help?

Aileen Campbell: All three and four-year-olds across Scotland are entitled to 600 hours, but we are targeting the most vulnerable: this year, provision is being extended to the most vulnerable 15 per cent of two-year-olds; next year, it will be extended to the most vulnerable 27 per cent. We are making our interventions earlier.

I stress again that the provision has to be high quality, particularly for those age groups, which is why we are ensuring, through Professor Siraj's commissioned work, that the workforce is as well developed as possible. The Care Inspectorate also has a role to play in making inspections to ensure that quality is there.

We know from the results in later life—some of the milestones regarding speech, language and transitions to secondary school—that if we tackle in the early years some of the deep-rooted sources of inequality, we can reverse some of the inequality trends.

It is important to recognise that in all that work, the early years collaborative and the work on raising attainment for all, which I think takes place in P1 to P7, a thread goes through to ensure that we tackle inequalities in education and are always routing back to the early years.

Maureen Watt: The Scottish public health observatory today published a report on health inequalities. Although it does not focus only on the early years, it points to the interventions that make a difference to health inequalities.

We need to give health visitors responsibility to make decisions. They know where best to spend their time to make a difference to families who need more help.

11:15

Aileen Campbell: Healthcare is important for every child. We do not just talk about targeting. All children deserve the best start in life.

The Convener: That is my point. We are talking about inequalities and how we reduce the gap between the most vulnerable and the well-off.

Aileen Campbell: We have a targeted universalism within that policy.

The Convener: We would be glad to hear some more about how we got to that targeted and proportional universalism—that universalism plus, or whatever we call it—but universalism on its own does not seem to be able to do it all. The committee is examining something in addition to that.

Colin Keir (Edinburgh Western) (SNP): We have heard quite a lot about health visitors during this morning's discussion, but what about the role that general practitioners will play during the next few years? How will their role evolve as the new policies are rolled out?

Maureen Watt: GPs are just one part of the jigsaw and they are obviously an important part of community planning partnerships. Hopefully, the main point of contact will be health visitors, and family nurse partnerships are also key. GPs will have a role but, hopefully, they will not be needed in the front line because we are making sure that people are healthier in their early years. Clearly, though, they have a role.

Colin Keir: You mentioned community planning partnerships among other things. At the Public Audit Committee last week, the Auditor General was a bit critical of community planning partnerships generally because how they work has not evolved as quickly or as painlessly during the past decade as it might have. Do you see any difficulties with rolling out any of the policies? Is everyone buying into them or is it difficult to get policies enacted at the local level because of the difficulties that local authorities have with NHS boards and others?

Maureen Watt: I was at a meeting of community planning partnerships last week. Roll-out has been patchy, as you say, and some are much further ahead than others. Work is going on between the Government, the Convention of Scottish Local Authorities and the health boards, however, and that is where we are going. It is incumbent on all those bodies to work together to make sure that CPPs are rolled out.

Aileen Campbell: In my portfolio, the early years task force brought key partners around the table and had a direct link with community planning partnerships. The key change that came from that was the early years collaborative, which has had a huge take-up. There were 700-plus at each learning session in the SECC, which showed in a way that has not been shown previously how keen the community planning partnerships are to tackle the issues that they are dealing with in local authorities and health boards.

All 32 local authorities and community planning partnerships are involved in and taking ownership of the collaborative ways in which they want to move forward. However, that is the key change that has resulted from the early years task force and the change fund. It was the first time that we had a financial mechanism that brought to bear money from the Scottish Government, local authorities and health boards. From that point of view, there is a lot to be positive about around the role of local authorities and health boards and all the community planning partners that are participating, particularly in the early years collaborative.

The Convener: Dr Simpson, do you wish to ask another question?

Dr Simpson: I will be very brief, convener.

I am interested in the fact that the membership of the public health review does not include any public health directors, particularly in view of the discussion that we had with the previous cabinet secretary about where responsibility for public health should be placed. In England, it has been placed with local authorities, but I think that difficulties are emerging with that approach and results have been very patchy. Can you supply the committee with the terms of the review, tell us who its chair will be and give us some rationale behind not having a director of public health either from Scotland or, indeed, external to Scotland? After all, it might be quite useful to get in someone from England who has experience of the review there and what has happened with the transfer. In any case, I find it incomprehensible that there is, as I understand it, no public health director on the review team.

Maureen Watt: We can certainly get you that information.

The Convener: It might be better if that response was fed back to us instead of our trying to get an answer now.

Dr Simpson: I did say that my question was a quick one, convener.

The Convener: That was very quick for you, Richard, but nonetheless important.

I thank the ministers and their team for their time and their evidence, which we will take into account in our report. The area is certainly challenging and complex and one with which we are all struggling.

Aileen Campbell: Have a good Christmas, convener.

The Convener: Indeed. I need to remember that this is our final meeting before Christmas. Merry Christmas to you all.

11:21

Meeting suspended.

11:26

On resuming—

Winter Resilience

The Convener: Item 5 is evidence from Scottish Government officials on winter resilience. We have Geoff Huggins, acting director for health and social care integration; Alan Hunter, deputy director for performance management and national programme director for the unscheduled care programme; Shirley Rogers, deputy director for the health workforce; and Dr Daniel Beckett, consultant physician, NHS Forth Valley. I thank you all for your attendance. Does anyone have any brief comments to make?

Geoff Huggins (Scottish Government): I will ask members of the team to say a wee bit more about their experience, but we will not make extensive opening remarks.

The Convener: Okay. After that, we will move to questions.

Geoff Huggins: My particular interests are in delayed discharge, health and social care integration and primary care.

Shirley Rogers (Scottish Government): I have responsibility for the health workforce and the quality and efficiency support team—QuEST. I have a particular interest as the chair of the task force on sustainability and seven-day services.

Alan Hunter (Scottish Government): I have been with the Scottish Government for almost a year. I came on secondment from Greater Glasgow and Clyde NHS Board, where I was a general manager in the acute sector for about 14 years. Prior to that, I had experience in hospitals in Scotland and England.

Dr Daniel Beckett (NHS Forth Valley): I am the chief medical officer's specialty adviser for acute and general medicine. I am also the national clinical lead for the whole-system patient flow improvement programme. I am the associate director of standards at the Royal College of Physicians of Edinburgh and a consultant physician in acute medicine in NHS Forth Valley, which is where I spend most of my time.

Dr Simpson: We have been fortunate for the past few years in having relatively mild winters and I hope that we may be fortunate again. However, I am concerned about delayed discharge numbers. The figures had been dropping since delayed discharge was defined as involving a delay of more than six weeks. In 2002 to 2003, when the programme came in, the figure was 3,000. The Labour Government reduced the numbers considerably and the Scottish National Party Government, to give it credit, had reduced the

number to zero by March 2008. However, in the past three years, the numbers have risen.

The latest report says that 450,000 bed days have been occupied, which is the equivalent of 1,100 beds occupied in our acute sector every day of the year. Given that problem and the fact that local authorities are cash strapped, how will you ensure that, if the winter is even moderately bad, our health service can manage the situation and continue elective surgery? I hear that a number of boards are predicting that cancellations of operations will increase significantly over the winter, which means that the Scottish Government's targets will not be met for even more Scots than the 10,000 a year for whom the legal guarantee is not met.

11:30

Geoff Huggins: I will talk about where we are on delayed discharge and then bring in Alan Hunter to talk about the work on elective surgery. First, I refer to the statement and comments that the new First Minister has made on the programme for government. The Government is clearly committed to tackling delayed discharge and it will take action to do so. In her speech, the First Minister set out the additional £15 million that would be spent across the winter to take additional steps in individual partnerships to reduce the number of delayed discharges.

I can say a bit about that work to illustrate what is happening in practice. NHS Fife is doing work to increase the number of step-down beds, which enable staff to move people on appropriately when they are ready for discharge from hospital into a location in the community. That is part of the process of—ideally—returning people home. Through the work that it has commenced, NHS Fife expects to take about 60 people relatively quickly out of its current number of delayed discharges.

In Glasgow, we have a system where the health board and the council are working towards a process of discharge for assessment. When appropriate, patients would not sit in a hospital bed waiting for an assessment but would return home quickly to be assessed and then move on.

The £5 million that the Scottish Government has offered—together with the contributions that health boards and local authorities are making, the national unscheduled care action plan money from earlier in the year and the £5 million that we allocated in the summer—is being used in targeted ways to address the short-term challenge and look beyond it to build systems that do not simply transfer the problem elsewhere. The intention of integration and the work on delayed discharges is to release the pressure on the NHS by ensuring that the whole system works effectively. That means that we need to take more evidence-based approaches in hospitals that enable us to work across the hospital-care boundary.

We are doing some work nationally. We have engaged with the Care Inspectorate on work that it can do to assist us to ensure that care homes can take people and that the quality that care homes offer does not mean that councils or the inspectorate must block people going out to them. Targeted support is being offered in the City of Edinburgh Council area, where access to care homes has been a particular issue. The approach is also being taken into other areas where a lack of access to care homes might cause a delay.

Through the work of the residential task force, we are thinking carefully about how we want to use care homes in the future. We are beginning to move increasingly to seeing them as part of a system of care whose objective is to enable people to stay at home for as long as possible. We see care homes in many cases not as long-term residences. Home is the appropriate long-term residence for people—that is what they tell us. We are thinking about care homes having a different function in the system from the one that they might have had before. We are taking that work forward in collaboration with COSLA and other colleagues.

To build on the work that we have done in Fife, we are working directly with partnerships to anticipate how things might operate under integration. In that context, we have worked directly with the chief officer as well as both partners—health and social care—to talk through the different solutions that they might adopt during 2015-16, when the integration partnerships come on stream. We have asked them to do that now because there is no reason to wait to do sensible things. As partnerships, they are stepping up to the mark to do that.

Internally in the Scottish Government, we have established a programme board to actively manage delayed discharge across the winter. That will meet weekly and will look at what I would describe as the grey data—the unvalidated data that we get weekly, which we do not publish. It will also identify across the period whether there are challenges or blockages that we might want to become involved in.

Delayed discharge is an area where local systems are best placed to design and develop local solutions, although there needs to be strong engagement between the centre and the localities. Our objective is to move the dial on delayed discharge across the winter.

Dr Simpson: Thank you for that comprehensive answer. I should declare that I have two interests

in relation to the issue. First, I am the director of a nursing home, although I am glad to say that, as it is based in England, it is not relevant to the Scottish situation. However, it gives me experience of what is happening in delayed discharge in the nursing home area. Secondly, my wife is the head of social care for a council, which is relevant to my second question.

Some local authorities, such as Stirling Council and Clackmannanshire Council, have no delayed discharges because they have reintroduced social workers in hospitals to ensure that there is early assessment on admission, rather than when people are ready for discharge. How will you ensure that you do not simply reward areas that have not been successful, which do not have step-down beds, which have not used care homes for short-term provision before people go home and which do not have—as there is in Edinburgh, under Peter Gabbitas—good integrated nursing and social care, which picks people up for 10 weeks and assesses what they need? In the long term, such a perverse incentive would be self-defeating.

Geoff Huggins: I agree. Our intention is that the approaches that we are working on with particular partnerships should apply across the system. The challenges of chronicity, multimorbidity and more people living longer have become pronounced in particular areas, such as Edinburgh and the Lothians, where we have challenges in accessing particular services. The situation is similar in Grampian and Aberdeen city.

If we do not see reform across the system, the challenges that are faced here will be faced elsewhere. We need to take a long-term strategic view of the whole social care system. The fact that a particular area is not challenged at this stage does not mean that it will not be challenged next year. We are entirely conscious of that.

Do you want us to say something about elective care or is that for a later question?

Dr Simpson: Someone else might come back on that important area.

If a hospital already has step-down beds, it will not be rewarded with funding to increase its number of step-down beds. If an area is running a cost-effective hospital-at-home scheme, it will not be rewarded for introducing that.

Will areas such as Stirling and Clackmannanshire, which have no delayed discharges, have made a big effort and have step-down assessment and so on, be rewarded? They are in deficit, as are all local authorities. Every single social care budget is in deficit. All local authorities are struggling enormously. How can they produce £5 million to match Government funding? If they already have such measures in place, should that be counted as their contribution towards the £5 million that you are producing?

Geoff Huggins: It is important to say that, in addition to the work that the additional money is funding, partnerships are taking other actions. Some of the work that is going on in Fife, where we have been directly involved, is being funded directly by the health board. The health board has looked at the sums and the structure and has identified that it makes more sense for it to spend the next £100,000 in a community location than in a hospital location. That will offer a better quality of care and be more financially efficient and, importantly, it responds directly to what people are looking for, which is to go home.

We are seeing a flexible use of resource. When the then Deputy First Minister introduced the proposals on integration back in December 2010, she talked about the need for us to think about how we apply money and effort across the system, to think from the perspective of the individual who is receiving care and no longer to think purely in organisational terms—between NHS this or council that. We are getting into that space, and our sense is that that is where the solution lies to the challenge that you have put down.

Dr Simpson: I conclude simply by pointing out that the integrated resource framework programme was introduced in 2009, but I hear from my local authority colleagues that many of them do not even know about the integrated resource framework spreadsheet. Even though it is fundamental to the integration budget, it has not been published, and we do not know what it is. We are within six months of allocating the first budget for the groups, and they still have no access to the spreadsheet, which I know they have asked for.

Geoff Huggins: I can certainly take those comments away with me. I know that, as part of the process that is being taken forward, colleagues who work for me and colleagues outside the Scottish Government are routinely using that information on the ground.

Dr Simpson: Indeed. I know that that is happening in Perth and Kinross.

Geoff Huggins: I can think of five partnerships where that is happening, because a very tall pile of data from those partnerships recently arrived on my desk. The granularity and understanding that we took from that information was really good. If there is a genuine challenge, I am happy to follow it up.

Dr Simpson: That would be helpful.

Geoff Huggins: Our objective is to ensure that the process is underpinned with data.

Richard Lyle: I have a supplementary about council nursing homes. Over the years, councils

have closed such homes because they had no en-suite facilities. What action have you taken and what discussions have you had with councils to ensure that they are signing up to the provision of the new step-up, step-down facilities?

Geoff Huggins: Over the next couple of months, we will carry out targeted work in areas where we will benefit from having more nursing home places. Although a number of nursing home places are unoccupied, they are not necessarily in the locations where we would benefit most from them.

Another challenge that we face is how much it takes to bring a home back into use, but the City of Edinburgh Council is working with NHS Lothian to bring Pentland Hill nursing home back into use, and a similar approach to other properties in the Lothians—one of which is a council location—could be considered. The issue is on our agenda and we have clearly identified it as an area for further work.

Richard Lyle: So you are working to ensure that councils do not shut nursing homes that we might need over the next period.

Geoff Huggins: We are concerned to ensure that any service that is provided is of a high quality and meets people's expectations. Within that, there are small flexibilities—say, four inches here or six inches there—that the Care Inspectorate can apply, but bringing homes back into use or maintaining them in use is more straightforward in some cases than in others. We are looking for a proportionate approach but, as I said, we have clearly identified that we can do more partnership working on the issue. That reflects the engagement process between us and partnerships.

Richard Lyle: That was only a supplementary question, convener. I have another question that I will ask later.

The Convener: That is why I let you in, Richard. I wanted to get some clarity about the step-down facilities and the flow-through that have been mentioned in recent Scottish Government announcements and press releases.

When I listened to your earlier responses, I looked at NHS Greater Glasgow and Clyde's winter resilience plans and noticed that it seems to have identified step-down facilities not just as a winter provision but as part of its forward planning. We need some clarity about that. Although the publicity has said that these step-down facilities are going to be put in place, a scant look at the plans suggests that they are not yet there. Are they? How much additional provision is now available across Scotland for winter resilience, and what is the longer-term view of step-down facilities? After all, as Richard Simpson has pointed out, high bed occupancy and delayed discharge are, unfortunately, things that happen not only in winter. There seem to be a couple of things going on here.

11:45

Geoff Huggins: I will talk a bit more about that. Step-up and step-down facilities are 365-days-a-year facilities and they are the future; they are a key future component of care in Scotland. They are already in use across Scotland, although not in a consistent way in all local authority areas. Our objective is for them increasingly to be seen as the first step for either assessment or reablement, on the basis that there is an understanding that many people, having had a period of time in hospital, require some additional support to get back to the full level of functioning that will enable them to return home.

About six years ago, my aunt—this is a personal story—went through such a facility in Northern Ireland, where she is resident. She had four weeks there and then a further two weeks, and then she went home. She is now about 90 and she has been living at home for the six years since she went through that process, having had a period of about eight weeks in hospital during which she picked up a hospital-acquired infection.

That is the future. People tell us that they do not want to go to a care home or a residential setting where they will lose their autonomy. They want to take every step that will enable them to go back to their own home. It is a strategic approach that will be taken right across the system. We are accelerating it in the run-up to this winter; we are offering support to some partnerships, and some are using it for that purpose. It is core to how the business will be delivered.

The Convener: What does that acceleration mean for step-up and step-down facilities? If we consider the issue in the context of resilience planning, what additional capacity are we creating in NHS Greater Glasgow and Clyde? I may be reading its plan wrongly, but it seems to suggest that it is doing this not for winter resilience planning but in a long-term, strategic way. What extra capacity is there in the various health boards?

Geoff Huggins: In Glasgow, the board's intention is to produce 90 beds for assessment. They will be a continuing component of its system with the objective that it will discharge people within three days of their being ready to discharge, which is also clinically indicated—

The Convener: Is that additional?

Geoff Huggins: That is additional to what it had previously.

In Fife, the board is looking at having two 30-bed units. That is how some of the £5 million that has been allocated is being used across the current period. It is being used in one or two other areas in the same way. In other areas, because of either the current structure of the service or the unavailability of a location where boards could offer such a facility, it is not part of the current use of the resource that has been offered over this period, but in our strategic engagement with partnerships we are looking to have it as a component of all systems and services.

I am not sure that we have an audit that enables us to make the distinction between different types of beds and to show change over time, but we could begin to look at how we might capture that.

The Convener: I am perfectly happy with your answer. Additional capacity is being made available. I was not clear about that from what had been said.

Some more clarity on the finance would be helpful. A number of figures have been bandied about in the past couple of days, including £15 million, £18 million and £1 million that was allocated in August, approximately half of which has already been allocated. There seem to be various pockets of money that have been brought together once or twice.

If we make a comparison with the amount of money that was made available last year for winter resilience planning, which was set out in a letter to the committee from the cabinet secretary at the time, Alex Neil, what is the increase on last year? What is the new money this year?

Geoff Huggins: There have been three relevant allocations during 2014-15. First, £5 million was allocated in the summer. Was that in June?

The Convener: It was in August.

Geoff Huggins: Secondly, £8 million was allocated through the NUCAP. That was part of the larger amount that would have been included in the letter last year, which covered a three-year period. Then there is the £5 million that is currently being issued, which is being supplemented by contributions from NHS boards and local authorities. That means that £18 million is coming from central Government across the period. We also recognise the contributions that are being made by local partners—NHS boards and local authorities.

The Convener: How does that compare with last year?

Alan Hunter: We invested £9 million from the NUCAP funding last year. The extra £10 million that has been focused on relates to delayed discharges and additional sums. We have more than doubled the money that went in last year.

The Convener: You have more than doubled it.

Alan Hunter: Yes—the central allocation.

The Convener: Did that money flow through over the years, or is it new money?

Alan Hunter: It is new money this year. The first £5 million tranche of the NUCAP money went out in August; the second £5 million went out in November.

Geoff Huggins: As part of the process of encouraging partnerships to think of themselves within the integration framework, we are beginning to receive their proposals to spend the £100 million integration fund. We will be ascertaining the degree to which the use of that resource supports our objectives around delayed discharge.

The Convener: That is being used to buy up beds.

Geoff Huggins: That money will appear in 2015-16, so it is looking forward to next year. As people make decisions over this winter, they may do so with the understanding that there will be resource support during the coming year.

Colin Keir: You mentioned NHS Lothian and the fact that it has managed to get hold of the old Pentland Hill care home. What kind of numbers are we talking about? What will it be used for, and what dent will that make in the problem area of delayed discharge? What kind of help will it be? How has the board managed to fund that?

Geoff Huggins: The board has used some of the allocation that we have offered, but that allocation clearly will not be sufficient for the work over the period for which it will be running the service, so money has been found between the health board and the council.

In the short term, the board's intention is to bring into use 60 beds for step-down care. It expects to have 60 beds available from the middle of January. That will take a significant bite out of the Lothian figure. That is the basis on which the board is doing that. Historically, the home had 120 beds. The 60 beds that are being brought in relatively quickly are the ones for which the process is more straightforward. The board will of course wish to be confident about being able to staff the new service and to operate the premises effectively as a step-down facility, having historically been run as a residential care home. The board is looking to a different service model. That facility will take a big bite out of the problem for NHS Lothian.

Richard Lyle: For 365 days a year, the out-of-hours service and NHS 24 cope when doctors' surgeries are closed. What plan do we have in place for this year, bearing in mind that, this Christmas, doctors' surgeries may close on the

Wednesday and then not open until the following Monday? Out-of-hours services will have to cope from 6 pm on the Wednesday, all day Thursday, Friday, Saturday and Sunday until 8 am on the Monday, and the same again at new year, over and above what they already do. What planning is in place to ensure that we have sufficient cars and doctors, and that we can cope with any possible snowy weather that we might have on the horizon?

Geoff Huggins: I will cover the initial part of the question, on the resilience that NHS 24 is building in. I will then bring in Shirley Rogers to speak about workforce and ensuring that we have enough people, which was the second part of your question.

The NHS 24 winter plan is on its website—we have asked all boards to place their winter plans on the web. That plan sets out exactly what it expects to happen at this stage.

NHS 24 is predicting that 2 January will be the busiest day that it has ever had. There are a couple of reasons for that, one of which is where new year falls in the week. Another is that, since the introduction of the new 111 number in the summer, there has been roughly a 20 per cent increase in calls generally. The service is being used more by the public anyway and this is a time when it would expect to be busier. It is basing its expectations on what it will need to do across the two four-day weekends, with a particular focus on a couple of spikes, which are probably the Saturdays. It is ensuring that it has the establishment on deck on those days so that it can respond to more calls than it has ever had before. It has recruited an additional 65 call handlers for the period, so more people will be available.

That gives you the story of what NHS 24 will do if what it expects to happen happens. Beyond that, it has looked at resilience, continuity and contingency should what happens be different from what is anticipated. That has been a wee bit of the NHS 24 story during 2014 already. Call rates to the 111 number have been less predictable than they were to the previous number, so there has been more day-to-day and week-to-week volatility. NHS 24 has already had to be more fleet of foot throughout the year in its responses to different pressures. It will take that learning in.

The plan that NHS 24 has laid out, which is on the website, deals with the different methodologies that it will use to address different challenges, particularly spikes in call volume, and the processes by which it will prioritise clinically significant calls, bring people back to their desks, extend shifts and bring people in, should it be required.

NHS 24 takes this work extremely seriously, so it sat down last week and considered its plan again, after having submitted it and put it on the web. The board spent a significant chunk of its time considering other things that it could do to address other contingencies. It is now considering whether there are other steps that it might build in so that it becomes more robust.

An interesting little nugget out of what we have seen in the recent period is the suggestion that, over weekends and in current out-of-hours periods—we run 52 out-of-hours periods every year, because every weekend is an out-of-hours period—people are choosing to contact NHS 24, which might be having an impact on accident and emergency attendances at weekends. That is suggested in some of the data, but I would be cautious about suggesting that there is a big behavioural shift, although that is clearly the sort of shift that we look for. The data is beginning to suggest that people are thinking about NHS 24 in a different way, and perhaps the 111 number has contributed to that.

Shirley Rogers might want to say something about the workforce and having enough people.

Shirley Rogers: Geoff Huggins has given the picture for community services, so I will touch on the acute sector's response. Our expectation is that boards will adopt the Scottish Government winter planning protocols, which specifically ask them to look at rotas during festive holidays and disruptions from whatever source, whether it be norovirus or increased activity for whatever other reason, such as travel or slips and falls caused by icy weather. We particularly asked for a focus on four specialties that relate to those, one being emergency medicine, for obvious reasons. The others are gastroenterology, geriatric medicine and respiratory medicine, which will allow us to deal with respiratory conditions arising from flu and so on.

We have a specific, targeted piece of work around those four-day periods. It is not the first time that we have had four-day periods but, nonetheless, they always make us thoughtful about service provision, so we spend a bit of time focusing on that. The committee will have seen some of the data that ISD Scotland produced at the beginning of December, which suggests that NHS boards properly using the methodologies that we talked about earlier when we were talking about rosters should have sufficient staff.

Over the past couple of years, we have moved into risk-based workforce planning across staffing borders and have tried to ensure that boards anticipate any areas of concern. At this stage, boards are not alerting us to any specific areas of huge concern for that four-day period.

12:00

Richard Lyle: I welcome the point that Mr Huggins made. I have had previous experience of driving with the out-of-hours service. If you phone NHS 24 and immediately get an appointment, you do not have to wait in accident and emergency; you can go straight in and get your appointment to see the doctor, or indeed the nurse, because in some cases a nurse can cope with the situation without a doctor. That relieves pressure on A and E, so I encourage people to do that. Having worked in hospitals on Christmas day, new year's day and 2 January, I have seen the pressures on A and E and on the service. Thank you for your comments.

The Convener: There has been a bit of publicity about GP practices not being available. I notice that one of our old friends, Dr Buist, was on television last night saying that GP practices are available over that four-day period. Do we know which GP practices will be available?

Geoff Huggins: I return to my opening comment, which was that we deliver an out-of-hours service 52 weekends of the year. Our general approach is that, during weekends and holiday periods, we will offer an out-of-hours service, which is a combination of GP out-of-hours provision and NHS 24. We have already had one four-day weekend this year; the Easter weekend was also a four-day weekend. At this stage, we are going through the process of ensuring that boards are able to fill their rotas to deliver the four-day weekend in the same way that they would deliver any weekend. We are staying in contact with boards and, as we did with the Easter weekend, we will take the opportunity when we talk to chief executives and chairs of health boards to get a sense of where they are on filling rotas.

Some areas are beginning to think about additional opening days for normal GP surgeries.

Richard Lyle: That is what I meant.

Geoff Huggins: That is effectively an experiment that a board is engaged in. At this stage, we do not know whether that is a service that will be taken up by the public. We do not know whether they will choose to use it, and we do not know whether it will be a more effective way of delivering the service than the current methodology, which is to go through NHS 24 and receive an out-of-hours appointment.

We are interested in the fact that a board has decided to take that approach, but we will want to see the implications and consequences before we decide whether it is a benefit. At the same time, we will ensure that boards are delivering a robust out-of-hours service, as they will this coming weekend.

The Convener: You operate on the reality, which is that normal GPs' surgeries are closed.

Geoff Huggins: Yes. That is the case every weekend.

The Convener: What was the effect on A and E figures at Easter?

Geoff Huggins: I do not have the A and E figures.

Alan Hunter: I do not have specific figures for the four-day Easter period, but we can get them for you.

The Convener: They were up quite significantly last Christmas, were they not? I think that they were up by something like 22 per cent.

Alan Hunter: The overall activity last year was up compared with the previous year, but our performance on waiting time was significantly better than in the previous year. It is not just a matter of attendances at A and E that can influence the figures; it is a mixture of attendances and the admission ratio that comes from those attendances, so there is not a direct correlation between the two.

The Convener: There is an element of risk, then.

Alan Hunter: Yes.

Rhoda Grant: What is different about the holiday that is coming up is that, out of 11 days, GP practices will be open for three days rather than for five or seven, so we are looking at quite a long period with little cover. That obviously affects the number of people going to A and E, which you have tried to deal with. It would be useful to know how many additional beds are put in to deal with pressure on A and E departments.

Alan Hunter: I have figures on that from each of the boards. As Geoff Huggins said, and as we have discussed, the issue is not just about beds. Particularly with elderly patients, it is not always best just to house them in hospital. That is why we are looking at step-down facilities and the different capacities and processes that we can put in place.

Having said that, I can give figures on extra winter surge beds. NHS Ayrshire and Arran has plans to put in 14 more acute beds this winter compared with last winter, with a potential to increase that by approximately 10 surge beds at the weekend. The board has also increased capacity in receiving wards by converting other beds, and it is introducing frail elderly pathways to support such people at the front door and get them back into their home with appropriate care.

NHS Borders is building on an ambulatory care assessment unit concept, and it is purchasing extra nursing home beds over the period. The

board has a surge capacity of 25 beds, which increases to 35 beds at the weekend.

Another example is NHS Lanarkshire, which is also introducing ambulatory care units in Wishaw and Monklands hospitals, with capacity for 35 patients per day in those units. The board also has 30 additional beds at Udston and 14 additional beds in Monklands, which will be available from January.

There is a similar range of responses in the other boards.

Geoff Huggins: The figures for last year's winter show that slightly over 5 per cent additional staffed beds were available over the period. During the previous winter—the 2012 winter—there were 7 per cent more beds than the norm. As part of the planning process, boards are looking to ensure that they can staff more beds and that more beds are available to respond to the sort of challenge that we expect.

Rhoda Grant: What is the percentage increase this year? You said that it was 7 per cent two years ago and then 5 per cent last year.

Geoff Huggins: Alan Hunter has outlined the capability in the system to open beds—those are beds that could be opened. We will know what percentage are actually opened only when we get to the post-Christmas period. However, from what we have seen, the scale will be similar to that in previous years.

Rhoda Grant: I want to ask about people with chronic conditions. One issue is that people who become unwell then wait and become very unwell in the interim period of four days—indeed, people might have to wait 11 days if they do not get an appointment in the three intervening days between the closures. What steps are being taken to encourage people to contact NHS 24 and to keep emergency appointments available for those three days?

Geoff Huggins: We certainly encourage people with chronic conditions who might require care to approach NHS 24. There is a clear commitment that they will see somebody appropriate and will receive care and treatment. As part of the winter message, we are clear that people who require treatment should come forward and seek it.

More generally, we ask people to think ahead if they know that, over the winter period, they will require a prescription or some other form of activity that does not need to be done on a particular day and is not for an issue that arises. It is clear that the message is not that people should not seek out help. We are clear at every stage that people should look for help.

Rhoda Grant: You say that you encourage people to get in touch, but how are you getting that message across?

Alan Hunter: That was included in the be health-wise this winter campaign. People are told to attend their GP in advance and approach their pharmacy early to ensure that they are well stocked for any escalation problems that they might have. Also, the winter planning guidance that went out specifically on respiratory disease encouraged boards, hospitals and GP practices to look at anticipatory care needs over the period, particularly for chronic disease patients. We have built that in, and boards are building it in to their winter planning arrangements.

Dr Beckett: There is a flu vaccination campaign for folk under the age of 65 with comorbidities, much as Rhoda Grant describes, such as people with respiratory or cardiovascular disease. Last year, just over 60 per cent of those people were vaccinated and 77 per cent of over-65s were vaccinated. It was the sixth year in a row that our figures have been above the World Health Organization's flu vaccination target.

Geoff Huggins: In recent years we have seen a smoothing out across the year. Activity has been less pronounced in winter than it would have been historically, and we are seeing more activity across the year. There is a pattern of activity in which people are busier for more of the time, but there are fewer spikes in the system.

That is reflected in the winter death figures, which have shown an on-going downward trend. For example, last year's figure was 17 per cent down on the figures for recent years.

Winter is clearly very significant, but some of the challenges now appear to be spread out. That can be attributed to things such as better work on vaccination and chronic care management. We are now seeing morbidities spread across the year rather than being concentrated in winter, although we plan on the basis that there will be some concentration.

Nanette Milne: I note from the Government's briefing that, last winter, far fewer wards were closed due to norovirus being either suspected or confirmed. Was that due to any specific measures? Can you enlighten us as to why that was the case?

Alan Hunter: Yes, some specific action was taken. Evonne Curran, who is the senior person in charge at Health Protection Scotland, introduced bay closures. Hospitals closed down bays rather than waiting and enclosing a whole ward, and kept the ward operating with stricter controlled infection measures. They also reduced visiting in those wards, for obvious reasons. After reviewing its action, Health Protection Scotland believes that

that was the right thing to do, so it is building it into the plans for this year.

Health Protection Scotland will also look at better on-call services for domestic teams so that we can get them in earlier to clean facilities rapidly. It is trialling the use of hypochlorite fluid in four hospitals to see whether that kills the norovirus earlier and quicker. The organisation believes that the stay at home campaign has also had some impact, and we are trying to get the message out to relatives and people who are ill that it is better to stay at home.

Nanette Milne: So if that action is repeated this year, we can hope to see better figures next year.

Alan Hunter: We hope so.

Geoff Huggins: An interesting point is that the experience last year partly reflected the fact that the 2013 norovirus strain was the same as the 2012 strain. At present, we are seeing similar levels of norovirus to those that we saw last year—again, those are below the levels that we have historically seen.

In the post-winter period, there has been an evaluation of what worked. When something goes well, it is quite good to know why, and a number of the elements that Alan Hunter has mentioned are part of that. We are now looking at norovirus management and recording not just in whole wards but in bays.

One key factor is that there is now more of a common understanding among the public that, if they are ill, they should not go to hospital. That has been cited by a number of staff in response to the surveys. People understand that people not only get well in hospital but also get ill, and that if they are ill they should not take their illness into hospital. It is really interesting: we cannot know yet what the story for this Christmas will be, but again it is looking like we will be in a good place.

12:15

Nanette Milne: Is there any predictability about how a strain of norovirus changes?

Geoff Huggins: There is advice provided by, I think, the centre for disease control.

Alan Hunter: HPS advice so far is that there is no way of predicting how bad the norovirus season is going to be, based on current data.

Bob Doris: The literature for the be health-wise this winter campaign makes for interesting reading. Indeed, what struck me was its point that winter resilience is a joint responsibility between the NHS and the individual and that we as individuals all have our part to play in our communities.

In that respect, some of the things that have come up in our conversation include knowing when to stay at home instead of going to a GP surgery or accident and emergency; ensuring that you have cold and flu remedies at home, should you need them, and that you have enough prescriptions; knowing when your GP surgery is open over the Christmas period; and knowing where your local pharmacy is, when it is open and when you should go there.

I am going to continue, convener, because my point is an important one. Other things include knowing when to go to a minor injuries unit instead of A and E—and, indeed, finding out whether you have such a unit—and when to use out-of-hours services or NHS 24.

When tied together, all of those things represent a pretty comprehensive package of healthcare provision over the winter period, but there is a lot of information for individuals to take in. We all have a responsibility to digest and be aware of it all and to take certain steps, but whose job is to put everything set out in the be health-wise this winter campaign on the one piece of paper or portal and get it out to individuals so that we can play our part and take on our responsibilities as individuals in the community? I stay in Maryhill in Glasgow. Who do I contact if I want all of that information for my local area?

Alan Hunter: NHS 24 is the lead health board for the campaign, but each health board was asked as part of the winter plan to carry out local initiatives. Boards have done so; for example, I know that there have been articles in papers in Stirling and that a lot of work has been done in Lanarkshire, the Borders, and Dumfries and Galloway. Each board has a responsibility for getting the information across to the general public through the local media.

Geoff Huggins: Yesterday, the cabinet secretary did the NHS Ayrshire and Arran annual review, and after the event she talked to the media about the winter message. The challenge is for us, directly, and the health boards to ensure that people get that message.

Bob Doris: I am aware of advertising campaigns on the television and the like, but I wanted you to tell me about the methods you are using to ensure that the message permeates across Scotland.

Before my final question, I want to make a general point. Time and again, we hear that that general practices should act as hubs at the centre of communities. At this time when we most need people to use the other approaches in order to take the strain off the system, could a single concise message go out to each household registered with a GP, setting out not only the

practice's opening times over the winter period but where the minor injuries unit can be found and when to use it, the use of repeat prescriptions, where and when to go to the local chemist and a variety of other messages?

The publicity campaign is great, but I am looking for a kind of one-stop-shop message to my constituents. Have you given any thought to how that might be captured? I realise that my idea will incur postage costs, but the cost savings could be huge. After I get some reflections on that, I will ask a final brief but related and, I think, important question.

Geoff Huggins: Your idea is really interesting. Indeed, with new technology and new approaches, it is probably more straightforward to do what you have suggested this year than it might have been five years ago.

The fact is that information about, for example, minor injuries is valid all year round, and the other challenge, which comes back to us, is whether the behaviours can be built in across the year. You mentioned pharmacies; with prescription for excellence, pharmacists are increasingly being seen as front-line primary care service providers. Pharmacies, too, might be locations where such information can be found, but we can certainly take away your idea about customised local information.

Bob Doris: Okay. I appreciate that.

Dr Simpson: Many GPs send out a letter on flu immunisation. Mentioning the winter plan for over the Christmas period in that letter and saying when the practice or a pharmacy will or will not be open will give local information. Bob Doris has made an excellent suggestion. It would not cost a lot to say that that should be done regularly.

Alan Hunter: We have a meeting lined up early in January with the directors of communication from each of the health boards. That is a good idea, and we will build it into that meeting.

Bob Doris: GPs repeatedly tell us that they should be the centre of a community health hub. That certainly gives them a key responsibility to take that message forward, perhaps for next winter.

My final question was going to be: how will we monitor the effectiveness of all those things? I would, of course, like you to answer that question, but we have not really spoken about the preparedness for at-home care packages over the winter period.

I think that we all know from family members that it is not just a matter of having prescriptions and medications and knowing when A and E, the chemist and the GP are open, for example. Given the nature of leave and the inconsistencies in staffing in local authority areas or agencies, how much work has been done to ensure that, if a person has a care-at-home package, that continues seamlessly throughout the winter period? I can think of constituents of mine who require four visits a day for fundamental primary care assistance. If we do not get that right, aside from affecting the dignity of the individual, it leaves them open to family members having to take them to A and E and the like. Obviously, very vulnerable and frail individuals would be involved.

Geoff Huggins: That is a really important point. Home is probably the location of care where more people will receive care over this winter. In the work that we did in 2009 when we had significant issues around access and the availability of travel with the snow, ice and everything, we liaised directly with local government systems to ensure that they had appropriate arrangements in place to provide continuity of care and that they knew who was receiving care and what the nature and structure of the care was, and to be assured that that was continuing. We would look to our local government colleagues. We do not monitor that in quite the same way in which we monitor the NHS, but that is part of the overall resilience work that we will do.

A key component of how we have changed the guidance on winter for 2014-15 from previous years is that we are now bringing in the interim chief officers of the integration bodies that will have responsibility for social care in the expectation that they will increasingly play a part in the interaction between health and social care. However, the current arrangement is the resilience approach to ensuring that we have appropriate liaison in place should winter become challenging. We do not have the same degree of granularity in terms of individual services or authorities as we would for hospitals or health boards.

Bob Doris: I do not have a follow-up question, but I make the observation that it appears that we need further work on that area across Scotland. I hope that integration will help, but one issue is who a person should call if their care visitor does not turn up on Christmas eve or Christmas day. How do they resolve that?

Shirley Rogers: We have been working with human resources directors from health boards and directors of personnel from local authorities for probably the past nine or 10 months, and one of the key priorities that we have asked them to focus on is joint workforce planning across the organisations for the delivery of integrated health and social care.

Bob Doris: Okay. Thank you.

The Convener: There are about 20 bullet points in and around all that for the health boards, such

as Greater Glasgow and Clyde NHS Board, but what is missing is the evaluation. I give a plug for the joint initiative with the British Red Cross—it is involved as well—to provide transport services that support the discharge of elderly patients. That is interesting and there is the added benefit that it can take people from A and E and receiving wards. The initiative is particularly well received because the British Red Cross not only transports the patients home but settles them and ensures that they have basic essentials. If necessary, it can also wait for relatives and carers.

A great deal of planning is going on. However, Bob Doris is correct that it is not obvious whether the analysis of what works that is applied in the health service is being applied in other areas. Certainly, the components seem to be there.

Alan Hunter: It is coming together. In preparation for the integrated joint boards we are having much closer contact through COSLA and directly with the shadow chief officers. David Williams, the chief officer of the Glasgow city health and social care partnership, is on the national unscheduled care steering group. He is advising and working with us.

The Red Cross initiative is a really good one. It works.

Graeme Dey: I want to ask about the work that is being done to improve the flow of patients in hospitals in winter time, particularly with regard to time of discharge. As I understand it, one of the biggest challenges in getting people who are able to leave hospital out of hospital timeously is the ability to access prescription medicines that the in-hospital pharmacy dispenses. It strikes me that if a way of cracking that problem for the wintertime could be found, we would have won a watch for 365 days of the year.

What work is going on there? Have you found a way to tackle the pharmacy issue?

Alan Hunter: We are working on that. A key message of our unscheduled care programme and our winter guidance is that the focus must be on time of day and weekend discharge rates. We have had a significant reduction in weekend discharges and the time of day makes a big difference, so we need to get a balance.

Have we cracked that specific problem? No, not yet, but we are working with the Royal College of Surgeons, the Royal College of Physicians and the Royal College of Nursing to focus on that. We believe that we will be able to make the cultural and behavioural changes that we need to make.

Getting the scripts out quicker involves the way in which ward rounds take place. Sometimes it boils down to the most junior doctor writing the script. We are looking at the way the ward rounds change and we are introducing things such as board rounds: instead of a full ward round taking place, a board round can quickly identify which patients can go home and prioritise their discharge. We are working on that.

We are also looking at delegated discharge, which the Victoria infirmary in Glasgow has introduced. In the wards where that has been introduced, the pre-noon discharge rate has gone from 13 per cent to around 35 per cent. We are holding learning events and we are rolling that out. At our unscheduled care six-monthly learning event in September, which we used to launch the winter campaign, we had a session on delegated discharge and we are developing improvement programmes on it.

Dr Beckett: I echo Alan Hunter's points. The pharmacy script problem is a difficult one to crack, but there are things that can be done, such as pre-emptive discharging the night before. If a patient has a care package starting the following day, the discharge script can be ready the night before, to go home with the patient.

We are starting to better understand the reasons why people are not going home in the morning. Work has been done on the day of care survey, which we have been looking at in conjunction with the Royal College of Physicians. It looked at what proportion of patients in hospital at any one time no longer need acute care. It depends where you look, although it is broadly the same in Scotland, England or Australia, but between about 20 and 25 per cent of patients do not need to be in hospital. Those patients could be waiting for various things: it could be pharmacy, as Graeme Dey said, consultant ward rounds, consultant decisions or multidisciplinary team decisions. Having a better understanding of why people are delayed in hospital allows us to structure how the hospital works to deal with those specific things.

12:30

The Convener: We are nearly on schedule now, but I want to raise a couple more points. Delegating the power to discharge will speed up the process, but does that mean that the ward sister or allied health professional can discharge patients?

Alan Hunter: Yes.

The Convener: How has that been received by patients and families? I know that delays can happen because people have to wait for the consultant to do his rounds, but is there not a certain reassurance for vulnerable or older people in not being rushed out of the hospital?

Alan Hunter: There will be agreement against set criteria, so that if the patient's bloods or X-ray come back and everything is okay and if they do not have a temperature, they will be discharged. Those set criteria should reassure people about the points that you have raised.

Dr Beckett: Communication with the patient is absolutely key. When I see patients on my ward round, I make it clear to them that I think that, say, they will get better tomorrow, and that if their temperature and blood tests look better, my junior doctor Dr Smith will get them home. Therefore, the patient knows that we are planning to get them home; of course, we are thinking about discharge when they first come in, but the patient and their family, the junior doctor and the nursing staff are made fully aware of and know what needs to happen before they can be discharged.

The Convener: Perhaps you can tell me whether I am right, but it is my understanding that for someone to be discharged early in the day their script needs to be in the robotics centre in Glasgow the night before.

Alan Hunter: That is right.

The Convener: If it is not there, is there not an automatic delay? It is not that it would be nice for the script to be there the night before; is it not that is has to be done the day before?

Alan Hunter: Scripts can be expedited for certain patients, but the standard practice is to get the script down before a set time. As the ward gets busier, the junior doctor might not get the script done and things will be delayed overnight. There are reasons for such delays in the system.

The Convener: Is there any way of circumventing that during the busy winter period by, say, working with local pharmacies?

Geoff Huggins: What your question is probably drawing out more strongly is the need to think about discharge, and throughcare, at the point of admission to ensure that discharge is contemplated on, say, Sunday afternoon and does not come as a surprise on the Tuesday morning and that the required steps, even if they are not carried out directly by the treating clinician, are being taken. As a result, people will understand it as part of a system in which they interact with other health professionals to ensure that the individual meets their own objective of getting home as quickly as possible. It is probably as much about mindset as it is about putting in place fixes when the thinking has not been done properly. That is the objective.

The Convener: Are there any other questions?

Dr Simpson: In Glasgow, a centralised robotic system dispensed medicines to local dispensaries in hospitals, but patients also kept their medicines in a defined area in the ward, and they were kept topped up and ready for discharge. That combination of centralised robotics for the whole of Glasgow and localised dispensing seemed very sensible, and NHS Forth Valley has a variation of that that works very well.

I have a final question about patient flow within rather than out of hospital. Clearly the boarding out issue is quite a vexed one; although we supposedly have a recording system, boarding out still has to be defined. I know that Dr Beckett has done some work on the matter—indeed, he and I have had conversations about it—and I wonder whether he wants to put anything on the record.

Dr Beckett: We have certainly traded emails on the issue. In fact, it is surprisingly difficult to define what a boarded-out patient is; nevertheless, we have managed to redefine it, and we are asking boards to report on a weekly basis the number of boarders that they have.

It is important to recognise that patients being boarded out is a symptom of poor flow rather than the problem itself. There are multiple manifestations of poor flow—boarding patients is one; others are crowding in emergency departments and higher readmission rates. If we tackled one of those in isolation, we would risk causing problems elsewhere in the system. Clearly, we need to improve patient flow across the whole system, and we are considering carefully how to do that. We will measure boarding as one outcome measure, while another marker will be performance against the four-hour standard in emergency departments, which we will measure. That work is being progressed through the unscheduled care steering group and the unscheduled care programme board.

As an aside, you will know that Scotland is really the only country that has done any research on the outcomes for patients who are boarded. I hesitate to put a date on when that research will be published, but within the next six months would be nice.

Dr Simpson: Another issue that I have been pressing in a number of forums is the linkage of cognitive assessment to boarding out, because of the dangers of that. I do not know where we have got to on that. If patients with cognitive impairment have to be boarded out, that creates a problem downstream of how to get them home and how they can be managed. If such people are institutionalised further, they will have particular difficulties when they are moved around. I wonder where we are on linking those two systems.

Dr Beckett: I am not aware of any direct linkage between the two, although a couple of health boards are looking to gather data on the proportion of patients with cognitive impairment

who are boarded out at any one time. The message that I am keen to get across is that all boarding is bad and we should seek to eliminate it by improving flow. Clearly, a significant proportion of patients who come into hospital are elderly and have cognitive impairment, so we should seek to ensure that those patients get to the right ward the first time, by improving flow and looking at variation in the system. As I said, we are taking forward that work.

Alan Hunter: The unscheduled care steering group is doing work on eliminating boarding wherever possible. During the older people and acute healthcare audits of hospitals, the importance of not boarding people with cognitive impairment is emphasised.

Geoff Huggins: We have done some work on people with dementia, who are a sub-group of people with cognitive impairment. I could certainly put together what we have on that, if that would be of help.

Dr Simpson: Thank you.

The Convener: We would appreciate that.

Bob Doris has one final question.

Bob Doris: It is a brief one. It is more of a mopping-up exercise so that the witnesses have the opportunity to put something on the record. Right at the start of our evidence session, we heard that the number of planned elective procedures will be downsized over the festive period. There will be less of them and then, depending on other pinch-points, some may fall by the wayside. Frankly, that has been routine for many years in the management of winter stresses and strains. However, the committee would be concerned if that included urgent elective procedures or emergency treatments, such as cancer treatments. Will you say a few words on that to get something on the record?

Geoff Huggins: I will offer a couple of comments and will then bring in Alan Hunter. That is certainly one area in which we expect NHS boards to be on the ball in their winter planning. The term “elective” indicates that the procedures are planned work, so the boards should look at the winter period and particularly the two weeks that are likely to be the busiest and think about smoothing work so that they do not rely on beds being available that might not be available. Some boards have worked in a way that involves a nine-week rather than a 12-week planning presumption, which means that they are more likely to be more robust. Work is already in place on that.

This year’s winter guidance makes a particular reference to cancer. The guidance draws boards’ attention to the need to meet the 31 and 62-day standards and to think about that as part of their planning process across the winter period. Because 31 days and 62 days are longer than the 10 or so days of Christmas, with robust planning, boards have the opportunity to perform effectively in that area. That particular issue is therefore now drawn out in the checklist that they are offered.

Alan Hunter will say a bit more about elective procedures.

Alan Hunter: That is part of the winter planning process, and there is an escalation process. The last treatments to be cancelled would be urgent ones and all the systems are geared towards ensuring that that does not happen. As Geoff Huggins said, the chief medical officer wrote on 30 October reminding boards about the importance of planning for maintaining the cancer multidisciplinary teams over the festive period and putting in place extra diagnostic support to maintain them if required. We have tried and tested systems, which I have witnessed, and it would not be urgent treatments or cancer treatments that would be cancelled. Wherever possible, the objective is not to board patients in surgical beds—the first thing is to avoid that.

The Convener: That brings this interesting session to a close. I thank all our witnesses for attending. Extensive measures are being taken—I found lots just looking over the issues in the past couple of days. It was interesting to hear your evidence, because we are talking about significant planning measures. We wish you a happy Christmas and hope that all of your planning is rewarded and that the service copes with all the stresses and strains over the Christmas and new year period.

12:41

Meeting continued in private until 12:56.

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