OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 19 September 2017

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Pàrlamaid na h-Alba

Session 5

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Tuesday 19 September 2017

CONTENTS

Col.
SUBORDINATE LEGISLATION 1
Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017 (SSI 2017/207) 1
NHS GOVERNANCE 2
DRAFT BUDGET SCRUTINY 2018-19 26

HEALTH AND SPORT COMMITTEE
20th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Kim Atkinson (Scottish Sports Association)
Aileen Bryson (Royal Pharmaceutical Society)
George Doherty (NHS Tayside)
Alison Douglas (Alcohol Focus Scotland)
Sheila Duffy (ASH Scotland)
Dr Andrew Fraser (Scottish Directors of Public Health)
Carolyn Lochhead (Scottish Association for Mental Health)
Elaine Mead (NHS Highland)
Richard Meade (Marie Curie)
Jennifer Porteous (NHS Western Isles)
Kenneth Small (NHS Lanarkshire)
Andrew Strong (Health and Social Care Alliance Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 19 September 2017

[The Convener opened the meeting at 09:30]

Subordinate Legislation

Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017 (SSI 2017/207)

The Convener (Neil Findlay): Good morning, and welcome to the 20th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not take photographs or record proceedings.

Apologies have been received from Alex Cole-Hamilton and Tom Arthur. We expect Bob Doris to join us; he might appear at some point.

The first item on our agenda is subordinate legislation. We have to consider one instrument that is subject to negative procedure: the Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017. No motion to annul the instrument has been lodged, and the Delegated Powers and Law Reform Committee has not made any comments on the regulations.

The committee first considered the regulations at its meeting on 5 September and agreed to write to the Scottish Government for further information. A response has not yet been received. That is disappointing, so we will write to the Scottish Government about that.

As members have no comments to make on the regulations, does the committee agree to make no recommendations on them?

Members *indicated agreement.*

NHS Governance

09:31

The Convener: Agenda item 2 is national health service governance. We will look specifically at staff governance. We have about an hour for the session.

I welcome to the committee George Doherty, who is director of human resources at NHS Tayside; Jennifer Porteous, who is director of human resources and workforce development at NHS Western Isles; Elaine Mead, who is chief executive of NHS Highland; and Kenneth Small, who is director of human resources at NHS Lanarkshire.

We will move directly to questions.

Colin Smyth (South Scotland) (Lab): Good morning.

I want to ask a couple of questions about the NHS staff survey. Much of the evidence that the committee has received so far suggests that the results of the survey, even when they highlight staff concerns, are largely ignored. The perception is that very little action is taken as a result of it. Is that a fair criticism in witnesses' health board areas?

Kenneth Small (NHS Lanarkshire): We have to look at what has happened as a progression. The annual staff survey, as was, is no longer. We ran a staff survey for many years, and there were a number of areas of frustration with it, but I do not think that one of the frustrations was to do with responses to the messages that came from it. The biggest frustration for me and NHS Lanarkshire—colleagues from other boards can speak for themselves—was to do with the inability to get significant numbers of staff to complete the survey, despite the power of partnership working with our trade union, managerial and clinical colleagues on encouraging staff to complete it. Over the years in which we ran a staff survey in Lanarkshire, I think that we managed to move our staff's participation in it from the low 20 per cents to the mid 30 per cents. Despite significant effort, the figure went no higher than that.

Our collegiate approach to the staff survey was always that we ran it and then got its results from the national engine room that developed and organised it. Our response to those results was to develop an annual action plan—again, in partnership with trade union colleagues and all the staff. The staff survey action plan would draw down the particular challenges, as well as the positives, that came from the survey results. We prioritised action against those results.

The staff survey action plan was an integral part of my governance framework and was regularly considered at the staff governance committee, which includes non-executive directors, trade union and managerial colleagues, and human resources professional colleagues. The actions were reported and, where appropriate, a redefinition of priorities was agreed for the next period.

I do not agree that the staff surveys' results were ignored. They were used to inform priorities for action and improvement.

George Doherty (NHS Tayside): I echo everything that Kenny Small has highlighted. NHS Tayside's experience of responses from individuals to the survey was similar: our best-ever response rate was about 35 per cent.

With iMatter, which is a tool that talks more to individuals' experience of the day-to-day workplace and their team, and to their views of the organisation, we have a response rate of 68 per cent. The level of engagement is much higher, which I think is because the exercise is much more meaningful for individuals.

The board still takes the key messages as a summation and receives a global report that is based on the totality of responses. However, the key differences are made day-to-day and are related to experiences of working within a team. The discussions happen there, led by the team. Where they can enact changes, they do. Through our area partnership forum with our staff side, the global action plan that we used to develop using the staff survey is now done using iMatter. NHS Tayside's board monitors our response to common themes that emerge across the organisation and which need action globally, as opposed those on which teams individually take self-leadership.

Elaine Mead (NHS Highland): NHS Highland's experience of the response rate to the survey was similar. We are pleased with the response now, using iMatter. I echo George Doherty's view that the fact that action plans are developed with and by local teams results in a lot more engagement, and in people taking a lot more responsibility. That is a real change in the approach to staff governance across NHS Scotland.

Jennifer Porteous (NHS Western Isles): NHS Western Isles has the same arrangements. We had, following the survey, action plans that were embedded in the staff governance action plan. Now that we have implemented iMatter, we are pleased that we have an employee engagement index of 76 per cent. We now focus on the team action plans that address the staff's issues directly at team level.

Kenneth Small: It is important to recognise that iMatter, as the replacement for the main components of the NHS staff survey in Scotland, now achieves a level of response that ranges between 60 per cent and 70 per cent, compared to the staff survey average of about 35 per cent.

Colin Smyth: Participation does not tell us what staff are saying; it just says that they are saying something. If panellists find that iMatter is more effective, can they give me an example from their health boards of a tangible change that they have made as a result of feedback from staff using iMatter?

George Doherty: I am happy to pick that issue up. NHS Tayside's written submission includes some of the key domains that are being reported back on and which give a sense of individuals' involvement. A strong response for us was about the extent to which individuals felt that they were involved in local day-to-day decision making within their teams.

An area that was identified through iMatter as being one that we needed to strengthen with our staff was the degree to which individual employees felt that they had a voice in the board's overall strategy. As a consequence, one step that we have taken is to move beyond area partnership forums and to put in place local partnership forums. Joint staff forums with our trade unions and line managers ensure that local plans, budgets, strategies and workforce issues are considered within their service. That is a clear example of where iMatter outcomes have created a strong position in terms of local governance. The staff survey did not do that.

Colin Smyth: Are there examples from the other health boards?

Elaine Mead: One concern in NHS Highland staff's responses from iMatter was about the visibility of our management. As a direct response, our actions have included encouragement and support, particularly to middle managers, to be out in what we call the gemba—the place where work happens. They are out daily with teams and are buddied with wards, in some areas. The visibility of senior and middle managers is now much higher, so staff can regularly see them.

We already had an arrangement through which the executive team went out, which was over and above the walk-arounds that we do for things such as our Scottish patient safety programme work. It is about getting back to the place where work happens. I hope that that action will improve the result on that next year, in our iMatter survey.

Colin Smyth: Obviously, we have not yet seen detailed results from iMatter because it is still being implemented. Are you saying that there will be, when we see those results, a substantial

improvement in staff satisfaction ratings on a range of things, compared to the results of the staff survey?

Kenneth Small: The difficulty with that is that you are talking about two different systems that will be challenging to compare and contrast. Giving iMatter absolute corporate commitment across NHS Scotland will, in time, allow us to look at trends in boards, and to look right down within boards into departments and clinical areas, but it will also allow us to look corporately at the NHS in Scotland.

iMatter, as a tool, has the potential to do that, provided that we give it longevity. That is one of the issues: let us give it a chance to work properly and to build confidence in looking at trends. iMatter has the potential to allow us to drill down much more readily than we ever could with the old staff survey.

Colin Smyth: Would there be any benefit in independent scrutiny of the work that you do around iMatter and the staff satisfaction survey?

Kenneth Small: I suppose that it depends, but I see no reason why it would not be of benefit, because we should be absolutely confident that what we are doing is the right thing and that it has the potential to make a difference. The old survey and iMatter already get independent scrutiny, because we take the results, including the action plans, to our staff governance committees, on which we have non-executive directors. In NHS Lanarkshire, our chair and our employee director are an integral part of that arrangement. They look, from a governance perspective, at the results, at what we are doing about them and at what difference that is making.

Miles Briggs (Lothian) (Con): Committee members will have met constituents who have experience of whistleblowing, who always raise the fact that there is no independent investigation; investigation is internal. Given your experience, what are your views on how that could be improved? With the establishment of an independent whistleblowing hotline, which has been suggested, could investigations be independent of the health board?

Kenneth Small: I am thankful that I have limited experience of whistleblowing. In the past three years in Lanarkshire, our whistleblowing occurrence has been nil. My involvement in relation to whistleblowing in the NHS in Scotland is as chair of the national human resources directors group. In that role, I was asked to support another board with the investigation and response to a whistleblowing case. I was seen as an independent contributor, which was accepted by the whistleblower and the board. There are benefits in having a level of objectivity that can sometimes be difficult to achieve within a board. However, in most whistleblowing situations, it is important to engage locally as well as having that level of objectivity because, arguably, you get a better result that way.

George Doherty: This might well have been presented in evidence to the committee previously, but all boards have a non-executive director who is appointed independently to act as a whistleblowing champion. In my board, that person is the vice-chair of the staff governance committee. The staff governance committee is co-chaired by a non-executive board member and an employee director, who is the staff-side chair, as elected by the trade unions. We bring a report to that committee every six months on all whistleblowing issues that have been raised. The whistleblowing champion has two roles: to give assurance that due process has been followed in our handling of cases, and to ensure that concerns are escalated, whether that be to the chairman or, beyond that, to the Scottish Government.

I agree that it is important that individuals have confidence that, when they raise concerns under the banner of whistleblowing—not just about wrongdoing, but in relation to risk—they will be dealt with appropriately. That is an ethos in all the boards, each of which has been asked to identify and appoint a whistleblowing champion.

09:45

The Convener: That person does not investigate the incident; their responsibility is to oversee the investigation.

George Doherty: The champion does not directly investigate.

The Convener: So who investigates?

George Doherty: The champion's responsibility is to ensure that an investigatory process is progressed and that matters that are raised are addressed. Their accountability is to the board, in order to assure the board that any matter that is brought forward under the whistleblowing policy has been addressed appropriately.

The Convener: By whom would such matters be investigated?

George Doherty: That would depend on the nature of the issue. For a clinical issue, it would be for an officer from the clinical governance line—for example, the medical director or nursing director—to take forward an investigation. For individual cases in which wrongdoing is raised, investigation would be through an appropriate policy person.

We also have fraud liaison officers who work with NHS counter-fraud services. Where there is an issue of wrongdoing, matters can be escalated

to counter-fraud services through the fraud liaison office.

The Convener: So, the investigation is not independent.

George Doherty: Counter-fraud services is an independent body.

The Convener: Previously, you referred to how clinical or other issues are investigated. They would be investigated by someone within the organisation.

George Doherty: Such matters would be investigated in line with our policies that have been agreed with our trade unions. The role of—

The Convener: Let me be clear on that point. Such matters would be investigated by someone within your organisation—for example, a senior manager, or the manager in the department.

George Doherty: Investigation would not be done by an individual who was connected to the case. It would be taken forward in accordance with the policy to ensure independent investigation. That is one of matters on which the whistleblowing champion provides assurance to the board.

The Convener: It is not an independent investigation if it is done by someone within the organisation.

George Doherty: It is an independent investigation under the terms of our policy to ensure appropriate due process.

The Convener: Okay. Miles Briggs has a question—

Kenneth Small: I would like to add to that. The committee has, I presume, taken evidence on the existence of a national PIN—partnership information network—policy on whistleblowing. The policy was built up nationally by a partnership of the NHS boards, the Scottish Government and the trade unions. That is the policy that George Doherty is talking about, and it is the policy that we apply corporately. It depends on one's definition of "independent".

The Convener: It is that policy that people have raised concerns about.

I apologise for the delay, Miles.

Miles Briggs: How many people are on permanent gardening leave within the panel's organisations? Do you have, or could you provide, those figures? How many have not returned to the health boards after the investigations?

Kenneth Small: Across the NHS in Scotland, I do not think that we have anyone on what is deemed to be gardening leave. There will be times when an employee is suspended from duty, without prejudice and on full pay, for a reason that they are made aware of. There are support mechanisms and regular reviews of the suspension built in to our normal policy approach. The reason for suspension is almost invariably disciplinary action. Very rarely will it be for health reasons: someone with health issues would be off work on sickness absence and there is a separate policy for that.

The answer to the question in relation to NHS Lanarkshire is that we have four members of staff who are suspended from employment. All are subject to active disciplinary investigatory processes, and are kept well informed of and engaged in that process. To my knowledge, we have never had anyone who was permanently on what you would deem to be gardening leave, because that would be a misuse of public resources.

The Convener: Does anyone else want to come in on that point?

Jennifer Porteous: NHS Western Isles does not have any staff on gardening leave. We have the same arrangement as that which Kenneth Small outlined.

The Convener: But you may have staff who are suspended on a long-term basis, pending investigation?

Jennifer Porteous: We have no staff suspended on a long-term basis. Where we have staff suspended, it is as a consequence of an investigation into a potential disciplinary matter.

Elaine Mead: It is the same for NHS Highland. We follow our policies and procedures and have people suspended as necessary.

Kenneth Small: I do not want to give the impression that suspensions are not occasionally quite long. I am the old man of the panel; I have been in the NHS for 40-odd years. In that time, probably the longest suspension that has taken place was approaching two years duration. Again, that was not because we had forgotten about that individual.

Quite often, particularly when we are dealing with senior clinical staff, the act of investigation is complex. With any such investigation, you invariably end up in areas that you had not predicted that you would end up in. Some suspensions can be for long periods, but we seek actively and proactively to manage the situation in order to keep suspensions to the minimum, while balancing the need for suspension with an appropriately comprehensive investigation. The norm is nothing like two years; suspensions are for a matter of weeks, or sometimes months.

Clare Haughey (Rutherglen) (SNP): I welcome the panel to the meeting. First of all, I seek some clarification on the evidence that we have just

heard. I should say that I am coming at this issue as someone who was on the staff side in the NHS, so I want to get some clarity for other committee members who might not be as familiar with NHS policies and procedures.

Is it the case in all the NHS boards represented today that if a member of staff is suspended, that suspension will happen under policies that are underpinned by the PIN guidelines, which are agreed in partnership with the trade unions?

George Doherty: Yes.

Elaine Mead: Yes.

Jennifer Porteous: Yes.

Kenneth Small: Yes.

Clare Haughey: Moreover, is it the case in all your NHS boards that a staff member's suspension is not a punishment and that, instead, it protects them and the integrity of the investigation?

Kenneth Small: Absolutely.

Elaine Mead: Without prejudice.

Clare Haughey: Exactly. Is that staff member supported throughout the time that they are off? Do they have a contact person in your HR department?

George Doherty: Yes.

Elaine Mead: Yes.

Jennifer Porteous: Yes.

Kenneth Small: Yes.

Clare Haughey: And do they have access to a trade union representative if they are a member of that trade union?

George Doherty: Yes.

Elaine Mead: Yes.

Jennifer Porteous: Yes.

Kenneth Small: Yes, and in addition, they can also directly contact our occupational health services in case they require other support.

Clare Haughey: Thank you.

Alison Johnstone (Lothian) (Green): I want to return to the independence of the whistleblowing champion, which is a concern that has been raised in some of the written submissions. In previous evidence, Sir Robert Francis said:

> "The concern that some people have expressed and which I think we have to look at is that a non-executive director has a corporate responsibility to the running of the organisation".—[*Official Report, Health and Sport Committee,* 13 June 2017; c 60.]

Can you clarify whether you are allowed to appoint someone who is not a non-executive director as whistleblowing champion?

Kenneth Small: As we have said, we are required to adopt and are expected to apply a national whistleblowing PIN policy—I think that we will be talking about PIN a lot today—and it sets out the investigation and decision-making arrangements for any case of whistleblowing. As it stands, though, it does not provide for what I think you have in mind with regard to independence; instead, it provides for an individual or panel to carry out an investigation within their current employment or connection arrangements, and that would include non-executives of a health board.

Alison Johnstone: Can you see, though, why some people might have concerns about a lack of independence?

Kenneth Small: Absolutely. I can see why that might be the case, and what I would seek to do with such an individual is to convince them, if I can, that the arrangements that we would put in place would be sufficiently distant from those concerned with or involved in the subject of the whistleblowing case. I hope that that would give them confidence and a level of reassurance about objectivity.

Alison Johnstone: Would it be possible to improve the process and policy to ensure that no one was left in any doubt whatever about the independence of the individual who is appointed as whistleblowing champion?

Kenneth Small: We would be foolish and naive to think that we could not improve on a lot of things. I would not disagree with you that in this case there is potential to build and sustain greater confidence.

The Convener: Have any of your organisations discussed the possibility of making this process much more robust and independent by appointing someone who does not come from those organisations?

Kenneth Small: That has not been discussed in Lanarkshire.

The Convener: Perhaps you could go back and make that suggestion, Mr Small.

Kenneth Small: I could well do.

Jennifer Porteous: I should point out that the whistleblowing champion is agreed in partnership. In 2015, I think, the Scottish Government wrote to boards about appointing a non-executive whistleblowing champion. As Kenny Small has said, we can always improve and feed into opportunities for improvement, but when these things are agreed in partnership at Scottish

partnership level, our role is to ensure that we implement the PIN policies.

Alison Johnstone: Speaking from my experience of being a non-executive director on a board, I think that the situation could be improved if the whistleblowing champion were absolutely independent of the board, because board members have certain responsibilities and they want to see that board performing well. My view is that that is a concern that we need to consider further.

I want to go on to the issue of blacklisting. We received written submissions from two doctors who detailed their experiences of whistleblowing and their consequent difficulties when they applied for jobs later on. Whistleblowers are not legally protected from the actions of a future employer. Does the NHS operate a blacklist?

Kenneth Small: Absolutely not.

Elaine Mead: No.

Alison Johnstone: In that case, why do you think that two of the written submissions that we have from doctors suggest that they have suffered consequences as a result of their whistleblowing? The Employment Rights Act 1966 protects people from suffering a detriment as a result of making a public interest disclosure. However, we have the written submissions that I mentioned, and I have met people who believe that they have suffered as a result of making such disclosures and who say that they have found it incredibly difficult, if not impossible, to gain employment again in the NHS.

Kenneth Small: That is a difficult question to answer. People's perceptions are a reality, but we must accept that that is different from the position that an NHS board would take as an employer. It might sometimes be difficult to rationalise those two positions and bring them together in a way that enables people to come to a common agreement. I can only repeat that, to my knowledge, which is based on working in many health boards north and south of the border, there is no such thing as blacklisting. I would play no part in that, personally or professionally.

George Doherty: I agree entirely with that position.

Alison Johnstone: Is that view shared by the other witnesses?

Jennifer Porteous: Yes. We have robust recruitment procedures that would preclude blacklisting.

The Convener: I do not think that there is a blacklist, but there is only a small number of boards and it only takes a few calls between human resources staff, directors, senior managers or whoever to say, "Don't touch her," or, "Don't touch him." Does that happen?

George Doherty: Like Kenny Small, I have worked in a number of boards across NHS Scotland as a director in NHS Scotland, and I have never encountered that. It is not something that I would sanction in my team. It has not been my experience.

Elaine Mead: As chief executive, I have not had any experience of that happening. Certainly, my HR directors would give me clear advice about not being able to do that, and we would not want to in any case. We want to appoint people on their merit. Recently, when I was appointing a director, I had no knowledge of who the candidates were, because we redact all their personal information before the information is circulated for the shortlist. Even though it might be frustrating, we have no idea who people are when we shortlist them for appointment.

The Convener: That is interesting. I do not want to identify the person, but I know of one case in which a person who raised serious concerns about clinical practice was suspended for five years. They had a previously unblemished record but, when they applied for one of 12 vacancies in the health board area, all the vacancies disappeared shortly after they submitted their application—the jobs were no longer presented. That person has never worked in Scotland again. That might be a conspiracy theory, but it seems a bit of a coincidence in the case of that individual.

Brian Whittle (South Scotland) (Con): When a petition on whistleblowing was brought to the Public Petitions Committee, we took a lot of oral evidence on the issue. It seems that there is a perception among NHS staff that whistleblowing will not be effective and that the whistleblower will not be able to effect change, and there is also a perception that being a whistleblower will be a blot on their copybook.

We have looked at the policies as they stand, whether they are good or bad. Should you be doing more to encourage NHS staff to come forward? As you say, very few of them do so, which raises a flag for me.

10:00

Kenneth Small: If I were sitting where you are, I would see the world in that way—that is my immediate reaction. However, I do not see it in that way because I see whistleblowing as a failure. If a member of staff gets to the stage of having to resort to a whistleblowing arrangement, it means that our staff engagement processes—and their openness and honesty—have failed. In Lanarkshire, we have very solid and effective arrangements for staff engagement at a variety of

levels—corporately through our operating divisions, right down to clinical teams and individual wards. That has a number of strands, which are driven through our approach to staff governance.

The starting point is our highly constructive and open relationship with our staff-side colleagues. Staff-side members are an integral part of our board and corporate management team. They work with us in an open-book environment such that if we have a financial or a clinical governance problem, the staff side is aware of that to the same degree as managers are. We do everything that we can to pass that message down through the organisation. Our non-executive and executive directors are out on the wards and the departments every week, conducting patient safety reviews and visits. An integral part of that is to promote their profile and so enable access. That means that, if staff have an issue, they know the relevant people by name and not just from a picture on a website.

We also go to the lengths of having HR surgeries, which go out to the organisation. I have a separate email address, which is called uMatter, to link it to the iMatter concept. Any staff member in Lanarkshire can email me at my uMatter account any time of day or night and they will get a response in 48 hours. They can ask me anything—and they often do. That is why I see whistleblowing as a failure. People who have issues or concerns have numerous routes and opportunities to raise issues, in the confidence—I hope—that they will be responded to.

Brian Whittle: I look at whistleblowing slightly differently. Although I do not like the term "whistleblowing", I would consider it an opportunity to re-examine the systems that are in place and see how they can be improved.

Kenneth Small: For me, if someone has to whistleblow, it is because other systems—the routine, embedded ones—have failed. People should feel confident and free to raise an issue as locally as possible—sometimes that fails locally and it is orchestrated up the organisation, but that should rarely result in a whistleblowing situation.

Jennifer Porteous: I concur totally with Kenny Small. In the Western Isles we have several methods for staff to raise complaints. We have Datix systems; staff can enter complaints, issues and concerns confidentially and then receive a response. We have normal complaints procedures, a grievance policy and a dignity at work policy. As Kenny Small says, the use of whistleblowing is a last resort. Those formal processes are supported by the patient safety walk-arounds, the chief executive open meetings and the availability of directors to receive comments. We also work in partnership with the staff side through iMatter and the various HR forums across the Western Isles.

Whistleblowing is a last resort. We work closely with staff to ensure that any concerns are raised as locally as possible so that the issue can be resolved as locally as possible.

The Convener: We had a session with middle managers in the NHS and they were very frank about the pressures that they felt under and the way in which the pressure from above to meet performance targets was driving everything. They said that innovation and concerns that were raised by their staff in the ward were often set aside because the target-driven culture is everything. They were very open and frank about that in our off-the-record session with them. Do you agree that that target culture is driving behaviours in the NHS that might end up being negative behaviours and might impact on front-line staff?

Elaine Mead: It is all about the culture of the organisation. We are there to deliver on the targets and the objectives that the Government sets for us but, importantly, we are also there to serve local people and protect our patients and clients. All staff in our organisations have the responsibility to say something if they see something, and we encourage that. Part of our local NHS Highland quality approach is to encourage staff to be open, and to work with integrity as part of a team. We triangulate what we are hearing in the boardroom by being—as I have already described—out on the shop floor and talking to staff. It is about accessibility.

I do not doubt that middle managers feel that they are under pressure in the system. However, they know that the most important thing is to protect the people whom we serve.

The Convener: Their argument was that they are not doing that. They were saying that they have ideas about innovation in their wards or whatever service they provide that are being stifled by the target culture and pressure from the top on them as individuals. They were very frustrated by that.

Elaine Mead: I am sure that they could feel frustrated by that, but we need to encourage staff to take responsibility for their own work and make the changes in their own workplace, and we in NHS Highland are doing that.

That takes time, but we are certainly encouraging local staff to take every opportunity they can to do their job and to change their job for the better. In fact, they feel more empowered and more engaged to do that. I come back to my point about that being an issue of the culture in the organisation. We have to live it as well as saying it. It is really important for the staff to know that they will be listened to and that they can influence

the way in which their jobs are working and how their services are run and organised.

The Convener: One third responded positively to the statement that staff are always consulted about changes at work but 41 per cent would not recommend the NHS as a place to work. Significant numbers mention bullying—15 per cent talk about bullying and harassment at work. That is the kind of thing that those managers were getting across to us. Is that something that you recognise?

Kenneth Small: Like Elaine Mead, I recognise that the life of the middle manager in the NHS and in any organisation is always a pressured one, because they have pressures coming from the staff they manage as well as from the staff who manage them. That is the life of a middle manager.

I echo Elaine Mead's thought that there are lots of pressures in the NHS. There are clinical pressures, public expectations and financial pressures, and these things come together to make the role demanding.

I do not recognise the statements that you are making either, convener. Middle managers are doing a good job in a challenging environment during difficult times. Speaking for NHS Lanarkshire, I can say that my middle managers are motivated, committed and good staff.

The Convener: Those are not my statements; they are comments made by people who were giving evidence to us.

George Doherty: I agree completely with Kenneth Small. One of the differences between the staff survey and iMatter is the sense in which everybody belongs to a team, and that includes our professional middle managers.

NHS Tayside is driving a values-based process of cultural development that has empowerment leadership at its heart. In the iMatter outcomes, what corporately starts at about 76 per cent for to the extent to which individuals are treated with dignity and respect increases into the 80 per cent range when we look at the environment in which they work as a team every day—and that includes our middle managers. I completely agree with Elaine Mead that, as with any organisation, we are required to deliver outcomes and, in our case, those outcomes are throughput in terms of treatment. However, underpinning all that is the overall responsibility that we all have for the quality of care that is delivered and the clinical outcomes that sit alongside that. It does not matter whether someone is a chief executive, or a nurse, an allied health professional or a domestic—we all have a similar responsibility and a similar goal to ensure that those are delivered.

Jenny Porteous referred to the Datix system with regard to risk. That system is there to do exactly that at any level in the organisation; it allows any individual to report where they believe there is an emerging risk, so that it can be addressed in the organisation. At every level of NHS Tayside, the Datix results are scrutinised and reported transparently to our board to ensure that if, in any case, a team feels that the pressures on it exceed its ability to deliver, we are able to take action.

Maree Todd (Highlands and Islands) (SNP): My question follows on from that. A recent poll in the British Medical Journal found that 91 per cent of doctors who responded believed that healthcare managers should be regulated in the same way as doctors are, and George Doherty has just said that healthcare managers take the same level of responsibility. The poll was accompanied by an editorial that quoted Sir Robert Francis and which said:

> "When we look at what really goes on in a hospital, in the engine room, we've got consultants and, alongside them, managers. Together they are meant to manage a service and yet one side is subject to a regulator, and could be in jeopardy for any decision that they make, whereas the other side is not."

I am interested to know whether any of the panel thinks that it might make a difference to the career of a manager or the quality of management in the health service if there was a regulated profession. If that would not make a difference, what would?

Elaine Mead: Maybe I could start—I think that my colleagues are looking at me.

I am very interested in that idea. There is a real opportunity for the validation of management in the NHS. I maintain a personal development plan to show that I keep up to date in what I do, which could be looked at by anybody, internal or external to the organisation. We all have to be able to evidence what we do. As Maree Todd says, validation is not there for managers at the moment, but my experience is that most managers continually learn. We are not subject to external validation but, personally, I would welcome it. A lot of managers would be very happy to subject themselves to the same scrutiny faced by our clinical colleagues, both nurses and doctors.

Maree Todd: And pharmacists and AHPs.

Elaine Mead: And pharmacists and AHPs. I used to be an AHP, as you know.

George Doherty: I agree entirely with Elaine Mead. I also point out that much depends on the definition of "manager". Many of our managers are already members of regulatory bodies—whether they are ward managers from a nursing background, who are regulated through the Nursing and Midwifery Council, AHPs, or human

resources practitioners such as us, who have a chartered institute, as do our financial colleagues. All the managers whom I have worked with are intensely keen on on-going professional development in their own practice. Looking at my colleagues, I suggest that that is an area in which all boards are active.

Kenneth Small: It is also important to recognise that the vast majority of managers in the NHS—whether they are clinical or generic managers—operate under a performance management cycle, so they held accountable, their performance is regularly and routinely scrutinised, and they have objectives set for them against which their performance is measured. On occasions, those objectives are numerical, but they are also qualitative and about personal style. To come back to the subject of today's meeting, they are also about how they lead and manage staff under the terms of the legislative staff governance standard. We adopt a very disciplined and robust approach to the standard, which I think does a good job.

Maree Todd: Does the career structure attract the brightest and best, or could more be done to improve it? I know that that is a hard question.

10:15

Kenneth Small: It is a difficult question. The answer, in part, is that we could do better.

Shirley Rogers, the director of health workforce in the Scottish Government, is leading an initiative that is looking back at our performance on leadership development, succession and talent management and questioning robustly whether we have got that right in the past and whether we have it right at present. There is a recognition that we could do better, and some thoughts are developing around that. There is a meeting on Thursday this week at St Andrew's house to look further at how we bring together a series of initiatives on that front that will, if they are accepted by chief executives and so on, put us in a better place to answer your question more confidently.

Maree Todd: I have a couple of questions on different issues. This one is for Elaine Mead in particular. NHS Highland operates the lead agency model, which is different from all the other boards. One of the advantages of the model, as it has been described to me, is that it has clear governance lines. Can you expand on that? Perhaps your colleagues can comment on how governance is different in other health boards.

Elaine Mead: It is a model that is unique in Scotland and, inevitably, I am biased about it. The clarity that we have around single management, single budget and single governance over the continuum of health and social care makes it very easy for me to be the accountable officer for the whole system. I can speak only for my system, but the challenges that we thought that we might have in transferring the employment of staff from the local authority to the NHS were in fact very easy to resolve with staff partnership support. We now find people working as genuinely integrated teams. The work of those teams has been even more beneficial to the patients and clients whom we serve than we anticipated.

The integration of health and social care can work in many different ways. As you are aware, there is an integration joint board model in NHS Argyll and Bute. However, we have been able to fundamentally change the whole culture of the organisation, with one team working in one organisation, as opposed to two different groups of staff working under different terms and conditions and with different policies that make it more difficult to take a single approach. As I said, I accept that I am biased about the lead agency approach, but it has been beneficial for us in NHS Highland.

Maree Todd: Does anyone else have a comment?

George Doherty: We have a different arrangement in Tayside, as has been highlighted. I would describe it as our being on a journey. It is about partnership and partners coming together. Integration for us is about mutual learning. We recognise that we are two different systems. In governance terms, as a health board we are very clear about where our accountabilities and responsibilities lie, whether those are clinical or, given today's agenda, about staff.

On governance for NHS employees, all our actions and reporting cover the members of our team who work in the health and social care partnership as much as they cover anyone who is based on the acute side. However, there is learning on both sides. I think that everybody recognises that we cannot impose one organisation's culture on another. There are examples of good practice, such as in the Dundee health and social care partnership. Although it still operates as the NHS and the local authority, people are coming together and acting as single teams, and they see themselves in such teams.

The iMatter tool is being applied across our health and social care partners, who are as keen as we are to understand the experience. The local authority wants to understand how the day-to-day experience of its social care staff in working alongside their health colleagues can be more effective so that we act as a single system. There will always be purse-string issues in some of that, but from a governance perspective—particularly a

staff governance perspective—we have a quite strong story.

Maree Todd: My final question is aimed mainly at Elaine Mead and Jennifer Porteous. As well as purse-string strains, there are real challenges with recruitment in the Highlands and Islands. One of the ways in which we have tackled that is by using targeted campaigns in Europe to recruit European health professionals. Given that we have you here today and that recruitment challenges are definitely a huge underlying cause of staff stress, I would like to hear your thoughts on how we are going to manage the situation post-Brexit.

Jennifer Porteous: In NHS Western Isles, we were pleased a couple of years ago to lead on a northern periphery project on recruitment and retention, which included the Arctic countries. We were the only health board in Scotland that was involved, and we worked in close liaison with Greenland, Iceland and Norway. We think that we are remote, but experiencing the healthcare structures in those countries makes us rethink that.

We got some very good learning from that experience. The main outcome was identifying that there are twin key challenges in remote and rural areas: social isolation and professional isolation. We cannot address one without addressing the other. If we focus only on one, we do so at a cost for the other, and the change is not sustainable. For example, a campaign for particular career opportunities or learning and development opportunities comes at a cost for social isolation. Likewise, a focus on social issues such as housing or schools will not be a professionally sustainable solution.

We have been looking at taking a twin-track approach. With the medical director and the nursing director, we have been looking at opportunities with my colleagues in the north, particularly in NHS Grampian and NHS Highland, for staff to be professionally supported by the bigger boards for periods of time. We are working with Shirley Rogers and her team in the Scottish Government to look at ways to implement such best practice across Scotland.

It is no easy solution. I have worked in various health boards during campaigns in eastern European countries for professions such as dentistry. Such campaigns might work initially, but unless the infrastructure is in place to give long-term support, they are not effective.

The Convener: Where is the recruitment campaign in Scotland? When I worked in schools, no one from the NHS ever came in and said to kids, “This is your career.” I have never seen a television campaign that says, “Come and work for the NHS,” or a newspaper campaign that says, “This is the career of the future”. Do such campaigns happen?

Jennifer Porteous: Yes.

The Convener: Where?

Jennifer Porteous: I am happy to pick that up. In the Western Isles, we have a placement scheme for school pupils to taste jobs in the NHS, ranging from catering to nursing. We are also starting a medicine for schoolchildren programme, to encourage young people who are interested in going to medical school—we have 90 places a year for that. We do local careers fairs in schools and across the islands, including Uist and Barra.

There are also national careers fairs; I think that one is currently going on in Liverpool. On Friday, we met and spoke to general practitioners who represent the health service there about the material they are going to use that focuses on remote and rural areas.

Again, we have a two-pronged approach. We have on-going placements for our local schools and colleges to support people in understanding the kind of jobs that there are in the health service, with a focus on encouraging people into jobs that they might not think they would be interested in, such as engineering and so on. We also have the national campaigns.

The Convener: The recruitment campaigns do not appear to be very “in your face.” There are private sector employers who very obviously use all sorts of methods to recruit people into posts, but the NHS, which is the biggest employer in the country, is well below par at doing that.

George Doherty: I support everything that Jenny Porteous has just described. There is a similar story in Tayside, although it is not as picturesque as Uist and Barra. Our engagement also starts at school.

My board has a very active modern apprenticeship programme; the cabinet secretary was in Tayside earlier this year, celebrating that programme. We have pioneering apprenticeships in social care, payroll, hospitality and healthcare and we are very active in promoting them locally across Tayside and beyond. We receive about 500 applicants per place, such is the demand to work in the NHS.

The point about opening up an understanding of the wide range of roles and professions that exist in the NHS has been well made. We can always be better—collectively and individually—at doing that, but we are extremely active in our communities, and we tend to take a high-profile approach to the issue.

Ivan McKee (Glasgow Provan) (SNP): I want to go back to the discussion about the iMatter

survey and how it compares with the staff survey. The iMatter survey is described as a continuous improvement tool, which I think is great—I have experience of such tools in previous work. It is valuable that you are moving in that direction.

The staff survey provides some clear metrics on whether the NHS is a good place to work and whether staff are consulted. Kenneth Small mentioned that iMatter is different and is not directly comparable with the staff survey. Will direct questions be asked at a top level that will allow us to make sure that the continuous improvement stuff is working and to take a view on how the whole system is performing?

Kenneth Small: The iMatter approach is embedded locally, but it also has a corporate structure to it. Every health board will ultimately—by that, I mean by the end of this year—have a staff engagement score, which will be built up from a pyramid of contributions from the local action plans and local participation by staff. As to whether it will explicitly say how good a health board is at staff engagement, it will not give the board a score for that, but it will give a feeling for general staff wellbeing on the basis of an arithmetical score.

However, as the HR director of my board, I can look at as many of the action plans—and their focus—as I wish to. An administrative approach is taken that will allow me to do so. There is nothing to stop individual boards picking and choosing certain things through the staff governance action plan, because we are not doing away with staff governance action plans. We will have corporate, divisional and local staff governance action plans that we will feed messages and priorities down through. If I perceive, as a result of being out and about and listening to people, or receiving uMatter emails, that staff are unhappy or aggrieved, I will say, in 2018-19, that I want a series of actions and proposals on staff engagement, enhanced staff training and development or whatever the priority topic of that year might be to be embedded in the action plans. It is a case of listening, but it is also a question of feeding in and informing.

Ivan McKee: Right, but there will not be a dashboard that will allow the committee to say, next year or the year after, that NHS Western Isles scored X per cent on this question and NHS Greater Glasgow and Clyde scored Y per cent on that question in the way that we can at the moment. Is it correct to say that we will lose that ability?

Kenneth Small: I think that we are gaining rather than losing—

Ivan McKee: We are gaining something else, but we are losing that ability.

Kenneth Small: It is something different, but that something different is embedded in greater participation and a greater feeling of being informed and being able to respond to what the staff are saying.

There is one other point that I should make, as we have not mentioned this yet. As part of a national exercise, we have looked at what iMatter covers. It is a series of questions that are largely what was in the previous staff survey, but they are embedded in an iMatter wellbeing quotient or score. However, there were elements of the previous staff survey that were not caught in the iMatter questionnaire. I am talking about areas of interest to the committee and to me that were largely to do with harder-edged—if I can use that term—issues such as bullying and harassment and health and safety.

Therefore, at the end of this calendar year, we will carry out a supplementary survey. We have managed the process as carefully as we can, because we do not want to confuse staff and make them think that we are just running another partial staff survey alongside iMatter. There is a gap in the current staff engagement on issues such as bullying, harassment and violence—whether verbal or physical—at work. We will conduct a supplementary survey on some of those harder-edged issues, which will be agreed with the Scottish Government as a corporate process across the NHS. That will feed into its own action plan, which will be aligned with and supplementary to the iMatter work.

Ivan McKee: Okay. So, in summary, we are gaining a lot, but we will not have the hard numbers that we as a committee can look at and say, "This is the score", and identify how it compares with last year's score and how, at the top level, different health boards' scores compare.

10:30

George Doherty: I go back to what Kenny Small described in relation to the iMatter outcomes at the board level. There is the staff governance action plan and, in Tayside, we have the people matter strategy, which is built on top of that. All of that is published and is in the public domain, so any member of the committee can look at our position from year to year, what we are doing and what, for us, are the key issues. We do that through our staff governance committee in open business.

Ivan McKee: I am still not sure. Does that mean that we will have charts of data to look at?

George Doherty: You will be able to track my board's progress.

Ivan McKee: At the moment, I can sit here and see that NHS Western Isles is the best on a particular question and compare, by health board, what happened in 2013 with what happened in 2015 across Scotland. Will we still be able to do that?

George Doherty: It is a matter for the Scottish Government to determine how it wishes to use the data but, as Kenny Small has already explained, each board has an overall staff engagement score, and that score is and will be published. The outcomes of the pulse survey that will be brought forward at the end of this year will be commonly reported across all the boards.

Kenneth Small: In the art of the possible, that ability to examine could happen but, as George Doherty said, the Scottish Government would need to be the parent body that analysed and interrogated and then created that report. The individual boards have their scores and build action plans corporately and locally in relation to those scores, but somebody else would need to aggregate all of that. To my knowledge, that is not routinely in the planned system.

The Convener: In its submission, NHS Highland said:

> "The Staff Governance Standard was implemented at a time of growth and relative prosperity, when the financial challenges in the NHS were not as significant as they are today. Engaging staff in times of austerity where there are real budget and staff pressures and the requirement for significant organisational and service change to ensure that services are sustainable, is more difficult."

Is that the nub of where we are at the moment? In our constituency caseloads, many of us—maybe most of us—have lots of NHS staff telling us that they are under pressure that they have never felt before. We have heard that in evidence, too. People not being released for things such as training and events has been mentioned. My wife works in the NHS and in a 12-hour shift last week she walked 10 miles and had two 15-minute breaks. That is not unusual. People routinely do not get things such as breaks. That kind of thing is going on, and staff are feeling real pressure. There are not enough staff to do the job and there is reliance on bank staff, for example. Do you recognise that? Are staff saying to you, "We really are feeling the heat here"?

Elaine Mead: I absolutely recognise that.

The Convener: I asked the question because that has not come over in your evidence today. It came over in your written evidence, which is really good, but the general feeling that I get from the panel today is that, in answering our questions, you are putting a very positive gloss on everything. Of course, it is your job to do that, but there has not been a recognition of the massive pressures that people feel on a day-to-day basis. Will you comment on that?

Elaine Mead: I am very happy to comment on that and, of course, to thank our staff, who do a fantastic job every day. It is important to do that in valuing our staff.

The NHS has to change. The current models of care are no longer sustainable, and we increasingly understand and accept that. This is a time of great change, and change causes uncertainty for staff, so we need to engage the staff in that process of change. As we transition from the old way of working to what will need to be a new way of working with potentially different models, that will sometimes feel very uncomfortable for staff. That means that the staff governance arrangements and our partnership working are more important than ever before.

Kenneth Small: I do not think that any of us has pretended anything other than that the NHS is a pressured environment for all at the moment, and it probably has been for many years.

The Convener: Is there more pressure now than ever before?

Kenneth Small: There is a different pressure. Increasingly, we see an opportunity through the national delivery plan to create, with a fair wind, a light at the end of that tunnel. Lanarkshire has a history of being fairly pragmatic and sometimes brave. At the moment, we are having a fairly challenging but, I hope, constructive conversation with Government on budget, budget capacity and capacity to deliver targets, care and health improvement in the way that we would like to. We are saying to Government that some of the targets that it has set will not be met because we do not have sufficient resource or capacity to do that, and we are having an adult conversation with Government about the art of the possible within that capacity.

Our calculations take into account the demands that we put on staff and our ability to recruit, retain and provide staff in certain areas. The islands are not unique—there are vacancies all over Scotland in general practice, primary care and community care. One of the approaches that we have taken to our ability to maintain capacity has been to engage with the very staff you are talking about, who are enduring the pressure, and to ask them, "What would you do?" We want to get their ideas on where we can make efficiencies, improve performance and reduce costs, based on their knowledge and experience of the front line, which is where it matters.

We have a rigorous approach of staff engagement, which goes down from our employee director through staff-side colleagues into wards and departments, to build ideas on the initiation of

cash-releasing efficiency savings and other efficiency savings, but the reality is that we will never have enough money. It will almost never be affordable to meet public demand and expectation as well as clinical expectation on modernisation, new models, the use of robots and all the other things that people would like to do in their clinical worlds. Therefore, we need to make the best of what we have. For my board in the west of Scotland, that is about how we make more sense of our joint capacity. How can we use the scale and complexity of the health service in the west of Scotland to improve our ability to deliver? That will bring challenges back to politicians and to the public, because services in people's back yards are possibly no longer affordable, so we need to aggregate and create economies of scale, through which people will get better care, but not necessarily in the same geography.

The Convener: Okay, folks, we are out of time. Thank you very much for your evidence. I suspend the meeting briefly to allow us to change the panel.

10:37

Meeting suspended.

10:42

On resuming—

Draft Budget Scrutiny 2018-19

The Convener: Under agenda item 2, we have two evidence-taking sessions on the draft budget 2018-19. We have less than an hour for the first panel, so I welcome Andrew Strong, assistant director of the Health and Social Care Alliance Scotland, also known as the alliance; Aileen Bryson, interim director for Scotland of the Royal Pharmaceutical Society; Richard Meade, head of policy and public affairs at Marie Curie; and Carolyn Lochhead, public affairs manager at the Scottish Association for Mental Health.

We will move directly to questions.

Alison Johnstone: There is a view that integration is making the delegation of funds complex and making it difficult to assess whether the allocation of the health and sport budget meets the Scottish Government's stated priorities. In the submissions that we received, Marie Curie noted that

"no additional or specific financial resource has been committed to"

supporting the commitment in the Scottish Government's health and social care delivery plan to doubling palliative and end-of-life provision in the community and that integration joint boards are expected to meet that from within their own budgets; and SAMH noted confusion over the allocation of new mental health funding and that

"publicly available detail"

on spending

"varies greatly between IJBs."

Is the available information on the health and sport budget adequate and detailed enough? What would support better scrutiny?

Richard Meade (Marie Curie): The health and social care delivery plan, which was published at the end of December 2016, was really welcome, particularly the commitment to doubling the palliative care resource in communities. Unfortunately, we have seen no sign of any additional resource for that. We have been told that integration authorities are expected to find the funding from within their own resources but, having engaged with 30 of the 31 integration authorities, we are not entirely clear where palliative care sits in their priorities. A cursory glance at their strategic plans shows that many of them do not even mention palliative care, even though we know that it is a national priority.

A letter to integration authority chief officers from the Scottish Government, dated 15

December 2016, listed palliative care as the second priority, but it cannot always be seen in authorities' strategic plans. There is not necessarily any evidence of resource being put into it, and we are yet to see any really strong movement on the ground to match that national intent and ambition.

10:45

Aileen Bryson (Royal Pharmaceutical Society): I have a general point. We lobby and advocate for changes where we feel that the pharmacy profession can make a difference to patient outcomes and where there is space for more efficient use of NHS resources.

All that the draft budget can tell us is where there has been an uplift; it cannot tell us whether any of that uplift will be spent in any of the areas in which we have made recommendations for positive change. We can make comparisons—from the old draft budget, we could see that the only body among the four independent contractors that does not have an uplift is pharmacy, so the organisation that does our negotiations would probably question that—but it is much easier for us to track progress if money is allocated to a particular workstream. For instance, the new money that is being allocated for three years for pharmacists in GP practice has now been baselined so that we can see where that has gone. That will be helpful, but the budget is not particularly transparent.

Carolyn Lochhead (Scottish Association for Mental Health): We see very different levels of detail in IJBs' reporting on and plans for mental health. It is difficult to compare, because the structure is not consistent across all of them—it is hard to see what is going in where. At national level, we welcome the £150 million investment that has been announced for mental health, but we have found it difficult to follow that from the first announcement to the more recent announcements about what it will be used for, how much has been allocated and how much has not. At IJB and at national levels, we could do with more clarity and transparency.

Andrew Strong (Health and Social Care Alliance Scotland): I agree with all the points that have been made. We are one year into the integrated systems and we know that there is some good partnership working between the third sector and the IJBs, not least through some of our members such as the Red Cross, the Food Train and the Royal Voluntary Service. Given the financial pressures that are being felt by IJBs and the rebalancing of some of the investment in primary and social care, it will be a challenge to support and protect preventative work, which is largely delivered by the third sector. The integrated care fund is one element and, in advance of this meeting, I tried to find out what integrated bodies have used that fund for. The information was patchy—there were different approaches to making available information that I would be interested in, about how they have invested that money, which organisations have benefited and what the outcomes have been.

When the health and social care delivery plan was published, it was made clear that a financial plan would be made available. I am not aware that it has been, at least not publicly. Perhaps the committee could clarify that with the Scottish Government.

Alison Johnstone: A recurrent issue has been the mismatch between local authority and health board budget-setting timeframes. The Convention of Scottish Local Authorities has suggested that those should be brought more into line, and the Pain Association Scotland has said that the misalignment causes real difficulties for

"commissioning ... services from the Third Sector".

Have panellists found that to be an issue? Do they understand the reasons for the mismatch and why it cannot be resolved?

Richard Meade: The vast majority of our contracts with NHS boards are three-year, long-term contracts, so we are on the point of negotiating our first round of contracts with integration authorities—that will happen over the next year. Until then, we will not really know whether there is a problem and whether the process works. Once we are through that first round, we will have a good idea of how well integration authorities are working with the bringing together of health and social care budgets and new routes for commissioning.

Alison Johnstone: Audit Scotland has suggested the benefits of longer-term budgeting. Richard Meade mentioned three-year contracts, which are clearly longer than some of the opportunities that witnesses will have had in the past. Does a short-term focus inhibit the transformational change that we would like to see?

Carolyn Lochhead: A short-term focus is really difficult, particularly for the third sector. We have contracts of various different lengths. If we have one-year contracts, it is really difficult to attract and retain staff. Short contracts are really difficult for staff to work under—they make it difficult to plan ahead—and it is hard for the people who are using the service to feel safe and secure and to understand the plan. Longer-term planning would help across the board and is much needed.

Richard Meade: I agree with Carolyn Lochhead. We are fortunate in that the vast majority of Marie Curie's contracts are at least

three years long, but on occasions when we have had 12-month contracts, we have experienced the same issues around recruitment and retention of staff and being able to deliver the service to meet our desired outcomes—often it is unsatisfactory for us and for those who are commissioning the service. Long-term contracts are much more successful because they allow us to invest in staff and to innovate, which is crucial as we move away from investing in acute services to investing in the community. Under long-term contracts, we have more time to innovate, develop, redesign and invest in services as we go along. Under short-term contracts, we are almost firefighting from the beginning in terms of how we keep the service going, retain our staff and recruit staff to replace those we have lost because they needed more job security than a short-term contract would allow.

Long-term contracts are the way to go. The whole third sector welcomed the commitment in the programme for government to third-sector contracts being at least three years long—I say "at least", because longer would be even better.

Aileen Bryson: I agree with that. It applies not just to the third sector, but across the NHS. Sustainability always comes up as an issue. Three years is better than one, but as you get towards the end, even three years is a problem. The issue is not an easy one to address, but in general strategic terms, we need to be thinking much longer term. Pilot projects are carried out and then there is no transfer to a long-term contract—or even one for a year. That impacts on getting the right staff and retaining them. The impacts are vast and cut across everyone.

Andrew Strong: I repeat Richard Meade's point. The issue is significant for the workforce—if you have a one-year funding model, within six months you will be needing to renegotiate. Before the meeting, we were talking about the particular implications that that has for people who work for third sector organisations; they face a challenge in deciding whether they can continue to work for an organisation or need to look for somewhere where there is more certainty about the future. There could also be implications for the Scottish Government's workforce plan around social care, given that £850 million-worth of social care is provided by the third sector. There might need to be some sort of recognition that people who work for third sector organisations that provide significant levels of social care will need reassurance about the future of their jobs.

The Convener: On the transparency of the budget, the Scottish Government is involved in a transnational open government programme and I would have thought that being able to understand the budget is a key aspect of open governance. Could the people who use your services pick up the Scottish Government's published budget and understand whether the money that is going into services has gone up or down?

Andrew Strong: No.

Aileen Bryson: That is a very broad question. Some people would and some people would not. Some people are good with figures and some people are not. It is a complicated document—my background is not in finance, so I think that it is complicated. How long is a piece of string?

Richard Meade: I would agree. It is not always about how much is being spent on services; sometimes the public will be more interested to know what services deliver, how they could improve their life if they needed to use them and whether they are available.

Providing information around health literacy—helping people to understand what services do and how they support people—is much more important than saying that X is spent on a service and that that has gone up by Y or down by Z.

Carolyn Lochhead: I completely agree with that. I would like people to be able to pick up a Government document and understand the difference that a service has made. In mental health, that information is difficult to find. We do not measure outcomes in mental health; we measure expenditure and other important things, but we cannot tell you whether anyone is any better at the end of their interaction with many of the services, particularly psychological therapies. I know that we are waiting for the results of the review of targets that Sir Harry Burns has been leading. We would like some sort of outcomes monitoring in mental health to be introduced as part of that.

Aileen Bryson: We agree with the point about health literacy. How do we teach our young people about these issues in the early years and education? How do we let people know how to use and how to navigate the NHS so that they can go to the right place at the right time? How do we get people to understand that medicines can cause harm and that there are risks? There is a big piece of work to be done around health literacy, which would feed into what has just been said about how people can understand the outcomes and the services that are provided. There is not a clear understanding of that in general.

Andrew Strong: I think that I can go a bit further than the glib answer that I gave earlier.

The committee has asked the IJBs about linking budgets to outcomes, which is important for what needs to be done in the future. I understand that the review by Sir Harry Burns, which will be published in a couple of weeks, will address outcomes and targets in a bit more detail. That

gives us an opportunity to consider the indicators around some of those outcomes, particularly the national health and wellbeing outcomes, which were being drafted as the policy was developed. The guidance always said that the indicators underneath those outcomes were a work in progress. In our view, they do not provide a comprehensive set of indicators for the national outcomes—for example, whether health and social care partnerships contribute to the reduction of health inequalities is judged by premature mortality rates and emergency admission rates, when a more complex understanding of outcomes is probably really what is needed to understand where investment is going and what difference it is making.

Clare Haughey: I have a specific question for Carolyn Lochhead. Your submission mentions the King's Fund's document about mental health's share of expenditure in NHS England. What does that budget cover?

Carolyn Lochhead: That is the NHS budget for mental health expenditure in England. I think that the subtext of your question is, are we comparing like with like? The answer is that it is hard to know.

Clare Haughey: It would be helpful if you could tell us whether we are comparing like with like—obviously, that is what the committee would like to do, and that is what we are talking about today.

Carolyn Lochhead: We have said that it is difficult to compare IJB budgets and other allocations. It is also difficult to compare expenditure across Scotland and England. Without a detailed knowledge of both systems, it is hard to say absolutely that we are comparing like with like, but I have no reason to think that what is covered is dramatically different. That is why we provided the information, but it is one point of reference and clearly you will want to consider other points of reference in relation to how Scotland is doing on its mental health budget. For example, we know that the budget share has started to reduce in the past year.

Clare Haughey: What do you understand the figures from England to cover? Do they cover the whole of mental health services including primary care, child and adolescent mental health services, infant mental health services, services for older adults and so on?

Carolyn Lochhead: My understanding is that the figures cover the majority of NHS mental health services in England. I do not know whether they cover all of the services, all the way through the age ranges. I would need to check that and get back to you.

Clare Haughey: That would be helpful. It would be helpful to have a comparator and to see whether we are discussing community mental health, tertiary services or whatever.

Carolyn Lochhead: I undertake to do that.

11:00

Brian Whittle: I think that my belief that the preventative agenda will be delivered primarily by the third sector is fairly well known. That gives the Government a challenge, because it is the predominant funder of the third sector. How can the third sector better align itself so that third sector organisations work in partnership with each other in delivery of the preventative agenda, and thereby make it easier, if you like, for the Government to fund them? Where do you currently sit on our being able to fund the preventative agenda properly?

Carolyn Lochhead: There are already some good examples of partnership in the third sector—for example, the work of the alliance, which many of us are members of, and other ways in which we work. It can be very challenging to work in partnership, because in social care commissioning—in which many of us work—the prevailing model is competition: tenders are put out and contracts are awarded. That pushes us down the road of competing with one another.

We would very much welcome examination of how we can commission and develop services in a different way so that we can work in partnership with each other. Nonetheless, I would say that we work in partnership fairly well, but it would be good to look at how preventative services are being commissioned and to ask whether they are being commissioned in a way that makes it possible for us to work in partnership. I would turn your question round slightly and ask whether we can look at the commissioning process and establish whether it supports partnership working.

Richard Meade: I agree. The integration agenda provides a real opportunity to treat the third sector as a genuine partner in partnerships' strategic commissioning plans, and to bring us to the table as soon as partnerships start considering their plans for how, for example, they might deliver palliative and end-of-life care services. Do partnerships involve all the key players from the third sector and do they bring us to the table so that we can come up with plans together? If they do not, the statutory partners might decide what is to happen and then bring in the third sector later, saying "This is what we've got. How can you help us?" Involving us and other relevant partners as early in the process as possible is much more likely to lead to genuine partnership working—not just among third sector organisations, but between the third sector, the statutory sector and the independent sector.

Andrew Strong: I echo colleagues' comments. One of the committee's previous evidence sessions discussed the Christie commission and the 40 per cent potential saving that it reported could be made through preventative investment. There is currently significant demand on services—many of which are provided by third sector organisations—which is not being met completely. We are therefore likely to see organisations such as the brilliant Good Morning Service, which is an alliance member, providing services that relieve pressure on health and social care partnerships.

One of the things that I want to push back to the committee is that the 40 per cent saving that is mentioned in the Christie commission report is admirable, and we need to work towards achieving it, but there is a need alongside that to reinforce the point that people need to be involved in design and delivery of services rather than forced into predetermined systems. I am not convinced that we have yet made enough effort on that side of things. There has been investment in preventative services, but we would like more work to be done on how people can shape services, whether through participatory budgeting or other models. I know that some health and social care partnerships are doing that already.

I contend that the committee's report on work with IJB stakeholders, which came out last week, probably reinforces that need, to some extent. We need to see the bigger picture rather than just take the view that if we invest here, we will save there.

Aileen Bryson: That is a very valid point, but true partnership working is very important. We cannot look at just the third sector; there has to be partnership working. There is huge untapped potential for public health and prevention work in the NHS working with the third sector. Therefore, I would not like the question to be thought of in terms of the third sector alone, although I understand where Brian Whittle is coming from and I completely agree on the social prescribing exercise. However, we should look at the principles of realistic medicine and the themes that have come through about how the NHS has to change. That means that absolutely everybody has to be involved in order to get traction in the preventative agenda.

Brian Whittle: I will just go back over something. Carolyn Lochhead highlighted competition for budget in the third sector. In fact, it is not just in the third sector, because the budget is almost siloed between the NHS and the third sector. Aileen Bryson made a good point that the issue is much bigger than the third sector. However, some organisations in the third sector deliver similar outcomes and compete against each other. Although third sector organisations need to ensure that they are properly funded, do you not also need to ensure that you align yourselves so that it is easier for the Government to fund you?

Aileen Bryson: I will shut up and leave my third sector colleagues to answer that one.

Carolyn Lochhead: We work jointly wherever we can and where the process allows us to do that. However, I come back to the point that it is down to the commissioning process to make it possible for people to work together, and to ensure that commissioners do not fund the same outcome multiple times.

Of course, there are different ways of looking at the commissioning process. In some areas, we have moved away from the traditional commissioning model and now have self-directed support, through which it should be possible to fund a number of providers to achieve a person's outcomes. That is a good example of where we could see change and a slightly different approach in order to recognise the importance of mental health. We know that people with mental health problems account for about only 5 per cent of self-directed support payments, so we could look at how we invest more in that side of the system so that people's outcomes, which are of course the most important outcomes of all, are being achieved.

Richard Meade: It is worth highlighting that there are lots of examples of good practice in which third sector organisations work in a complementary way and in partnership—certainly among those of us who work in palliative and end-of-life care. Through the Lothian palliative care redesign programme, our Marie Curie hospice in Edinburgh works closely with St Columba's Hospice to ensure that we provide city-wide hospice cover. The two often speak and share information and, potentially, work on the same referrals to ensure that people get the right care. There are lots of good examples, but as Carolyn Lochhead said, we have to go back to commissioning arrangements and to have early conversations between commissioners and potential partners about delivering services.

Andrew Strong: There are examples outside health and social care that we can look at. The employability programme, for example, is in the process of being commissioned, and a number of third sector organisations are coming together to make bids separately from each other. Organisations are working closely together on that, so there might be lessons for health and social care from how that commissioning process is being managed.

Maree Todd: As you guys were speaking, I thought about an example that I came across in

the past couple of weeks of precisely the sort of partnership and collaboration that you are talking about. There is a palliative care pharmacist on Skye whose post came about because of collaboration between a statutory organisation, industry and the third sector—the NHS, Boots the Chemist Ltd and Macmillan Cancer Support. That is not the only such example that I have come across in the Highlands; we tend to get cross-sector working in the area. Are we ahead of the game, or is that happening all over the country?

Aileen Bryson: Similar work on palliative care has been done in Glasgow; I am not sure who followed who on that, although the Highlands are ahead of the game, in that what you describe is not happening across the country. I think that we would all agree that that theme applies to everything.

We have pockets of really good work, which we want to be translated into something national. We need to get the data and the outcomes and then take forward that good work. It would be really useful if there was something in the budget that translated to that, because the outcomes from that project in Glasgow are fantastic for individual people—it is very person-centred. We hear about district nurses, but we do not have district pharmacists. However, in that project it was almost like having a district pharmacist who followed patients to where they needed help; it was a good example of cross-sector working. Models like that for various therapeutic areas would be an excellent way of bringing in the third sector and having partnership working.

Maree Todd: When the general public are asked about palliative care, they say that they do not want to die in hospital. However, that is still what happens in a large number of cases. Is there any shift in direction in that respect?

Richard Meade: That is absolutely right. We know from evidence that every year about one in four people who needs palliative care while they are dying misses out on it, and we know that just over 50 per cent of people die in hospital, although the vast majority of people would like to die at home or in the community. We therefore know that there is a great deal of work to be done.

The Scottish Government has an ambitious commitment that by 2021 everybody who needs palliative care will have access to it. We have talked about the commitments in the health and social care delivery plan, but we lack the data and evidence at the moment to show what progress we are making towards achieving that vision and ambition. I know that the Scottish Government is committed to developing better data to support palliative care, but it is not just a palliative care issue; we need better data on whether people's outcomes are being achieved, whether our investment in services and policies is delivering on the ground and improving people's lives, and whether we can see trends in that progress. At the moment, we do not see in that in palliative care. We know that one in four is missing out and that more than 50 per cent of people are dying in hospital. We need to see data that shows that the situation is improving and that there is progression.

It is not just about outcomes, though. It is not necessarily fair or true to say that someone who has died in hospital has had a bad end-of-life experience. We also need to capture information about quality of care and people's personal outcomes, given that some people want to die in hospital.

The Convener: I am sorry, but could we stick to the budget issue, please?

Richard Meade: I am sorry.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I will follow up on my colleague Brian Whittle's line of questioning about engagement. Community Pharmacy Scotland has said that the new health and social care partnerships

> "are still working through how best to engage and manage their budgets and are finding this challenging. Equally we find it challenging to engage."

Has that been your experience of engagement? Do you know whom to go to and speak to?

Richard Meade: I would say that the situation has improved over the past 12 months, but it has been a real challenge. As I think I said previously, Marie Curie is present in 30 out of the 32 local authorities and we have struggled to engage. A colleague has said that last year we did not even know whom to ask. At least we now know whom not to ask.

The situation is getting better, but it is quite a challenge to find the right person. The partnerships are still trying to work out internally who sits where in terms of commissioning budgets and commissioning plans. As I said previously, the proof will come when IJBs start to commission services that are on existing contracts. Perhaps in 12 months it might be worth the committee's while to look at how service level agreements have been developed with integration authorities, especially with the third sector, and how they are working out. That would be a good line of inquiry.

Carolyn Lochhead: I agree with that point, because we are still seeing how integration is going to work out. There is a specific point around the third sector interfaces, which exist in each IJB area and have the role almost of representing the third sector in that area to the IJB. That is a very challenging role for anyone to undertake. To take the views of the entire third sector, which does

many different things at many different levels and scales, and represent those in a meaningful way, is extremely challenging. I agree with what Richard Meade said about the difficulty in knowing whom to go to and how things work. There is a particular third sector angle to that.

Andrew Strong: On the back of that, I will say that I have made the point to the committee previously that the third sector interfaces are not well funded to do that role. That means that a lot of work is not getting representation at IJB level, whether it is local work or national third sector organisations that are working in particular areas. There is something to be looked at in terms of their capacity building.

11:15

Colin Smyth: All your written submissions make quite strong pitches for additional investment in particular areas. Marie Curie obviously emphasises

“the need for ... investment in palliative care”,

while the Health and Social Care Alliance argues for more “investment in social care”. SAMH refers to psychological therapies and the pharmacists have highlighted the importance of the roll-out of the minor ailments service. Does the health service make sufficient use of evidence when it is making budget decisions?

Andrew Strong: That is an interesting question. In that respect, I should flag up some work that Glasgow Caledonian University is doing just now on developing a framework for making difficult budget decisions in health and social care. Concepts such as health economics, decision analysis, ethics and the law have been integrated to come up with a framework for shifting the balance of care, and it is now being tested with four health and social care partnerships. It will be interesting to look at that work and the recommendations and analysis that result.

Many of our members have described their frustration at well-evidenced activity forming an essential part of health and social care pathways, but not necessarily being reflected in strategic commissioning decisions. Our self-management fund, which amounts to £2 million a year but which could use 10 times the funding, invests in innovative forms of self-management support and in supporting the third sector to work in partnership. It covers a number of different programmes. However, even though those programmes are well-evidenced and have been piloted and had some great outcomes, they are not often funded through statutory resources, and we have long been concerned that good practice emanating from the third sector does not lead to wider scalability.

Carolyn Lochhead: One of the difficulties with mental health is that there is often not a lot of evidence to follow. Earlier, I mentioned the lack of measured outcomes in some areas of mental health. Psychological therapies, which has been highlighted as part of our submission, is a good example of where a great deal of effort has been put in and a lot of very technical work done on setting up new systems to monitor how long people are waiting, and the point at which the clock starts and stops. However, although we know that, nationally, we are not meeting the 18-week target for access—only 72 per cent of people are seen within that time—we do not know whether, after receiving whatever psychological therapy, people feel better. It is quite important to know that when choosing where to put budget.

The improving access to psychological therapies programme in England has a way of measuring recovery rates. The target is for 50 per cent of people to achieve a recovery rate, and that is determined by their mental health being measured as they move through the programme. The programme is on target to achieve that recovery rate. It is the kind of thing that we hope we can move to in order to ensure that the NHS has better outcomes-based evidence on which to make budget decisions.

Aileen Bryson: The fact is that the evidence on this is sometimes difficult to find: I think that the committee would struggle to do so. Even though we have a lot of key stakeholder engagement, it is difficult to find the discrete pieces of work that we know are going on across the country, and there is no real method of bringing all that best practice together so that we can gather the evidence. We lobby for areas in which we know we can make a difference, and it is great when we can engage with the committee and talk about and progress those issues.

Moreover, when we have evidence, it takes a long time to turn it into practice or to take cognisance of work that is going on in other parts of the United Kingdom. For example, we are now going to look at care homes, where we know from evidence from other parts of the United Kingdom that we can make a difference to patient care, and make savings for the NHS.

A jigsaw needs to be brought together. I understand that that is a challenge for the committee: we all find it a challenge in our areas.

Alison Johnstone: The submission from the Royal Pharmaceutical Society mentions funding for pharmacists in general practices and emphasises what a positive step forward that would be. You also say that it is

“nowhere near the level of resource required to provide every GP practice with access to the expertise of a

pharmacist as promised by the current Scottish Government in the SNP manifesto in 2016".

Are you discussing that with the Government and are you hopeful that the proposal will be progressed?

Aileen Bryson: Since we submitted, there is a new document from the Scottish Government called "Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland". It lays out a lot of the things for which we advocated in our manifesto. Our concern is how that can be implemented and enabled without additional funding. Previous successful strategies, such as "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland" in 2002, had extra funding.

It depends on the wording. We would like to think that people have access to the expertise of a pharmacist. Some members of the committee have signed up to the proposal in the manifesto we had during the Scottish election in 2016 "Right Medicine—Better Health—Fitter Future" on everybody having access to pharmaceutical care. If there is a good local arrangement and people are speaking to each other, GPs and pharmacists can work closely together.

One size does not fit all, and how much access a practice needs depends on its geography and the set-up of the practice. Each general practice is different. We know that the funding is not enough overall even to give a half-time pharmacist to every practice. The original proposal was for 140 full-time equivalents. The Government is working towards that, but we know that it will not be enough.

A lot will depend on expectations. We need more workforce planning and we need a clearer idea of roles and remits and where the Government wants people to work. We know that, if we get the pharmacists in the right places in primary and secondary care, we can make a difference.

The Convener: Thank you for your evidence. I suspend the meeting to change the panel.

11:22

Meeting suspended.

11:27

On resuming—

The Convener: I welcome to the meeting Dr Andrew Fraser, director of public health science, Scottish Directors of Public Health; Kim Atkinson, chief executive officer, Scottish Sports Association; Sheila Duffy, chief executive, ASH Scotland; and Alison Douglas, chief executive, Alcohol Focus Scotland.

We have around an hour for this session. We will move directly to questions.

Alison Johnstone: In order to scrutinise the budget, it is obvious that it has to be clear and accessible. The written submissions suggest that people are not always finding it so. Alcohol Focus has noted that alcohol and drug partnership budgets have become harder to track. The SSA has noted a lack of detail on how the sports budget is allocated. If panel members were listening to the earlier evidence, they will have heard that that was the view of SAMH and Marie Curie too. I am interested to hear from this panel whether the information available on the health and sport budget is adequate or detailed enough.

Alison Douglas (Alcohol Focus Scotland): As Alison Johnstone has alluded to, the concern about alcohol and drug partnerships funding is that it has always been routed through the health boards. When we saw the significant reduction in funding that happened two years ago, health boards were asked to make up the difference, or at least to ensure that there was no loss of support available to people. Even prior to that, it had been clear that it was extremely difficult to track funding. ADPs would tell us that they did not always have control over the funding that it had been indicated should have been available to them. It has always been the case that that funding should be topped up by local partners, but it has always been difficult to track where it has gone and how much has actually been invested—and more so now that the health boards have been asked to top it up.

As you will know, Brian Whittle submitted a freedom of information request, asking health boards whether they had made up the shortfall. The figures that came back indicated that about half of the health boards had not made up the shortfall, and we questioned the accuracy of some of the figures that we did see. Transparency is an issue.

We strongly welcome the additional £20 million for alcohol and drug treatment that has been announced in the programme for government, although it is not yet clear how that money will be allocated.

11:30

Sheila Duffy (ASH Scotland): The tobacco control budget was fixed for the lifetime of the five-year strategy that was issued in 2013, so it remains fixed for this financial year. In real terms, that represents an on-going decline, and it is less than 1 per cent of the total health budget.

I have some concerns about the fact that the funding for stop-smoking services, which used to come to those services through the tobacco policy budget, is now going into health board bundles that cover a much wider range of issues. It is hard to track the prioritisation at a local level and whether enough information is getting through for the boards to understand what a massive impact tobacco has on health.

Kim Atkinson (Scottish Sports Association): I suspect that, as was mentioned in the earlier discussion, some people are better with numbers than others, so it can be tricky.

The widest challenge from a sport and physical activity point of view is that 90 per cent of investment in sport in Scotland goes through local authorities. There is continued investment from the Scottish Government. The £2 million additional investment in the current financial year was very well received by our members and, I am sure, by colleagues in the wider area of physical activity and sport. However, understanding the wider contribution of local government is part of the challenge.

Before Derek Mackay made his statement in Parliament on the Barclay review of non-domestic rates, we had a discussion with him about the potential £45 million hit on local sport and leisure trusts that is proposed in the review. There will be a challenge if that comes about. There are a number of parts to that.

A third strand to consider is lottery funding, which makes up a significant proportion of the investment in sport and physical activity in Scotland. That funding is decreasing, which is a further hit for sport and physical activity.

There are a number of challenges in understanding not only what is being invested in sport and physical activity but how other partners contribute. A huge contribution is made by a range of health workers and we think that more could be done in that area, although I am sure that the Government is investing in that workforce. The same is true in active travel. The announcement to double the active travel budget was very well received, and we are optimistic that it signals a move towards prevention, which we have discussed many times. That investment could be replicated in broader sport and physical activity.

There are a number of challenges in understanding what is spent where and how we can maximise the contribution that the funding makes.

Dr Andrew Fraser (Scottish Directors of Public Health): You will know well how budgets are distributed in the health sector. The overall health budget has been relatively protected, but it is under increasing pressure and areas such as public health are no exception.

It is always quite a challenge to pick out from the global sum that is allocated to health boards and so on how much goes towards prevention—estimates are made in the various submissions that the committee has received—and, within that, how well people use their time or resource for prevention in other activities. For instance, alcohol brief interventions have benefit. They are mainly rooted in primary care and similar community-based settings, and they are a brief part of a wider intervention that people would have on an individual basis with a health professional. However, it is difficult to identify the cost of them separately and, therefore, to provide a cost benefit equation for such things. That is the main point that I would make about the health budget.

I support Kim Atkinson's point that a lot of public health-related spend is not in the health budget, but relates to how other sectors allocate resources, local authorities being a particular area of interest.

Alison Johnstone: Thank you for all your responses. When Dr Helene Irvine spoke to us a couple of months ago about the preventative agenda, she said that GP funding could be considered as preventative spend—if we funded that service properly it would prevent more acute cases and people presenting at accident and emergency. Andrew Fraser spoke about the difficulty of placing prevention above other services. There is always that tension: we feel compelled to address symptoms, whether people present them at A and E or at the general practice, and that often means that we cannot invest in prevention in the way in which we would like. There have also been some discussions on the need to have more evidence for prevention. The health budget is very demand led, but is there a need for dedicated funding for preventative measures? Are we focusing enough on that or does the funding always tend to get removed and sent to the area of greatest need at that time, for fairly obvious reasons?

Andrew Fraser: The answer is both. Sheila Duffy and Alison Douglas will be able to talk about identifiable funding for various programmes. I go along with Helene Irvine's general premise that primary care is prevention—if primary care is adequately resourced it prevents the need for secondary care.

Yesterday, Sheila and I were talking to a colleague who works in obesity who said that they get feedback from people in primary care to say that prevention is not part of their task and they just deal with disease. There is a spectrum of perspectives on whether primary care is prevention. That raises the question, what is

prevention? Is it primary prevention to prevent diseases from happening, secondary prevention to detect things early and nip them in the bud or tertiary prevention, which is rehabilitation and getting people better from diseases that they already have? I would like to shift towards the primary and secondary end, rather than dealing with the tertiary end, as I am sure that we all would.

Clare Haughey: When you talk about primary care, are you talking about GPs or about the primary care service? Health visitors are certainly there to carry out preventative work.

Andrew Fraser: I readily admit that. I had GP feedback in mind when I gave that example. There is ring fenced, identifiable investment for health visitors. We were talking to AHPs yesterday. Their contribution to prevention is very energetic, particularly amongst older people. They are looking at much more effective prevention among all age groups right throughout the life course. That is not confined to general medical practice—I would include dentists and pharmacists as people who have a great contribution to make in that respect.

Kim Atkinson: A significant part of our response was consideration of the national performance framework and whether we would make changes to the structure. The idealist in us would say that we do not talk enough about healthier life choices, prevention and increasing activity as part of that. There is something idealistic about the health service role in promoting good health as well as treating bad or poorer health. The notion that as people are living longer, their lives should be healthier and happier is a broad mixture. We can work collaboratively on that.

The previous panel talked about conversations with Sir Harry Burns. When Sir Harry Burns was the chief medical officer he said that the best spend in public health was on sport and physical activity and that the key indicator of life expectancy is how physically active a person is. However, we still do not correlate those when we talk about prevention and health. The programme for government and the national performance framework talk about life expectancy as one of the fundamental indicators in a wide number of areas, but they do not link sport and physical activity to that, despite what the former chief medical officer has said. As ever, the challenge is moving upstream, rather than downstream. We need to work out where we all have responsibility for that.

We are part of a Scottish Government working group that is having some really interesting discussions about who is responsible for helping us to make the inactive active, if that is the biggest benefit. It is certainly not the responsibility of the small £34 million budget called sport and physical activity; rather, I would like to think that it belongs to the breadth of the workforce that Andrew Fraser mentioned.

I know that there has been work on trying to get GPs to add questions when they meet patients. Often, GPs are the people who are most likely to meet the inactive. Patients are asked whether they smoke or drink, but why would it cost more to ask a third question about how physically active they are? Only 4 per cent of the Scottish population know how physically active people need to be for their health. We talk about self-directed care, life choices and what people can do to make changes, but only 4 per cent of the Scottish population know how active they should be to improve their health.

It is not just about the small budget for sport; prevention is about looking at cross-budgeting in a way that we have not seen yet. There are change funds and innovation funds, but I am not aware that a change fund or an innovation fund has been about sport and physical activity. New research always needs to be done, but I do not know who holds the research on that and who is the guru in those areas. Alison Johnstone, who is one of the co-conveners of the cross-party group on sport, will know that Professor Nanette Mutrie will be at the next meeting of that group. She is the United Kingdom's leading expert on the health benefits of sport and physical activity. A number of people have that information, but we do not pull that information together and really look at it, as we would see it, and see the contribution that sport and physical activity can make.

Sheila Duffy: We know that, in Scotland, 10,200 people die every year from a disease that is caused by smoking and tobacco. We know that those deaths are preventable and that smoking is the major preventable cause of disease that we face. Behind each death, there are 30 or more people living with chronic disabling disease. This is not about this year's smoking figures; it is about decades-past experience of smoking.

If we are concerned about the on-going sustainability of our healthcare system, we must invest in the future and look at prevention that works. We know that certain measures can be taken in tobacco control that are highly cost effective and which work in reducing smoking rates.

We should also look beyond the figures. For example, many medications are half as effective if the person smokes. Can we routinely advise people to stop smoking in the way that we routinely advise that people should not drink alcohol when they take certain medications in order to make those medications more effective and cut the costs to our health service?

Alison Douglas: At the local level, when there is a discussion in an alcohol and drug partnership about the profile of the prevention, treatment and support services that it undertakes, it is inevitable that the effort will be focused on the treatment services, because they are the principal cost. That is also an historical thing. Up until around 2009, the alcohol and drug action teams—or ADATs—focused on the treatment end. It was only with "Changing Scotland's Relationship with Alcohol: A Framework for Action" that the emphasis on prevention came into the portfolio. However, there is a patchy effect across the country.

At both the national and local levels, because of the organisation and intensity involved in commissioning and delivering treatments, trying to get that right and having the workforce there to deliver them, it is inevitable that the focus of attention will go on treatments. That is why clear direction needs to be given on what preventative activity local alcohol and drug partnerships are expected to undertake.

An important part of the picture is preventative activity that, in essence, costs nothing. I am talking about whole-population measures. The Parliament has provided leadership on minimum unit pricing but, equally, we need to address marketing and availability, which are the other two highly effective low-cost interventions. They do not cost much, if anything. Perhaps they will cost a court case, but I would hope that you would get the funding for that back when you won it.

Those are the things at the population level that will have the most impact. They are the primary preventative measures, and they have to be part of the mix.

The Convener: Do you have any idea where the Government thought that the alcohol and drug partnerships would find the money to make up what was taken from them? Do they have cash stuffed down the back of the sofa or in piggy banks that they can say they have saved for such an occasion?

11:45

Alison Douglas: I understand that the cabinet secretary made it clear to health boards that they were to ensure that there was no reduction in the delivery of outcomes, either by delivering efficiencies or by making up the shortfall in resource. That was the Government's expectation of health boards.

The Convener: An analogy would be that, although your wages were reduced, you would continue to provide the same things for your family or your household as you had with your previous wages.

Alison Douglas: I think that this committee knows very well the pressures that health boards are under regarding all facets of what they have to deliver.

The Convener: I am trying to get at whether that was a credible approach to sustaining services in such a vital area of work as drug and alcohol treatment.

Alison Douglas: No.

The Convener: Thank you.

Brian Whittle: In its submission, the Scottish Sports Association quotes a Scottish Government document as saying:

"Physical inactivity costs the NHS in Scotland £91 million/year",

but further on it gives the cost of things including obesity, diabetes, mental ill health, smoking and drinking, and it is the thick end of £30 billion. It strikes me that people with any of those conditions are helped, in part, by being physically active. It is a driver for all of them—if someone is physically active, they are less likely to smoke, less likely to drink to excess, more likely to have control of their weight and less likely to have type 2 diabetes.

If the Government is using the figure of £91 million for the health budget for prevention and sports, is it misaligning where the spend should be? To me, the health budget for prevention and getting people physically active should be about the £30 billion cost of the preventable health conditions that currently exist. Do you agree?

Kim Atkinson: Funnily enough, I am quite keen on that question. Our colleagues at the British Heart Foundation recently commissioned some research—it has not been formally released yet—by Dr Charlie Foster, who is an eminent UK professor in the economics of preventative health measures. That research estimates that £77 million per year could be saved in the Scottish budget through physical activity and sport. However, the researchers have been able to measure against only five health conditions: heart disease, diabetes, cerebrovascular disease, gastrointestinal cancer and breast cancer. It is important to say that the list does not include dementia and mental health. It is well recognised that, if those areas were added, that estimate would be very conservative. The issue will be picked up at the next meeting of the cross-party group on sport, of which I know Brian Whittle is a member.

It is important to understand the economics behind the issue. We know that physical inactivity is the fourth-highest risk factor in global mortality that has been identified by the World Health Organization. We know that there is a 30 per cent reduction in all causes of mortality in people who

are physically active, and that physical activity reduces the risk of more than 20 chronic health conditions. We know all that, yet we are still a developed-world nation in which 2,500 people die every year due to being physically inactive.

The question is how we can better align the spend, as Brian Whittle said, but the economics and numbers are just one side. The last time we were before the committee, we talked about making Scotland more active and about how, if we were all 1 per cent more active, we would save £85 million over five years. We would also save 157 lives every year. How do we put numbers on the quality and extent of a person's life? That is the hard part.

The point that Brian Whittle was making is that it is necessary to understand the integrated nature of prevention and where the responsibility for that sits. When, across the healthcare workforce, people ask, "Do you smoke?", "How much do you drink?" and, I hope, "Are you physically active?", there should be a combined answer. It is not about one, the other or the extra; it is about what the whole looks like. We will all benefit, on a population health level, if we understand those interactions. I do not think that we are quite there yet, but the potential is absolutely enormous.

Sheila Duffy: Brian Whittle is talking about the Government spending £91 million in the sports budget and £12.2 million per year in relation to tobacco. However, the question makes me think that we should be spending more in relation to tobacco, because a recent UK all-party group report suggested that such spend would deliver a return on investment of almost 1,110 per cent over five years. We can send you the reference for that.

I am not arguing for sharing the pot; we need to co-ordinate. Brian Whittle has spoken about diseases to which many factors contribute, and all our organisations expend energy on trying to improve people's health. The cross-party group on improving Scotland's health: 2021 and beyond, of which Mr Whittle is a member, does that well—it discusses the many non-communicable disease risk factors and how we can learn from one another, join up and share what we do. Many people suffer from multiple morbidities, which we need to work together to address. I do not want to squabble about the cause and who is responsible.

Brian Whittle: You have highlighted what I said. The cost to the Scottish economy of smoking is £0.5 billion; if we were more active, we would save £91 million. I am trying to get at the cross-collaborative function. If we could persuade all the smokers to be more active, it is likely that they would not smoke or drink. That is what I was getting at. When the Government looks at those budgets, it must look at the behavioural drivers of a reduction in preventable health conditions.

Alison Douglas: I do not have the research to hand, but I think that there is some evidence that participation in sport is linked to increased alcohol consumption—

Brian Whittle: Increased consumption?

Alison Douglas: Yes. I know that Brian Whittle would not be an example of that, but a lot of socialising after sport is alcohol driven. I can look into that and get you some information.

Brian Whittle: I will come back on that point, if you do not mind. I suggest that alcohol consumption and having a poor relationship with alcohol are not the same thing. I would like your comments on that.

Alison Douglas: I totally agree with that. However, 14 units per week is six pints of beer. I would hazard that a number of five-a-side football players consume that after one game.

Brian Whittle: We need to have a proper debate about that.

Kim Atkinson: I will leave Brian Whittle, in his wisdom, to have that debate, but it is unfair to assume that the issue is five-a-side football, which is just one of our sports. Huge numbers of people participate in sport, and there are many initiatives such as walking football that tackle a wide number of things. As Brian Whittle has said, sport and physical activity are ways of improving health in its own right, but sport is also a vehicle for assisting people to do a wide range of things. We see that in mental health practices, in work between the Alzheimer's Society and our members and in the relationships between our members and cancer charities. That point is important, but it is not what I had intended to lead with.

It is important to understand that the cross-budgeting that Brian Whittle spoke about is a big challenge at local authority level. Everybody at national Government level agrees that more could be done; one of the biggest challenges for sport and physical activity is what is done at local authority level. As I said, more than 90 per cent of investment in sport in Scotland goes through local authority budgets. Increasingly, local authorities are running services through trusts, the budgets of many of which are being decreased. Scotland has 13,000 sports clubs—I am sure that many of you have heard me quote that figure before. Many clubs are supported in their work—whether that is sport for its own right or as a vehicle for other benefits—by local sports development officers, who are funded by our local authorities. Every hit to a local authority budget or a trust budget undermines the ability of those clubs to provide their invaluable support.

That support is for two groups of people. The focus to get inactive people to be active is huge—

there is a 20 per cent difference between the activity levels of the most active and the activity levels of the least active people. However, just as important, and which we often do not touch on, is ensuring that we keep active those who are already active. Given our ageing society, keeping those people active is—if you will permit me to say so, convener—prevention in reverse. If there is a decrease in the 900,000 people who are currently members of sports clubs, things will start to go the wrong way and we will start to have a less active population. Yes, we must focus on getting the inactive active and on the contribution that everyone can make in that respect, but an equal priority is to keep the active people active throughout their lives and to encourage them by offering a wide range of activities.

The Convener: Given that local government has had £0.5 billion of cuts, I would think that the last thing that it, sports organisations, trusts and all the rest would want is another bill on top of that. What impact is that approach going to have?

Kim Atkinson: There are two points to make in answer to that question. First, as was mentioned earlier and in the previous evidence session, we need long-term budgeting. Although cutting the sport and physical activity budget might seem to be an easy solution today, that will have a strong impact on people's health in X years. That requires that we understand the evidence that Alison Johnstone mentioned earlier and realise that physical health benefits might take time to appear.

However, the mental health benefits, which were highlighted by our SAMH colleagues in the previous evidence session, will emerge much faster. Given that one in four of us will, at some point, suffer a mental health issue and that 30 per cent of the population are on antidepressants, savings can be made in every possible respect, whether they be financial, in the quality of personal life or whatever.

Secondly, we were really pleased to have a discussion and conversation with Derek Mackay on sport and leisure trusts and business rates before he made his announcement. The challenge with regard to the bill for that, which the Barclay report estimates is £45 million, is significant. Are local authorities likely to say, "Right—if that's the cut, we'll put £45 million back into the trusts"? If that does not happen, we might be looking not only at the closure of facilities and clubs being unable to provide somewhere to play or places to enable participation, but at an impact on the many local authority run programmes that help to get people active and provide them with the opportunity to find activities. The report contains an understanding that we need to support community sports clubs, by which our members are delighted. However, although that is really important, if we do not support the work of local authorities and trusts, there will be no facilities for clubs or parks and playgrounds, where many people are active.

It is a big challenge. We are concerned about it, and I know that our Sporta Scotland colleagues are looking at the scale of that work. However, we are pleased that we and our Sporta Scotland colleagues have had discussions with Derek Mackay and that his announcement was about consulting more and understanding inadvertent consequences. We are optimistic that those discussions will continue.

Dr Fraser: I would like to pick up on something that Kim Atkinson just said in order to broaden things out. This is not just about single factors. Many people are more likely to drink more or to be more sedentary than others, but they will usually have a lot of factors in common; a common-factors approach would look at people's lives.

It is also not about trying to find a single solution—to be fair to everyone in the room, no one is suggesting that there is one thing that will sort the situation. Let me quote a piece of research from the Glasgow Centre for Population Health on the GoWell programme, the main focus of which was regeneration and health. The question that the researchers posed after looking at the data was: what makes people go for a walk? Sport is one thing, but mass activity—even fairly lowly types of activity—is what is going to bring us back from the precipice with regard to health and the health burden.

The answer to the question is that people want to leave a nice, tidy house that they are proud of, go for a walk along a nice, well-kept path where they feel safe, and go to a facility that is not just good but very good, whether it is a sports facility, a shop or a bus stop. Those are the things that make people get up and go, and the components include housing associations, community associations, local authorities, inclusive economic growth policies that have been operationalised into rows of good shops and so on. It is a huge and pressing issue as far as activity is concerned, but it will not necessarily be solved via an identifiable budget. We will need cross-working in that respect.

One thing that has not been discussed so far is where community planning partnerships come into this. Although that might not be a central focus of the Scottish Government, the ability of CPPs to influence budgets and the allocation of budgets at the local level is key to addressing many of the issues that have come up today. How we allocate funds to the alcohol and drug partnerships and to local priorities for physical activity and sport will increasingly be determined by organisations,

associations or alliances such as those. As well as their having the ability to make decisions and see them through to the good outcomes that we want to achieve, there needs to be the expectation that they will do so.

12:00

Kim Atkinson: Walking is very accessible, obviously. Ramblers Scotland, which is one of our members, has done a huge amount of work, and 7,000 people now access the Ramblers medal routes app, which is a significant number of people trying to find ways to walk a bit more.

It is also important to provide diverse activities, because one sport does not fit all, and we should be proud of the diversity of sports that we have in Scotland.

Of their own volition, a number of governing bodies are working to identify how to enable people who might want to start by walking but who have a passion to do something else to find an activity that has the accessibility that walking provides for so many people plus a different kind of motivation. For example, a huge amount of work has been done on walking football and walking netball, and walking basketball is now being introduced. Sports bodies are looking to see how they can appeal to different people such as those who are motivated by something that is a little bit different, those who like walking in the outdoors—which is great, whether that is for travel or for its own purpose—and those who like a social aspect to sport and to meet and engage with other people. That work is a priority.

Linked to that is the chief medical officer's "Start Active, Stay Active" guidance, which clearly says that there is a dose-response element to sport and physical activity. Except among older adults, there is a dose response at all ages—the more active someone is, the better the health benefits they will reap from their activity. We need to start people being active, but we also need to focus on keeping active those who are already active.

The health and wellbeing outcomes that have been identified do not currently require the integration authorities to report on their contribution to sport and physical activity because it is not one of the outcomes that they focus on. That is linked to Andrew Fraser's point.

On the convener's earlier point, if one of the outcomes was around the opportunities that local authorities have, we would understand better the integration that Brian Whittle spoke about—not only the contribution that they can make but the contribution that we all, collectively, can make as part of that.

Maree Todd: This is a very simple point and its moment has almost passed. As somebody who spent 20 years working as a specialist pharmacist in mental health, my ears pricked up when Kim Atkinson mentioned that 30 per cent of the population takes antidepressants. I understand that the figure is nearer to 14 per cent.

Kim Atkinson: My understanding is that the percentage has increased, but I am now checking the figures. I apologise. You are right—30 per cent of GP consultations are related to mental health, but 14 per cent of the population take antidepressants.

Colin Smyth: I would like to return to a point that was raised by Kim Atkinson about the impact that the Barclay review could have on sport. In your discussions with the finance secretary, have you highlighted the fact that, at the moment, a number of local authorities have chosen not to go down the route of establishing trusts or arm's-length external organisations? With the establishment of an ALEO, a tax loophole is pursued, and the local authorities that have not gone down that route are currently penalised in that they have to pay rates. Therefore, there is not a level playing field for an ALEO and a local authority. Has that been discussed?

Kim Atkinson: The membership body for trusts in Scotland is Sporta Scotland, with which we had a brief discussion. I know that Sporta has spoken to Derek Mackay, and I am sure that that issue was part of the conversation. I hope that our colleagues at Vocal Scotland—sports colleagues in local authorities—will have had a similar conversation.

I understand why the review said that there is a level playing field and I am not arguing against that. However, there is a halfway house, for want of a better phrase, of the type that has been identified for universities. There are areas of universities that are core business, which they are funded and resourced to do, and there are areas in which they might be competing with a private market. I would like to think that there is a halfway house for local authority sports trusts, which would allow them to say that they are doing fundamental work to help people to be active or more active and to provide vital support around sports development officers, sport facilities and a wide range of other things. Prevention would move into reverse if we were to lose those things. I am not arguing against the level playing field argument—I appreciate that that is someone else's area and not mine—but we need to ensure that we do not back-pedal and go significantly backwards.

I hope that there will be an opportunity to do something in the forthcoming consultation on water and sewerage rates, which are being reviewed. At the moment, the vast majority of

sports clubs are not allowed to access rates relief for water and sewerage because the definition on which the relief is based relates to charities and community amateur sports clubs, and very few sports clubs are either of those. From that point of view, we do not see a level playing field operating for sports clubs. We are having a conversation with the Government in which we are keen to point out that the definition that is being retained in the Barclay recommendations, which we hope that Derek Mackay will continue with, should be adopted in the water and sewerage rates and that that will provide a level playing field.

Colin Smyth: I have taken a careful note of the number of times that you have used evidence or figures to back up your case, and I notice that you all use various figures in your written submissions. Do you think that we use evidence enough when it comes to making decisions on health spending? Given the number of competing interests and the amount of competing evidence, how are we able to make judgments on the basis of that competing evidence?

Andrew Fraser: My part of the clinical specialties is built on the presentation of evidence and we want people to pay due heed to it. There are all sorts of issues with the usability and the quality of evidence. No evidence is perfect, because it does not tell you specifically that such and such a thing will work in a particular context. There is a lot of evidence out there of things that might work, but, in terms of the scrutiny that is required before something can go into public provision, the bar is set much higher for preventative interventions than it is set for clinical interventions—there is quite a bit of evidence of that. The committee will see all sorts of issues around high-cost, low-volume interventions that are of marginal benefit. Those interventions have an opportunity cost because, if you have them, you will not have other things.

The other thing about preventative interventions is that they sometimes involve people's personal decision making or the decision making of a population, which are areas into which people sometimes do not want to go—certainly, the media makes it difficult to do so.

There is a bit of doublethink about preventative interventions and the evidence relating to them in terms of the desirability, the ethics and the standards by which we measure things. We give those factors quite a hard time. Sometimes, those preventative interventions could be put in the "too difficult" pile, with distinct issues of individual decision making relating to marginal interventions being seen to be easier, although not cheaper, to resolve.

Sheila Duffy: That is a really interesting question, and it is one that we struggle with. ASH Scotland went down the line that evidenced-based medicine was taking and said that published peer-reviewed evidence will give us an objective measure that will enable us to say that we are not basing our view on a few people's anecdotes but are using data that can be generalised.

Published peer-reviewed evidence is a good foundation for the decisions that we make. On top of that, you have to listen to experience because it takes four years for evidence to get into the public domain and be published and peer reviewed. As decision makers, you will get some good steers on the evidence and how it relates to other evidence from bodies such as NHS Health Scotland.

There is a need to be careful about anecdotal experience. We find that the people who are extremely vocal are those for whom something has worked or those who are being incentivised by commercial interests to put forward the view that something works, whereas the people for whom something has not worked tend to be less vocal. We have seen that in some of the social media consultations that have taken place with the committees. It is an on-going question that we wrestle with, and I sympathise with your position.

Alison Douglas: I would highlight minimum unit pricing as an example of an extremely effective preventative intervention—it is one of the most effective options available to us. However, because it had not been tried elsewhere and because the thinking about its effects was based on extremely detailed modelling, people took a long time to reflect on that evidence and be persuaded by it. As Sheila Duffy mentioned, there are those who are trying to deflect and distract by proposing alternatives such as community alcohol projects, which are invested in massively by the alcohol industry but have been evaluated as providing very little benefit.

Brian Whittle: On preventative spend, is one of the issues how to quantify the money that will not be spent? How do we get the Government to commit to spend by talking about the money that will not then be spent?

Sheila Duffy: The projections for the increase in dementia cases have not continued on the expected trajectory. The best guess is that it is because of heart health campaigns. It is possible to look at some of the things that have happened and to quantify savings a little bit.

Going back to Andrew Fraser's earlier point, there is a need to do both: to deal with the immediate stuff and the people who are sick and to say that, if we are interested in the health of our children and grandchildren in Scotland, we have to act now to put in place measures that will have an impact. It is like a small farmer deciding to grow cabbages to feed himself next season but also to

grow oak trees because, in 50 years' time, he will want to build a house.

Dr Fraser: This will not help you at all. However, as Sheila Duffy spoke, I thought about Sir John Crofton, who founded ASH Scotland in the 1970s—he was a respiratory physician of great distinction. In the 1950s, he battled tuberculosis and pretty well conquered it in Edinburgh. He then switched his attention to another wave of respiratory-related illness; as that dwindled but did not go, that was followed by asthma. We are now dealing with the respiratory effects of all sorts of other things, including air quality.

The problem is that if we fix one thing, something else emerges. My health economics colleagues would point out that you cannot necessarily say that, if you deliver 50,000 alcohol brief interventions, you will be able to shut a ward. Other things, which have been waiting in an informal unseen queue to get attention, move into that ward. It is very tough to say that, for a given intervention, you will make a saving of a distinct amount. Costs shift and other priorities need to be addressed.

Brian Whittle: I am not suggesting that you save money for the NHS. I am suggesting that money can be reallocated to other priorities.

Dr Fraser: The explicitness of that decision making is a big challenge. For a given investment and savings, we want to achieve longer, healthier lives, as Kim Atkinson said earlier—longer lives spent away from requiring costly health care. That may be so, but a lot of people need care because of demography, expectations and technology.

Kim Atkinson: I agree with what has been said, and I do not say that it is easy.

On holistic budgeting, the issue is whether you save by being able to provide healthcare to people who were not able to receive it before or in other areas of the wider budget. People who are more physically active have 27 per cent fewer sick days, performance at work can increase by 5 per cent when employees are physically active and staff fitness programmes can reduce absenteeism by 15 per cent. It all makes us a more productive nation.

The question whether we are saving in terms of the wider health budget is for someone who is better at economics than I am. However, such spend will increase productivity and savings in other areas. If we look holistically at budgets in a way that I do not think we are doing at this stage, there could be savings that make a wider package worth doing.

The Convener: Andrew Fraser said that his specialism was based on evidence. Brian Whittle and I probably come from different places. Brian is talking about individual behaviours driving change, whereas I think that structural change in the economy needs to happen in order to impact on people's health and wellbeing, particularly in deprived communities. Dr Fraser has spoken about an evidence base. Is there any evidence of significant resource being shifted from areas that are more affluent to areas of relative deprivation in order to bring about the structural change that will impact on people's health and wellbeing?

12:15

Dr Fraser: Kat Smith, who is an academic in Edinburgh, has looked at evidence and the way that we treat it. Because upstream interventions—those that deal with the causes of the causes—are difficult to study, studies of downstream or risk-factor interventions are more numerous. They are more straightforward to do and they find end points such as smoking-related conditions. Such interventions have been much better studied, so the evidence base behind them is much firmer than the evidence base for complex interventions at community level.

A few years ago, Audit Scotland looked at the distribution of primary care services, and dentists and pharmacists came out better than medical services. We have a challenge in skewing the distribution of primary care facilities in the health sector towards people and communities with proportionately greater needs. I return to the point about community-based priority setting and skewing things that way. Earlier, there was a discussion of business rates and whether greater business activity in an area means that there is less need. Skewing resources towards areas where there is greater need is probably about finding where there is less business activity. We need to find structural ways—upstream ways—of diverting resources to the people and communities with the greatest needs. We must keep a very close eye on that. I venture to suggest that the allocation of resources at community planning level might help, but it will not help at a macro level—it is a sort of meso level. We need to do all those things to shift resource towards where it is most needed.

Sheila Duffy: Kim Atkinson talked about releasing equity in other ways, such as through the health of the workforce. One in three adults in the 20 per cent most deprived communities smokes, compared with one in 10 in our 20 per cent least deprived communities. If we could take action to reduce the smoking rate in those 20 per cent most deprived communities by 1 per cent—from 35 to 34 per cent—we would release £13 million a year of disposable income back into those communities, and I am certain that it would

not be spent on anything nearly as damaging as tobacco.

The Convener: Does anybody else want to come in?

Brian Whittle: I just want to mention that my view is not quite as narrow as you said, convener. I have more of an holistic approach.

The Convener: I am sure that we will hear your view developing over time, as the rest of the committee has influence over you.

Alison Douglas: One point that we have not touched on is about generating additional income. As the committee will be aware, we had a public health supplement on large retailers that sell alcohol and tobacco, but that has lapsed. There is a strong case for reintroducing something along those lines and not necessarily only for premises that sell both alcohol and tobacco—it could be either alcohol or tobacco as well as both. That would be a way of generating additional revenue that could be dedicated specifically to tackling and preventing health-harming behaviours.

The Convener: Finally, we will take it as a given that you all want more money in the budget process. However, given that we have to report to the Government on the budget, what are your other asks? You can have a minute each.

Dr Fraser: It will take less than a minute. We would like less waste of resource that we devote to marginally beneficial activity.

The Convener: For example?

Dr Fraser: I am talking about things without a proven evidence base that they work. Alison Douglas and others have mentioned some. There are high-cost drugs for which there is insufficient evidence, or marginal evidence, that they work. People need to be very searching about the quality of evidence behind decisions that are taken to allocate such drugs. The opportunity costs of making such decisions are very major on the comparatively low-cost prevention programmes that we have been talking about.

The Convener: If the areas that you have mentioned are in common parlance among your peers, it may be worth while forwarding them to the committee in order to identify specifics. That would be helpful.

Dr Fraser: Okay.

Kim Atkinson: I have a couple of things, convener. In sport and physical activity, we talk about "spin", but there is also a language that is a culture of investment, which is exactly the point that Sheila Duffy made earlier, and which would be across prevention areas. We see local authorities and leisure trusts being tasked with income generation. Surely the point is that anybody who is being active in that way is an investment, so we need to look at the language around that. There is a focus on helping to keep active people active. Because we have an increasing and an ageing population, maintaining our levels of physical activity and sport means that we are increasing them, if that makes sense, so that is a win and there is recognition there.

Our members always talk about physical literacy. To return to education, which I know was raised with the committee before, that is not just about the number of hours of physical education but about young people coming out of school and being physically literate so that they are then able to be healthy in whichever way they choose through sport and physical activity throughout their lives.

When the Scottish Government was reviewing the national performance framework, we had a conversation with it in which we said that it is all well and good to look at each indicator in its own right, but asked where we should look horizontally at opportunities for working more collaboratively. Whether that is created by extra budget facilitation or is just better spend, we could do more of that through a range of areas.

Lastly, in the previous session, the topic of sustained and longer-term investment was raised. Many organisations work on annual budgeting. It would be a fascinating exercise, across the voluntary sector—and, I am sure, other sectors—to understand how much time is spent trying to work out next year's budget and where it is coming from, when we could be far wiser in spending our budget if we could identify our priorities and provide sustained and long-term investment in them.

Sheila Duffy: I have three points. I would like us to ensure that we maintain targeted stop smoking support, particularly for communities where smoking rates are high, such as among those with mental health issues, in prisons—where we aim to go smoke free—and in our poorest communities. I would like that to be backed up by the mass media, to encourage the whole population to quit smoking, because we know that 67 per cent of adult smokers wish that they were not smokers.

We should also remind people that second-hand smoke is toxic and encourage smokers to take it outside the house.

The third thing is about joining up. At a time when we all have really limited resources, we need to be smarter and wiser about how we use them. For example, we are working actively to take a co-ordinating role around no smoking day activity and the intended mass-media stop smoking campaign that the Government is

planning for next year, to see how we can maximise the impact of such initiatives.

Alison Douglas: The point at the top of my list would cost nothing: it is about having marketing restrictions, particularly to protect children and young people, and looking at availability and how the licensing system supports and manages the widespread availability of alcohol in Scotland. Both those things would be perfectly deliverable without any spend at all.

Secondly, it looks as though funding for ADPs will be increased again and that is extremely welcome. However, there should be a clearer message about the expectations on them around preventative activity: the emphasis is too strongly on treatment.

Thirdly, like Sheila Duffy, I feel that there is a real gap regarding public communication. We know that 80 per cent of people are unaware of the low-risk drinking guidelines and that 90 per cent are unaware of the link between alcohol and cancer. We need to give people the information to make better choices.

Finally, we should look at mechanisms for ensuring that the health-harming industries that are driving such problems contribute to the cost of preventing and treating them.

The Convener: I thank everyone very much for their evidence this morning. As agreed previously, we will now go into private session.

12:24

Meeting continued in private until 12:57.

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