OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 10 September 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
23rd Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
Ruth Maguire (Cunninghame South) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephen Boyd (IPPR Scotland)
Carol Calder (Audit Scotland)
Professor Chik Collins (Glasgow Centre for Population Health)
Emma Congreve (Scottish Health Equity Research Unit)
Professor Cam Donaldson (Glasgow Caledonian University)
James Dornan (Glasgow Cathcart) (SNP)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 10 September 2024

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 23rd meeting in 2024 of the Health, Social Care and Sport Committee. I have received apologies from Ruth Maguire. James Dornan will be joining us remotely as a substitute.

The first item on our agenda is to decide whether to take item 3 in private. Do members agree to take that item in private?

Members *indicated agreement.*

National Performance Framework (Proposed National Outcomes)

The Convener: The next item on our agenda is an evidence session to inform the committee's scrutiny of the proposed national outcomes, which were recently published by the Scottish Government as part of its periodic review of the national performance framework. I welcome to the committee Emma Congreve, co-lead of the Scottish Health Equity Research Unit, and Professor Cameron Donaldson, professor of health economics at Glasgow Caledonian University.

We will move straight to questions and I will start. What are the witnesses' views on the proposed new care outcome?

Professor Cam Donaldson (Glasgow Caledonian University): The introduction of the new outcome is highly commendable. It reflects caring, which is an aspect of society that has been long neglected, partly because much of it is made up of informal care. Equally, it reflects what is happening with respect to public services and the integration agenda, which you will all be highly aware of.

The idea that

"We are cared for as we need throughout our lives and value all those providing care"

needs some unpacking. There are questions about what need is and who determines need. Often, a third-party determination of need is implied, and in the national health service, that would involve a healthcare professional in negotiation with a patient or a member of the public. Also, what do we mean by valuing those who care? A complex array of paid and unpaid carers would be covered by the outcome.

Discussions are still to be had about what the indicators might be under the outcome. I have some concerns about financial implications and caring. Those require tracking because we are very much in a mixed economy—private as well as public. It is different from the NHS in that respect, although there are now grave concerns about what is happening with private versus public in respect of healthcare. However, that is a different matter and a different outcome.

Emma Congreve (Scottish Health Equity Research Unit): I echo a lot of what Professor Donaldson said about welcoming the new outcome as an outcome in its own right. It is great to see that. The longer definition in the notes accompanying the legislation is comprehensive, in that it covers the areas that you would wish it to cover. However, I will say a little bit about what is slightly missing. There is not much around the

integration agenda and how the health service and the care service are co-dependent. It is in the health outcome, but not in the care outcome, and I would like to see a little bit more on that.

There is a major concern about the outcome and how it is drafted. I understand that it is trying to represent the Scotland that we want to see, but it feels as if we are a long way off being able to realise what is in the outcome. What Professor Donaldson said about being able to assess need and who determines that need is a key issue. In Scotland, we have no way of even estimating unmet need and how many people may require care services. There is a lot in there in terms of implementation.

Although the appetite is there, I think that the outcome feels a bit detached from the ability to realise what is in it. It is a little jarring, given that we know the reality for people who draw on care services in Scotland. We need to recognise that delivery is by the public, private and third sectors. They all need to be part of realising the ambition, and we need to bring that out more. I know that there are concerns about the private sector in some of this, but it is a core part of delivering what is in the outcome. Those are my initial thoughts.

The Convener: That was very helpful. We will explore more of those themes as we go through the evidence session.

Audit Scotland highlighted the need for better support structures for both paid and unpaid carers. Professor Donaldson referenced unpaid carers. How might the NPF capture the role of unpaid carers?

Emma Congreve: Recognising that role and quantifying its value is very complex. I am speaking more with my Fraser of Allander Institute hat on, where we have done a lot of work in particular with people with learning disabilities, and their families, who draw on support. The ability to recognise that they exist is missing. If the NPF can somehow work out how to measure that through its indicators, that would be very welcome.

A lot of it is about the time that people devote to caring that goes unseen. It would be really good to be able to pull out that recognition. If the Scottish Government wanted to, it should be possible to bring together survey evidence on the issue, although that would never be perfect. When we talk about value, we need to unpack that, because you cannot just put a pound sign on it. It is more complex than that. Often, we have come to look at it by looking at time as the value, in a way, and using that to approximate what it could mean if the state were to provide that amount of time for care, or if people were to be paid the minimum wage for that time. We use time-use surveys to try to gather that information. That is quite an interesting way to come at the issue—not to devalue care while you are trying to value it, but to understand what it means in practice. That would be a great thing to see from the outcome.

Professor Donaldson: I tend to think of these things as 2x2 frameworks that allow us to track what is going on. In this case, I think that we need a framework that allows us to answer two questions. First, who cares? That is, who is doing the caring? I do not mean “who cares?” in the pejorative sense. Secondly, who pays? As part of that, I think that you might have a 2x2x2—who is paid and who is unpaid? That is the framework that we need to put in place to help us to track what exactly happens over time with respect to the outcome.

The Convener: You have referenced the third, public and private sectors. Evidence that was submitted to the consultation highlighted issues around improving care services and the need for fair wages and fair conditions for paid carers. How can the national performance framework prioritise the sustainability of care work to enhance the wellbeing both of carers and of those receiving care?

Professor Donaldson: I think that you have answered the question with respect to workforce issues. The workforce is key. It is inevitably about levels of pay that allow us to retain a sustainable workforce that is there and is able to meet the on-going needs of the cared-for population in particular locations. There might be other aspects to do with job conditions that would help sustainability, but I think that the main issue will inevitably be related to pay.

Emma Congreve: There is an area that the national outcomes could focus on relating to implementation and how we understand whether things are improving through the mechanisms that we have. That includes how care services are procured, what are the terms and conditions that sit within them, and setting out procurement operations in a way that means that it is not a race to the bottom in which the lowest value gets the contract, which ultimately puts pressure on the wages and terms and conditions that can be offered to paid carers.

I know that this is an ambition through the national care service reforms, but we could track the way that care is procured and whether that enables good terms and conditions to be offered to paid carers in the public, private and third sectors. In the third sector, things are often pushed down because of the way that procurement is set out. With these outcomes, it is no surprise that the biggest concern is around implementation, what you are monitoring with the indicators and how that relates back to the outcomes. Finding mechanisms that relate to

something that the Government can do—procurement—which then links to an indicator that you can measure and which relates back to the outcomes, would be valuable and is desperately needed for the national performance framework as a whole.

Professor Donaldson: At a more institutional level, it would also be useful to track what is happening with respect to public and independent sector provision. For each area, is it going up or down, and if it is going down, which would be the concern, why is that the case? Being able to answer that question might help us to address sustainability at an institutional level.

Sandesh Gulhane (Glasgow) (Con): Sandesh Gulhane (Glasgow) (Con): First, I declare my interest as a practising NHS general practitioner.

Thank you for coming in to give evidence today. I have a simple question, which is possibly extremely complicated to answer. How do you envisage our measuring the three new outcomes, and what is your definition of success?

Professor Donaldson: Can you clarify what outcomes you are referring to? There is the caring outcome.

Sandesh Gulhane: Yes.

Professor Donaldson: Health.

Sandesh Gulhane: Yes.

Professor Donaldson: And?

Sandesh Gulhane: Housing.

Professor Donaldson: Housing. I am sorry but I did not know that we were covering housing today.

I think that health is reasonably well established—

Sandesh Gulhane: I am sorry, it is wellbeing. The three new outcomes are wellbeing, economy and fair work, and housing and care.

Professor Donaldson: Right. Emma, you seem to be more willing to speak than I am.

Emma Congreve: I will speak at a slightly higher level because there is a lot of nuance in those individual outcomes. That is true across all the national outcomes, whether they are existing, being amended or new. Choosing the indicators is one part of measuring progress and success. The key thing is a mechanism through which you can understand how the outcome relates to an actionable policy, programme or practice that has a measurable impact on an indicator that can then demonstrate progress towards the outcome.

09:30

At the moment, a lot of the national outcomes seem to say that this is the Scotland that we want it to be and some indicators look like they broadly tally with that outcome. However, the bit in the middle, where you understand the link and the mechanisms and how they are implemented between levels, often feels as though it is not set in stone. Everything and anything can go into those policy mechanisms. What is needed is a little bit of thinking about what the logic model is that gets you to the outcome through the actions of whoever the actors are in Scotland. I know that it is not just the Scottish Government; all of Scotland gets you to those indicators.

If those indicators are not moving or are going in the wrong direction, the key thing is that you can then try to understand why that is. Has something gone wrong with those intermediate mechanisms or has something else entirely been going on that has influenced those indicators, such as the pandemic, for example? The key thing is being able to isolate the impact of the actions that are being taken. That is critical if the NPF usable to hold decision makers such as public sector leaders to account. Without that, you are just a bit lost and saying, “Yes, of course, we agree with the outcome but what is happening with the indicators? Things are happening but we are not really sure.” I would like the focus to be on measuring progress and evaluating over time.

Sandesh Gulhane: The data is analysed by measuring performance against the previous year. We might be doing awfully overall, but a bit better than we were doing last year, and that is reported as being positive or performance being maintained. I would like to delve into that a little bit more.

Let us start with healthy weight. That is an indicator that is reported as being maintained, but if we interrogate that a bit further, we find that 65 to 68 per cent of adults and 36 per cent of children in Scotland are overweight. The World Health Organization reports that 43 per cent of adults worldwide are overweight, so Scotland’s figures are more than 20 per cent more than the worldwide figures. Are you happy with the number of Scots who are overweight that is being reported in the paper as being maintained or positive?

Emma Congreve: That is an important point. As an analyst and an economist, I struggle to understand it when we look at the indicators and trends and see definitions such as “maintaining”, “worsening” and “improving”. It is sometimes quite hard to understand how they relate to what is in the graph.

There is a lot of work to do to help people to understand what is being measured and why. If

there is a change from last year, or no change, it might be statistically robust to say that progress is being maintained. That might be within the margin of error and statistically that is okay. However, from the point of view of somebody who is trying to understand whether Scotland is doing well or not, it does not really help.

To take your obesity example, I do not think that anybody would say that Scotland is performing well when measured against some of the comparators that you gave. However, I do not think that that is what the indicator within the health outcome is showing, but it is not accessible. It is barely accessible to me as an economist, in trying to understand how the outcomes are being measured.

Sandesh Gulhane: It feels a little bit as though it is saying the opposite of what we know the reality to be. I know that you appreciate that obesity causes heart disease, liver disease, cancer and plenty of other issues. Just last year, 15,176 people were referred to tier 3 weight management services for obesity. That is an increase of almost 4,000 people, yet this indicator does not talk about obesity; it just talks about being overweight. Do you know what is happening with obesity rates and whether they are worse among people who are more deprived?

Professor Donaldson: No, I do not know. That is not an area of specialism for me. I would predict that the answer to your last question is that obesity would be worse in areas of greater deprivation. That is the case for just about any indicator of health or ill health.

I was equally puzzled by the background note and its claims of what is being maintained healthwise. The date that is used in the background notes is 4 August 2024, but there is no reference to a baseline date. There are also other aspects such as international experience and benchmarking against other countries but, in my preparation for the meeting, I found that three of the areas for which maintenance is claimed had actually declined. They are healthy life expectancy, healthy weight, and risky behaviours. I was looking at the end point in the data that I had available from searching around on the Scottish Government website, and it was sometimes 2021 and sometimes 2022. The baseline differs. It ranges from 2003 to 2010, which I presume is just a reflection of when data collection started for an indicator. I was puzzled by those aspects.

However, even if healthy life expectancy is maintained, I am not sure that I would see that as a success because that indicator has improved generation on generation, successively over decades, and has now stalled. If maintenance is the best that we have, I am not sure that that is particularly impressive.

Sandesh Gulhane: I am glad that you—

The Convener: Sandesh, you can maybe come back to this when we move on to theme 3. We seem to be straying off-piste a little bit from your supplementary question.

Gillian Mackay (Central Scotland) (Green): Other than the revised wording, in what ways do you think the national performance framework can better integrate mental health services in broader public policy to ensure long-term improvements in mental health services and preventative care?

Professor Donaldson: It is hard to answer that question specifically. On the general point that I think that you are making, my view is that just what the outcomes and the indicators say is not so important. Of course, they are important but it is what you do with them that is key.

I am also an economist, so I think about how the indicators relate to patterns of resource use. Going forward, it will be key to create a framework that takes the outcomes, and particularly their indicators, and relates that information to patterns of resource use and expenditure across the public sector, the private sector if we can, and in private lives. The convener talked earlier about unpaid carers coming into the framework. Then we could begin to see whether what an indicator is telling us matches what patterns of expenditure and resource use are telling us and, if not, why not. We can then think about how to move resources around to create better wellbeing overall.

I will take another indicator—healthy life expectancy, which we were just talking about. We could map that across different geographical areas in Scotland and look at how that indicator relates to how health and social care expenditure is mapped across those geographical areas. Is there a mismatch? Do areas that are doing better also tend to have higher amounts of resources spent in them? Again, I predict that there would probably be a mismatch. The question then becomes: how do we move the resources around so that they are going more into areas where there is detriment in what is happening with that indicator? If we could do the same for mental health, it would be incredible.

Emma Congreve: We are straying back to the health outcome, but it obviously relates quite strongly to care.

On mental health, I agree with what Professor Donaldson is saying about mapping to resource, but with so many of the issues that are coming through in physical and mental health, the solutions lie within other areas of the NPF and not within health and social care services, although they have a role, of course.

The health outcome uses the word “prevention”, but the rest of the outcome talks about health and health services. Success in improving people’s mental health is a cross-cutting issue. However, because the NPF is set out in portfolios, it feels as though it does not speak to that cross-cutting prevention in any meaningful way. That is my major contention. It is good that mental health is recognised, but as for where it sits in terms of making progress, it cannot just be measured within the health outcome, and that is quite a problematic feature of the NPF.

Gillian Mackay: That is great. Thank you. Prevention is the other aspect that I wanted to pick up on, because commercial determinants of health are not really referenced at all within the NPF but, as we know, they have a massive impact on people’s wellbeing.

Emma Congreve touched on things not speaking to each other across the whole piece. How can we track and tackle some of those commercial determinants of health within the updated health outcome to make sure that we take a broader environmental view of the landscape to make sure that what is done has the impact that we need it to have?

Emma Congreve: In the longer wording around the health outcome, commercial determinants are mentioned in respect of minimising the impact of unhealthy food, tobacco, alcohol and drugs. How that is actioned, however, is another question, which is not included. There is almost an assumption that it will happen, so the implementation point applies.

When we are talking about prevention, it comes before even the commercial determinants. It is about people having the resources for an adequate standard of living so that they can make healthy choices, and there being no barrier that prevents people from being able to make those choices. The commercial determinants of health are important, but on their own they cannot fix the problem. Behind that is the understanding of how people’s incomes, living environments and communities overlap to produce the poor outcomes that we are seeing and that are accelerated by the commercial determinants that you mentioned.

09:45

Professor Donaldson: That reflects what Emma Congreve was saying about how the various outcomes interact with each other. There was an earlier question about fair work, which is another aspect of commercial determinants of health. There are probably some readily available indicators of fair work, such as the degree to which employers comply with the living wage and so on. We might need to explore a bit more how we measure and how we embark on trying to do that, which relates to the broader measurements of job quality and job satisfaction, which will inevitably work through into people’s mental health and physical health and wellbeing.

Paul Sweeney (Glasgow) (Lab): I want to pick up on a point that was raised last week in the pre-budget scrutiny session. Michael Kellet from Public Health Scotland suggested that the planned refresh of the national performance framework offers opportunities to further prioritise preventative spend. He talked about the split between revenue and capital spend in the 1990s, when there was a change in national budgeting. Does the panel agree with that approach in principle, and how do you think it could potentially work in practice if we further developed ring fencing, if you like, of preventative spend as well as of capital and revenue?

Professor Donaldson: I am sorry to sigh, but, every time there is a review like this, it is an opportunity for preventative spend—is it not?—and then that never happens. Then, when we get into dire budgetary straits, it is one of the things that is easily cuttable—a typical false economy, if you like. The solution might be ring fencing, which you alluded to in your question, but how you do that and where that ring fencing happens is less clear to me. Over the years, across the United Kingdom—obviously including in Scotland—we have tried ring fencing in local authorities and in the NHS, but it does not seem to work.

I apologise for giving a rather negative response to what was put forward as a positive opportunity.

Emma Congreve: As Professor Donaldson says, when we do these refreshes, it is an opportunity to come at things again and to recognise that what has been tried to date has not led to a significant shift in how budgets are allocated. There is a lot to be said about budget transparency, which would have to come before any ideas about ring fencing—if that was pursued—because, at the moment, it is incredibly hard to see where money is being spent in the Scottish budget. We get a good idea of budget allocations through the budget process, but then it is very hard to see where spend has occurred and what has changed through the year. Speaking with my Fraser of Allander Institute hat on again, we have been asking for more transparency in that. It could be an interesting idea, during the budget scrutiny process, to push for the spend that is allocated on health, particularly in the NHS, to set out what is preventative and what is responding to pressures in the NHS.

The problem is that we know that demand on the NHS is going to rise and rise due to demographics and other factors to do with the

nation's health, so it would be interesting to understand how some of that investment in health could go not directly to the NHS but perhaps into preventative spend. That investment could be in housing, fair work or the social security system, and we could be shown what is intended from that allocation of spend. In order to justify diverting money out of the health service, there clearly must be accountability and an understanding of whether that spend has led to any form of prevention and has prevented further spending in the NHS down the line.

I think that everyone agrees that we need that shift in order for the NHS and health services to be sustainable in the long term. However, I think that, at the moment, there is not enough confidence in the transparency of the budget process to allow the forensic analysis that I have talked about to happen. I would be concerned if there was a shift like that without all the transparency that is needed to track that information over time.

Emma Harper (South Scotland) (SNP): I will have other questions for Professor Donaldson later, but just now I am thinking about one of the papers that I have read. It is about how programme budgeting and marginal analysis can be used to look at how we do national performance framework interventions and achieve goals with the marginal resources that we have available when everybody wants a piece of the pie. We always talk about prevention, and Paul Johnston writes a blog about how much money is spent on it. The Institute for Public Policy Research suggests that £2.3 billion of Scottish health boards' budgets is directed at responding to the impacts of poverty. We also talk about mental health, obesity, chronic disease, chronic obstructive pulmonary disease and all those things—everything overlaps and it is difficult and complex.

My question is for both Professor Donaldson and Emma Congreve. How do we use programme budgeting and marginal analysis to achieve more transparency in addressing our national performance framework?

Professor Donaldson: Programme budgeting and marginal analysis trips off the tongue nicely. I did not want to use jargon here, but thank you for mentioning it. That is precisely what has been at the back of my mind when I have made some of the comments that I have made.

For those who are not aware of what programme budgeting and marginal analysis is, it is basically a framework for managing scarce resources in any situation. In my experience as a health economist, we have usually worked with different parts of the NHS to help them to plan use of their next year's, or their next few years', resources. Programme budgeting is just a statement of where we are now in terms of how we are spending our resources. It is completely unthreatening—it is just saying how we currently spend our resources. The marginal analysis bit, as Emma Harper indicated, then leads us into thinking about how we might move those resources around to get more benefit in total. That, in plain language, is what programme budgeting and marginal analysis are about.

I would like to see a programme budget to go with the national performance framework. I have hesitated to put it in those terms before now, because there is an element of self-promotion—as Emma Harper picked up, I have written quite a lot about programme budgeting and marginal analysis. What is the requisite spend in relation to the different indicators in different parts of the public sector and the economy? Can we divide that spend according to other key aspects, such as population demographics and geographical areas? Can we—to use the example that I gave earlier—try to match local NHS expenditure with data on mortality rates? Are we spending more in better-off areas and less in the more deprived areas? If that is the case, what can we do, using marginal analysis, to move resources around in order to improve the situation? There is a lot of potential in having a set of programme budgeting data that goes along with the set of indicators underlying the framework.

Emma Congreve: The work that we are doing at the Scottish Health Equity Research Unit highlights the issue that we are talking about in terms of the IPPR's reporting on, for example, the amount of money that is being spent on interventions because of inequalities in communities.

One thing that you need to be especially mindful of in considering Professor Donaldson's approach is that, if we were to reduce the levels of inequality and poverty, we might see a reduction in the amount that needs to be spent through the health service, which would be a good thing. If we word the outcome "We will invest in the NHS", that gives the impression that it will always be about spending more money. However, if you tackle the socioeconomic determinants that underlie poorer health outcomes, that could lead to a reduction in spend. When you are linking budgets to outcomes, it is critical that you are able to analyse what is going on under the bonnet. You have to understand why spend might be increasing. Is it a short-term thing? Is it to get on top of an issue, then spending will fall? We have to be much more forensic in how we track these things. Even understanding programme budgets properly, which Professor Donaldson spoke about, would be a step forward.

Sandesh Gulhane: I want to go back to what we spoke about a little earlier, Professor Donaldson, when you said that you are looking at some other indicators that are not so good. I want to look at that in a bit more detail.

If we look at healthy life expectancy—which, again, is recorded as being maintained—we see that Scots can expect to remain healthy only to the age of 60 for men and 61 for women. That is the lowest figure since data was gathered, and I am pretty sure we know that it is worse in more deprived areas. Do we know what the trend is in those more deprived areas and what we can really do about it?

Professor Donaldson: I think that Emma Congreve is better placed than I am to answer that question.

Emma Congreve: Again, I refer to the work of the Scottish Health Equity Research Unit. We will publish a report tomorrow that covers some of that and looks at some of the indicators in the most deprived and least deprived areas of Scotland, as measured by the Scottish index of multiple deprivation. I will return in a moment to issues with using that area-based measure.

I think that most indicators of inequality in health outcomes show big gaps between the most deprived and least deprived areas, and, from our analysis, we know that those gaps have remained wide over the past few years and over the period of the pandemic. Some of them have marginally improved, but some of them have got marginally worse.

The key thing is that we are not seeing a systematic reduction in levels of inequality, which we would need to see if those headline population average statistics are to change. It is a key point that, to shift the national average, you have to make progress in the most deprived areas or among the people in the most deprived areas who have health issues. We need to shift the outcomes for people in the most deprived areas up, not bring them down—that is what will secure improvements.

10:00

So, yes, in terms of the NPF, you would look at the data and say that progress is being maintained, but the changes that we have seen over the past few years have been marginal. The key thing is that the figures are not improving significantly.

I will make a very small point on the use of the most deprived and least deprived areas. All through the NPF, there is a reliance on the Scottish index of multiple deprivation's indicators of the least and most deprived areas to track inequalities. However, we know that the majority of people who are living in poverty do not live in the most deprived 20 per cent of Scotland. So, we are capturing an area of Scotland, or multiple small areas of Scotland, but we are not capturing lots of people in poverty, with low incomes, who live outwith the most deprived 20 per cent of areas. Within health inequalities research, we need a better understanding of individual and household finances and housing in all those situations instead of relying on area-based measures, because we are missing quite a lot of nuance and people in doing that.

Sandesh Gulhane: You are saying that the situation could be far worse than we know.

Emma Congreve: Unfortunately, yes, it could.

Sandesh Gulhane: In my city of Glasgow, there is famously a gap of 15 to 20 years in life expectancy between those in the least deprived areas and those in the most deprived areas, as we measure it at the moment. However, you are saying that it could be far worse.

Let us look at some other indicators on which we are perceived as not doing so well. We know that mental wellbeing has been worse over possibly the past decade—pre-pandemic to now—and is continuing to worsen. What should we be doing to reverse that trend? Do we have any data about our young children and kids? Anecdotally, we are all told that mental health is declining, but that does not seem to be being captured.

Emma Congreve: I come back to the socioeconomic determinants and our understanding of the issues. It is about not just the level of income that families have, but the certainty and security of that income, and many factors affect the security of a situation. It is about someone's earnings from work and what is happening with the social security system. Changes to the social security system over recent years have often made people feel quite uncertain about what they will get at the end of the month.

It is also about someone being secure in their housing and knowing that they can afford to stay there. According to a lot of the qualitative literature, it is these factors that cause long-term persistent stress. Not having certainty and security in their situation erodes a person's mental health and, indeed, their physical health over time. It is about understanding the precarity of people's living situations.

Because of the changes that we have been through since the financial crisis, some of the indicators around life expectancy started to shift from 2010 onwards. It is a longer-term issue that we face. Over the period since 2010, a lot of issues—from the financial crisis, the recession and changes in social security to the austerity agenda

and then the pandemic—have upended people's lives, and you can understand how, when people are living with uncertainty and precarity, that stress boils over into poor mental health. Children observe that within their family environment, and that is coupled with other factors such as social media use and that kind of thing, which I am definitely not an expert in. Those intersections are really important, especially in the qualitative literature, in helping us to understand what people think is going on in their lives.

The Convener: I am mindful of the time, so I ask that questions and answers be sharper, please, if people do not mind.

Paul Sweeney: I highlight that, although mental wellbeing is the only health indicator that has shown declining performance, the mental health budget has faced real-terms cuts in recent financial years. How can we translate such framework findings into meaningful actions? Is there extra data that we could gather to demonstrate what is happening? It goes back to the point that was made earlier about well-intentioned reports not necessarily leading to firm, tangible outcomes.

Professor Donaldson: The two trends lead us precisely to the question that you have asked, so at least we are getting that far. We are able to track what is happening with resources vis-à-vis that particular indicator, but what action is taken is left more open to question. It partly depends on experts' diagnosis of the mental health challenges that we face and what they think is underlying them. That might lead us to think about—this goes back to an earlier question—how we could get greater marginal gains or pay-offs by investing more resources, or reinvesting existing resources, in specific areas, although I cannot say what those areas would be.

We also need to think about tracking programme budgets. As well as doing that at the national level against the framework, we should think about how things are playing out in more local jurisdictions in relation to health and social care integration. From my experience of working with such organisations, they do not necessarily discuss the NPF when they think about planning rounds and such things. Why are those issues not being considered at that level? Those organisations might face the same issues with mental health, but there seems to be a disconnect between what goes on at the national level and what goes on at the more service-based local level.

Emma Congreve: It is really important that we understand how budget decisions relate to the outcomes in the NPF, because the budget is so wide ranging. Even last week's announcement on the fiscal situation was quite wide ranging. Being able to pin things through to the NPF is quite a challenge, but with the decision to cut mental health funding, for example, you would expect to at least see some evidence that, through the decision-making process, there was discussion about, or analysis of, the impacts on the NPF outcome on mental wellbeing. One would like there to be recognition that such thinking played a part. The Scottish Government might produce that information internally, but it is not published. Our worry is that the NPF is not front and centre in budget decisions, because, for it to be valuable, it probably should be.

Emma Harper: I have a quick supplementary question. I am looking at the 11 national outcomes that we are seeking to achieve. The last one is about poverty. We know that, if we tackle poverty and try to counter the impact of 14 years of imposed austerity on the Scottish people, education and other things will be supported. I am interested in what you think needs to be targeted in order to tackle poverty in Scotland.

Emma Congreve: The main drivers of poverty, when measured by income, are quite well understood. There are lots of different measures of poverty, and one is linked to the statutory child poverty targets. The key routes to tackling poverty are through earnings, social security and housing—particularly housing costs and other costs of living. Those are the three key areas, and they are quite well understood from what we understand of the Scottish Government.

However, other than key exceptions such as the Scottish child payment, what is not well understood is what is being done in those areas that can be traced through as having an impact on reducing poverty. Even with the Scottish child payment, it is still quite hard to see the impact coming through in some of the poverty data.

We have quite a good grasp of the problem and where the solutions lie, but we have less of a hold on how the mechanisms and policies that have been put in place will impact on poverty and how we could track progress over time to ensure that what we want happens.

Emma Harper: We have seen health and social care integration, but integration joint boards might need a bit more autonomy to choose how to further enhance integration in order to support people. Should we strengthen IJBs' financial decision-making powers to ensure more effective integration?

Professor Donaldson: Yes. The impact would, of course, need to be tracked. In my view, which is evidence based, integration has stalled—that was the case even before the pandemic. We still have big problems with indicators relating to integration, such as delayed discharges.

Where do we go from here? Do we keep going as is? Do we go backwards? I do not think so. Integration is a really good idea, but we have to give IJBs—and, by implication, communities—more say in how resources are spent.

Emma Harper: I read in one of our papers that, in some health boards and health and social care partnerships, geriatricians look after older people, but, in other areas, primary care teams and multidisciplinary teams do that. That affects how we tackle the issue of delayed discharge and free up hospital beds. Do you have an opinion on whether some areas are doing better than others and on how we should learn from places that seem to better manage the issue of delayed discharge, for instance?

Professor Donaldson: That is another on-going problem in the system. We have pockets of good practice, but somehow we do not seem to be able to spread that across the rest of the system. There is some sort of implementation gap or problem with the spread of good practice. Research and evidence will be needed to diagnose why that is the case and determine what can be done about it. A lot of the variations are based on what people have always done in particular jurisdictions. How do we shift mindsets? That is a key issue.

Emma Harper: I am conscious of the time, so I will stop there. Thanks.

Tess White (North East Scotland) (Con): Professor Donaldson, Audit Scotland highlighted concerns about the lack of clarity in budget documentation regarding the impact of specific budget interventions on long-term health outcomes, and we have heard this morning that it is hard to see where money is being spent in the Scottish budget. How can the NPF improve transparency and ensure that budgetary decisions are closely linked to achieving measurable health improvements?

10:15

Professor Donaldson: In some senses, that is covered at the national level. If it was possible, we could have, along with the framework, an accompanying programme budget exercise. That would mean that, along with the framework, the outcomes and the indicators, we would have a budgetary system that related to the indicators and the outcomes. That would be done at the national level.

At a more local level, where decisions about resources have an impact on people's lives, I am not sure that there is a particularly strong incentive for IJBs, which have been referred to, to comply with or participate in the idea of a national performance framework in relation to how it will impact their planning and commissioning rounds. There is a disconnect, so we need to think about how we can create incentives so that the performance framework is not just at the national level. It should be aggregated from the local level up to the national level.

Tess White: What has been said about it being hard to see where the money is being spent and what the outcomes are is alarming. We do not know what the outcomes are, and we cannot manage what we do not measure properly. The committee's meeting this morning is extremely important, because we are pressing pause and asking whether things are working. Is there any way of creating some hard wiring so that we know what the impact will be of spending X amount of money on something? As I said, the situation is alarming.

In its pre-budget scrutiny last year, the committee heard that the NPF is described as the Government's "north star", but the underpinning route has not been adequately mapped out. Is the NPF the best way to determine outcomes-based budgeting, or is there a better way?

Emma Congreve: What the NPF sets out is really important; it is positive to have that statement of intent. If how each year's budget linked to the outcomes was set out, with pound signs attached to the outcomes, that would be a really good step forward. It is difficult to do that, but it is possible. It is feasible to align all the Scottish Government's spending lines with the outcomes, and that would be incredibly helpful. It would help with budget transparency, and it would make the NPF more meaningful as a way of holding the Government and other parts of the public sector to account.

A lot could be done with what we have, but we need to take a leap forward to see whether pulling together a programme budget approach alongside the NPF could allow us to link the NPF with budgets and track what happens over time.

Professor Donaldson: We have a wonderful framework for thinking about what we want our country to look like. It is linked to the sustainable development goals, which I am a big fan of, because they are a great statement of the common good in practice.

However, there are two key issues. We need to think about how aspects of the framework relate to one another, as Emma Congreve explained, and we need to think about how we can link activity and budgets at national and local levels back to the NPF. Tess White said that the fact that that is not happening is "alarming". I was critical of what is happening at the local level, but I would like to defend people who are working at that level, too. In a sense, their accounting systems are set up for

different purposes—that is all. We need to think about how the information in those accounts can be more aligned with the framework.

Tess White: Thank you.

Joe FitzPatrick (Dundee City West) (SNP): Briefly, on the point about tracking the spend to ensure that we get the outcomes that we hope for, should we look to any international examples to see whether other places do this better? There will be differences, but can we learn something from them that will help Scotland to do this better?

Emma Congreve: The Scottish Government has to report to the Treasury on spend in particular areas, which is done by a series of conventions according to which category it is spent under. You can see some of these programme spend totals coming out through Treasury documents, which are called the "Public Expenditure Statistical Analyses" statistics. That also comes through into "Government Expenditure and Revenue Scotland" in some respects. Some of the plumbing is there for pulling the figures into meaningful categories of spend that you can track over time, but they are not routinely put in front of the Scottish Parliament. When we come to look at the budget each year, we see the previous year's budget, in terms of what was put in it, and we see the budget for this year; we do not have another column that shows what was spent in the previous year.

However, from our understanding—again, this is Fraser of Allander Institute analysis—that would be feasible, but it is not being done routinely. I will not say that it is an easy win, because these things are never easy, but it is possible. It would probably bring us a bit more up to the level of reporting that the UK Government does around some of these things.

We can say a lot about local government accounting being done unhelpfully, but local authorities report back every year. Local government finance statistics come out every year showing what they are spending on every area. The Scottish Government is almost a bit of an outlier in not having the same level of routine reporting back to the Scottish Parliament on what is spent year to year. That data will be buried somewhere, but it should be brought it to the surface.

Joe FitzPatrick: Is the data on what is spent not in the outturn accounts that the finance secretary puts out every year?

Emma Congreve: It is within lots of the detail. If you go through all the budget revisions through the year, you can get to the figures eventually. It is about transparency and routine to make it easy to find figures that are split out meaningfully and accessibly to those of us who are interested in tracking spend over time. That is incredibly difficult to do with what is publicly available, but it should not be.

David Torrance (Kirkcaldy) (SNP): Good morning. Looking ahead, what role should the public play in shaping the future development of the NPF, and how can public engagement in setting national outcomes be improved?

Emma Congreve: This is a key point, which, again, comes back to Scottish Health Equity Research Unit work about understanding community perspectives on this—what people want to see and what they feel would be a success and a good outcome—with that informing not just the NPF outcomes but what the mechanisms, policies and programmes are. That is a key feedback loop—those perspectives informing people further up the chain when it comes to what happens and what is put in things such as the outcomes. It is hard to do, because you can do public consultations and get lots of responses, but if you want to find out the views of more disadvantaged communities or people who do not routinely engage in political debate you need to put a lot of resource, time and effort into finding those views. However, I would like to see a bit more of that.

Professor Donaldson: There are quite systematic ways of doing that through more qualitative research. Without getting into it, a method—Q methodology—that is promoted by a colleague of mine, Professor Rachel Baker, is really good at finding out what people's underlying value systems are with respect to these thorny issues, and it can help with the participation of the hard-to-reach groups to which Emma Congreve has referred.

David Torrance: In the context of many short-term targets for health performance, how can the NPF be used more effectively to inform strategic decision making?

Professor Donaldson: That goes back to how we take this amazing framework and push it forward into action in strategic decision making. It requires thinking about how the different aspects of the framework relate to one another. It is about how the framework relates to resource use on the ground and how people on the ground, such as those making decisions on health and social care integration—I am sorry; I keep coming back to that as an example—are incentivised to participate, whereby the NPF is a major part of their annual commissioning and planning rounds.

The Convener: I thank the witnesses for their evidence. I am very grateful for your time. I suspend the meeting briefly for a changeover of witnesses.

10:27

Meeting suspended.

10:39

On resuming—

The Convener: We will continue our scrutiny of the proposed national outcomes with a second panel of witnesses. I welcome Stephen Boyd, director of IPPR Scotland; Carol Calder, audit director, performance audit and best value at Audit Scotland; and Professor Chik Collins, director of the Glasgow Centre for Population Health.

We will move straight to questions, and I will start. I am keen to hear from the witnesses their views on the proposed new care outcome.

Professor Chik Collins (Glasgow Centre for Population Health): It is a wise and useful addition to the framework. If you are going to have a framework like this—and you are going to have one—it seems sensible and wise to include care. The representations that the committee has had from A Scotland That Cares and Oxfam Scotland sum up the issue quite well. From the GCPH point of view, I welcome the inclusion of that outcome.

Carol Calder (Audit Scotland): I agree with that assessment. It is helpful to have the reflection of mental health as well as physical health and to include the care indicator. The devil will be in the detail of how we measure the new indicators along with the others.

Stephen Boyd (IPPR Scotland): I do not have much to add to what has been said. Given the growing importance of care services to creating the society that we all want to live in and the growing economic importance as a result of the share of the workforce that is likely to be employed in care and so on, having a separate indicator on care makes absolute sense.

The Convener: Audit Scotland has highlighted the need for better support structures for paid and unpaid carers. How might the NPF capture the role of unpaid carers?

Carol Calder: As I said, the devil is in the detail. It will be about what indicators are developed to align with the outcome and the accountability framework to support that. Which agencies will be required to report on those indicators? What will they measure? To what extent will they take into account the issues for carers as well?

As you said, we have produced a report with recommendations on that. We would like a clear line of sight between what the agencies involved with carers do and the outcome itself to demonstrate what works and what helps, and to see what does not work so well. It is about the accountability framework that exists between the high-level outcome and what the individual agencies that are involved actually deliver on the ground.

Professor Collins: The submission from A Scotland That Cares has some remarks on that. It says that an indicator could be the quality of life of unpaid carers, and gives specific examples, such as the right to breaks, access to mental health services and life chances for young carers. You have some good input towards that outcome.

Stephen Boyd: The issue is probably reflected right across the national performance framework. How do you design qualitative measures that tell you what you want to know with regard to the quality of life of unpaid carers? That is probably quite tricky and doing it well is probably quite expensive. It will require a lot of engagement with those whose quality of life you are seeking to measure.

The Convener: Thank you.

Gillian Mackay: What are the witnesses' views on the proposed revision to the health outcome? To what extent is the proposal appropriate in placing a renewed emphasis on mental health and physical activity?

Professor Collins: The latest wellbeing survey for NHS Greater Glasgow and Clyde shows, I think, that about a third of adults have scores that are indicative of depression. That signals a clear need and a clear issue, and it is important that the framework and the indicators tap into that. Again, we welcome that emphasis.

Stephen Boyd: I agree with that. There are a number of trends at the moment and, this morning, we have seen the latest labour market statistics. We do not have granular detail for Scotland on those measures, but we know that, since Covid, there has been a significant increase across the UK in economic inactivity that is attributable to mental health problems. The figures with regard to the 18 to 24 age group are particularly worrying. In recognising the importance of mental health and trying to build the society that we are all working towards, it is proper that that issue is reflected in the outcomes.

10:45

Professor Collins: I am sorry, but can I make a slight correction to what I said previously? The figure of a third of people relates to the poorest communities. The figure is a quarter for the population as a whole and a third for the poorest communities. Both are significantly high scores that we need some concerted focus on.

Gillian Mackay: Absolutely. From the previous panel of witnesses, we heard concerns about the siloed nature of the NPF and the need for links

between the portfolios in order to have good outcomes as a whole. Does more need to be done on the links between, for example, fair work and health and the determinants that they have in relation to each other, to ensure that the NPF can realise its aims?

I will go to Carol Calder, as she is nodding.

Carol Calder: The short answer to that question is absolutely yes. The determinants of health cut across Government, and one agency cannot deliver all the outcomes in the NPF. There has to be shared accountability, joint activity and joint clarity about how the roles are joined together. We need to look at it holistically. To look only at health spend in relation to the health outcomes gives you only part of the picture. Education, economy and housing all have an influence. As I said, the determinants cut across Government.

That is really tricky to do. As a scrutiny body, we scrutinise agencies and organisations, and we will always need to do that, but we are working to try to look across organisations and consider place, people or prevention, as opposed to organisational scrutiny. We need scrutiny that goes across the agencies that are involved to properly demonstrate progress against the outcomes. That is the only way to get the full picture of all the contributions that are being made towards progress.

Professor Collins: Health is probably the issue that crystallises the necessity for those perspectives more than any other. At the GCPH, we are not primarily concerned about the delivery of healthcare; we are primarily concerned about health as produced over a longitudinal period by the interaction of a range of social determinants of health, which cut across the full spectrum of policy domains. That understanding is now fairly well assimilated in the policy mindset of Government and local government and a range of other agencies.

The challenge now is, on the one hand, to think about the technical and technocratic aspects of policy delivery across policy domains while, on the other, thinking about how we deliver the outcomes of a national performance framework that was conceived in quite a different time. There have been changes even in the period since the updating process began, just a couple of years ago. The document that we received that summed up the process described what has changed since the last time, which is basically that the climate crisis has become significantly more concretised, plus Covid has happened. Of course, rather more than that has happened that has been significant, including a lot even in the very recent period.

The challenge is how we deliver all this in what is becoming an adverse economic context and, in particular, an adverse fiscal context. People are saying that the implementation gaps are about resources and delivery. The solutions that we have or might come up with to cut across various silos begin to take effect only if we can think in concrete terms about how we deliver any of it, and about what we prioritise in the current very difficult fiscal situation and projected fiscal outlook.

Stephen Boyd: If the national performance framework is working effectively and efficiently, it should be a tool to help to break down that siloed approach. There is a conversation to be had about whether it has worked in that way. I have experience of that from both inside and outside Government. As we move forward in looking at the indicators underneath the national outcomes, a lot of thought needs to be given to how they can be mutually supportive. I have already mentioned the connection between people's experience of the labour market and health outcomes. It is important to design the indicators to ensure that that is reflected in both strands.

Gillian Mackay: Prevention is another aspect that the NPF notes but does not have a lot of detail underneath it as to how we actually get there with policy. I am particularly interested in the commercial determinants of health and in health-harming products. Does there need to be a broader emphasis in the NPF about the factors that influence public health? If so, what strategies could we put in place or embed underneath the national performance framework to ensure that we address those commercial determinants of health?

Professor Collins: Do you want me to start with prevention or with the commercial stuff?

Gillian Mackay: I will let you choose.

Professor Collins: They overlap, but they are not exactly the same.

The preventative stuff is important. However, again, the immediate challenge is how one focuses on prevention in the way that one would like to—longitudinally—in the context of resource scarcity. People are likely to have to prioritise what is critical and urgent. For instance, local authorities and health and social care partnerships are increasingly struggling to deliver their statutory obligations. It is important to concretise the discussion in the here and now of what is actually happening. If we imagine that that will be the scenario for the next few years, we need to consider how we reorientate the way that we have thought about prevention in the past in order to actually try to engage with that reality. Of course, prevention is a fantastic thing but, in the current context, it is likely to be deprioritised.

One example is that, recently, NHS Greater Glasgow and Clyde pulled the advertising for this year's flu jab. That advertising was about preventing the worst of the extreme difficulties that

are likely to occur in our hospitals in two, three, four or five months' time. If we are currently not able to think about prevention on those timescales in the way that we would like to, what does that tell us about how else we are, and are likely to be, thinking about prevention?

On the commercial determinants of health, the Scottish Parliament has done some good stuff, such as the smoking ban and minimum unit pricing, but it has been a long haul, and it is likely to continue to be a long haul. That certainly needs a critical focus. There has been a trend towards a focus on a wider range of commercial determinants of health. That is likely to take up quite a lot of time in terms of policy focus, but I imagine that it need not be incredibly resource demanding to deliver in practice. I know that Scottish Government colleagues are working on a population health framework for the next 10 years, and I understand that a stronger focus on commercial determinants of health is likely to emerge out of that. That is essential.

Stephen Boyd: I share Chik Collins's concerns about the current fiscal challenges and the potential impact that those might have on preventative measures. That is certainly a risk in this year's budget.

On the commercial determinants, next week, IPPR UK will publish a major report on health and prosperity, which will include a series of recommendations in that area. Colleagues would not thank me for pre-empting those recommendations at the committee today, but I would be happy to come back to you or make sure that you see a copy of that report next week.

Gillian Mackay: That would be great.

Carol Calder: Many of our health-themed reports have talked about the lack of focus on prevention. I think that that is because of the budget situation that agencies are in. Prevention requires a medium and longer-term planning horizon. Multiyear budgets would help with the planning. We also need alignment of the outcomes with the policy commitments and the strategies, to give a clear line of sight for the agencies, because otherwise they will just perform to what they are measured on.

Unless we measure what is happening across different agencies, they will continue to work in their silos and there will not be a shift to prevention, because people are firefighting in the short term. It is about three-horizon planning, and planning at a Government level as well as a public agency level. If we have more financial certainty, even with caveats on that, we can plan over a longer-term horizon.

One of my colleagues says that trying to shift to prevention currently is like trying to overhaul the engine of an aeroplane mid-flight. We need to plan forward. That is not easy, but we need an alignment of policy, strategy and funding and we need monitoring of what works and what does not work so that what does not work stops being done and we focus on what works. I know that that sounds very easy but is very difficult, but it is a collective responsibility for not just the public sector but the private and third sectors, which have a huge role in contributing to delivery of the outcomes.

Gillian Mackay: That is great. Thank you.

Joe FitzPatrick: I will pick up on the idea of preventative spend, preventative work and monitoring what is and is not working. This Parliament is responsible for outcomes around health and care, but we do not have control of all the inputs. Decisions that are made in another place—such as the decision to have 14 years of austerity and the decision that is likely to be made today on the winter fuel payment—have an impact on the health of vulnerable people in Scotland. How do we know that the outcomes that we see mean that our preventative work has not worked? Perhaps it has worked, because, due to the actions of Westminster Governments over a number of years, the situation would have been much worse if we had not done that work, even though the outcomes make it look as though it has not worked.

Carol Calder: Professor Collins can probably give you a more in-depth answer than I can, but I will say that it will always be difficult to strip out the data to find the causal link. Do we really need to know the causal link or do we just need to know enough to enable us to say that certain activity is not producing the outcomes that we expect? If we are just going to measure the delivery of the outcomes and we say, for instance, that spend in health has gone up by 5 per cent and performance has increased by 4 per cent, that does not tell us anything. Some elements of what is happening within the system might actually be causing the performance to go down and it should have been much higher as a result of that investment. Unless we know what each contributing area is doing and we have clarity about what it is delivering, we will not know what we need to stop.

It comes down to aligning policies and strategies with the outcomes, and then aligning the accountability with the agencies that can contribute to that. Of course, the picture is not clear because the work goes on across agencies. We will never be able to say, "The NHS did this, which produced that", with a direct causal link, but we can show that we are monitoring at a certain level so that we can tell that particular initiatives and particular spend areas are not achieving the anticipated benefit. We need to plan for the impact

and measure the impact, so that, when you get to the point where you are delivering, you can tell what the impact of different initiatives has been.

Professor Collins: If I understood Carol Calder rightly there, I do not think we disagree. I think that the point that is being made is that, if you are dealing with an outcome in relation to which there is complex causality, with a wide range of contributors having a role in shaping an outcome, it will be difficult to disentangle the causal contributions of different people. It is important to know what the big causal drivers are. Especially when it comes to population health, there is a huge body of evidence now that shows that we are living through something that we are probably not sufficiently aware of day to day in terms of the population health trends, which we could probably call unprecedented in modern times.

11:00

From about the middle of the 19th century, population health is on a steadily improving trajectory for the population as a whole. That was not disrupted by the hungry thirties or by the very difficult de-industrialisations and associated conflicts of the 1980s and the early 1990s. However, about a decade ago, that continual trend of population health improvement, outside of wartime, breaks down and we begin to see a deterioration for the population as a whole, with falling life expectancy and significantly adverse outcomes for the poorest and most vulnerable groups in our society. We know that that was largely driven by austerity. I know that not everyone likes that term, but let us just use it as shorthand for the decisions that were taken a bit less than 15 years ago at Westminster, which have been the key driver of that adverse population health trend.

In that context, we have to say that there are measures that the Scottish Government has taken that have definitely made things less bad than they would otherwise be, and those have to be embraced and, to a degree, celebrated. We have some evidence to show that excess mortality in the Scottish context—Glasgow compared with Liverpool and Manchester, for instance—was decreasing in recent years, although that was largely because things were getting worse faster in Liverpool than they were in Glasgow.

I hope that that is an answer to your question. We will not disentangle all the causal elements. We need to know the big picture and what the key drivers are, because we need to come to terms with those key drivers, either to mitigate them or to somehow begin to overcome and reverse them. What we really want to do is return to the trajectory that we had about 15 years ago, which was population health improving and at least the absolute inequalities between the richest and the poorest declining.

Stephen Boyd: I should have said at the start that I am very new in the post and that this is the first time in a few years that I have been thinking about health and social care issues. I was previously working with the Scottish Government, almost exclusively on economic issues.

This morning, I was looking at performance against current indicators. I do not think that the Scottish Government website is fantastic at explaining the changes in performance and, as far as I can tell, it certainly makes no attempt to even attribute successes and failures to the policies of the Scottish Government or of others. That is an issue right across the national performance framework. On the economy side, there is a tendency to think that changes in gross domestic product or productivity performance are a function of Scottish Government policy and, of course, they are not—there is a range of global and UK factors impinging on that as well.

Attributing success or failure to policy making at any particular level will be challenging and it is an issue that the analysts working with Professor Collins and within the Scottish Government could perhaps do a lot more work on. It would be helpful if at least that conversation was reflected in some way in the national performance framework section of the Scottish Government website. It does not seem to be at the moment.

Professor Collins: I will add to Stephen Boyd's point about how the progress against the indicators is reported on the website currently. Of nine indicators, five are shown as maintaining, three as improving and one as worsening. As I went through those one at a time, I tended to think that there were maybe some significant buts that could have been registered against the classification that was given. Healthy life expectancy is recorded as maintaining but, in fact, there have been sustained declines for both males and females, with the largest declines for the poorest people.

The Convener: Professor Collins, I am sorry to interrupt you, but we will come on to that specific theme a bit later on, so rather than pre-empt some of my colleagues' questions, we should hold fire on that one.

Professor Collins: Okay, great.

Paul Sweeney: I want to pick up on the point about root cause being linked to prevention. In our pre-budget scrutiny session last week, Michael Kellet from Public Health Scotland said that the planned refresh of the national performance framework offered opportunities to further prioritise preventative spend. The example or analogy that he gave was the separation of revenue and capital

expenditure in the fiscal frameworks, which was introduced in 1998, and he suggested that something similar could be done in order to secure and protect preventative expenditure in order to deal with root-cause problems. Is that something that you would agree with, and is there a practical way to achieve that?

Professor Collins: Is that for me, Paul?

Paul Sweeney: It is for you, yes, and anyone else who would like to contribute.

Professor Collins: I have spoken a lot so I will sit back a bit.

Carol Calder: I am not sure that this answers your question exactly, but what we are seeing at the moment in the NHS is a freeze of capital investment. Some of that investment was for national treatment centres. Those national treatment centres were critically important to the plans for reducing backlogs and, until we can reduce backlogs and waiting lists, we will always be firefighting. To shift to prevention, there has to be investment. The fact that we do not have multiyear budgets inhibits the boards' ability to do long-term planning and to invest to save. I am not sure whether that properly answers your question.

Paul Sweeney: It highlights the relationship with capital investment, yes.

Stephen Boyd: The suggestion that you mention is a really interesting idea but I would be reluctant to give too strong an opinion on it without having thought through the consequences. There are probably some challenges in separating out preventative spend—it is probably not as easy a task as separating revenue and capital—but it certainly sounds like something that is worth interrogating further.

Professor Collins: I broadly agree with that.

Paul Sweeney: Thank you.

Sandesh Gulhane: I declare my interest as a practising NHS GP.

Professor Collins, I am glad that you started speaking about the framework. It says that health risk behaviour is maintained, with 26 per cent of people doing two or more risky things. The framework as a whole shows us where we would like to be and where we should be. However, in 2003, there were 1,277 alcohol-related deaths, the highest number since 2008, and, in the past six months, we have had 600 drug deaths. That represents almost 2,000 bereaved families, and our thoughts are with them. That is the worst rate in the UK. Is there a point to having an aspiration when we are simply not seeing any results?

Professor Collins: You certainly do not want to give up an aspiration. There is a discussion about how you connect your long-term aspirations to your short-term goals. The health risk behaviours was not an issue that I picked up on specifically, but I picked up on a number of others where I thought there was a danger of the reality of the key trends in relation to these indicators not being effectively summed up across the piece, and it is important that that is dealt with.

Should we give up on long-term aspiration? Absolutely not. Do we need to think strategically about how we try to connect short, medium and long-term actions to try to get to those long-term goals? Yes.

Population health science, at one level, is really not that complicated. If you reduce people's access to positive social determinants of health, health will tend to decline. If the access to those positive determinants of health is skewed such that the poorest and most vulnerable people have even less access than some of the rest, your health inequalities will grow. Based on the current economic and fiscal outlook, unless something quite significant happens, it looks like those trends are set to continue, so we may be in that space of trying to think about how we make things in the short term less bad than they will otherwise be. In fact, that is the response that we gave to Scottish Government colleagues earlier this year when we were asked what could be done in the current situation and how best to invest money that could be saved by stopping spending bits of money in other areas.

Being realistic about what we are trying to achieve in the short to medium term becomes very important, but I absolutely do not think that one should then dissociate that entirely from the longer-term vision of a society that is characterised by wellbeing, which you want to achieve. I think that any democracy should be trying to achieve the wellbeing of its population.

Sandesh Gulhane: I am glad that you are here, Professor Collins, because I want to talk about Glasgow. One of the areas that I also picked up on was healthy life expectancy being 60 for males and 61 for females, which is the lowest since data was gathered. We heard from the previous panel members that we seem to be looking at that issue in terms of areas rather than in terms of people who are most deprived. The situation is probably even worse than we think for those most deprived versus those who are least deprived. Do we know whether healthy life expectancy is going up or down for those who are most deprived? Given that the situation in Glasgow is quite stark with regard to the 15 to 20-year difference in life expectancy, what can do to try to reduce that gap?

Professor Collins: We know that healthy life expectancy is going down for the most disadvantaged communities.

Sandesh Gulhane: Going down?

Professor Collins: Yes. We know that—that is well established. It is going down faster for those communities than for other communities. What you need to do for those communities is to improve their access to positive social determinants of health. We need to try to support young people, make sure that they get a good start in life and make sure that people live in decent affordable housing, that they have a good experience of the education system and that they are well supported in times of need and get the care that they require. Those are the social determinants of health. We need to strengthen and improve access for those groups to those positive social determinants of health. It is not that complicated in terms of understanding what you need to do, but the actual delivery of it is another thing altogether, and that is obviously made much more difficult by the prevailing economic and fiscal outlook.

Sandesh Gulhane: Carol Calder, again, the healthy weight indicator is recorded as being maintained, but the figures show that 65 to 68 per cent of adults and 36 per cent of children in Scotland are overweight. That compares poorly with the figures from the WHO that show that, worldwide, 43 per cent of people are overweight. We also know that obesity levels in Scotland are pretty high compared to the UK and across Europe. However, the way that the data is presented—I think that Professor Collins spoke about this earlier—does not seem to reflect how bad the situation is; it just says that the position of the indicator is maintained from last year. Do you think that we need to look at a different way of reporting so that we can start to see not only where we are compared to last year but where we are compared to other places?

Carol Calder: It is always helpful to have comparative data because that is how you can learn from places where the situation is better. The comparisons could be international or regional within in Scotland. Performance indicators and outcome indicators are indicators; they do not tell the whole story. You have to go deeper and understand what is happening on the ground. That might involve supporting indicators that can give you the picture that you want, but it is also about looking at what works, identifying what works, where the spend has gone, how that public money has been used, and whether the impact can be demonstrated.

11:15

From an auditor perspective, we find that it is difficult for the agencies to demonstrate the impact of the work that they have done. At the start of doing something, an agency will set out intended outcomes and benefits, indicators and modelling. However, at the end of the project, there will not be the analysis of what has been achieved in the same way, partly because you cannot separate out the global and societal influences.

We are doing a piece of work that is not weight related, but involves drugs and alcohol, and we will publish a report soon that will dig deeper. The work that we are doing involves an audit of how the money has been spent, what has been effective, what the measures tell us and what the service users say about what works and what needs to change. As colleagues on the panel have said, the situation is difficult, given the lack of funds across the piece. That makes it much more important to be able to understand the bang that you get for your buck and what works, and to stop doing the things that do not work. That might be different in different localities and in relation to different demographics.

It is not that the outcome is wrong or that the measures that you have been reading out are wrong. They are only part of the story—a small part of the story—but they identify where we need to dig deeper. The question is always this: why is something the case? What lies underneath that?

Paul Sweeney: Mental wellbeing is the only health indicator that has shown declining performance, yet the mental health budget has faced real-terms cuts in recent financial years. Do the witnesses have a view on how we can translate findings within the national framework into a set of clear, tangible actions that relate back to that? You mentioned the inability to translate expenditure into performance or outcomes. Is there more data that we could be gathering to help to drive that improvement?

Carol Calder: As I have said, it is about clarity of alignment. We need to know that the data that we are collecting in the public sector will give us the evidence that we need to show that the work that we are doing is having an impact. It is hard to measure impact; it is much easier to measure your inputs. However, the crux of it is being able to measure what impact has been made as a result of the investment in the activity that has been carried out in a particular area.

Stephen Boyd: A lot of work could also be done on the national performance framework website. This morning was the first time that I have looked at it in any detail for some time. It is clear that a lot of work has gone into it and some effort has gone into making it accessible to a wide audience, which is good. However, I think that the categorisation of performance into those three categories—improving, maintaining and declining—is not particularly helpful. It lacks nuance and could serve to obscure some important trends, as has already been pointed out.

Another big gap, which you are getting at, is that there is no connection between performance as currently measured and Scottish Government policy. If the whole point of a national performance framework is to determine policy, break down siloed approaches and so on, it would be helpful if we could make some connection between that performance and the measures that are currently targeted at improving that performance. Clearly, links to current budget measures or budget spend would be helpful in that regard, but at the moment there is nothing like that on the website, which I think is quite disappointing.

Professor Collins: I think that we have the data that we need, but this is about trying to get the services actually delivered to the people who need them. I have been at GCPH since the beginning of 2023 and, just before I arrived, my colleagues were doing some work to support the creation of a new set of mental health hubs, which were going to be a way of delivering early intervention to prevent people becoming more ill and requiring acute admissions. We did some work towards supporting the development of those hubs, but just at the point when we concluded the work the funding was no longer available to continue with that initiative.

More generally, last week we saw an £18.1 million reduction for mental health services across Scotland. My point comes back to the critical challenge of how we will resource delivery in order to meet this growing welter of needs that we are facing. That requires some shorter-term thinking while we try to get back to the improving trajectories that we want.

I hope that that answers the question; I cannot quite remember how it was formulated.

Paul Sweeney: I was asking about how having very high-level indicators breaks down into a set of clear actions that are monitored over time; for example, aligning certain activities in primary care, such as deep-end GP practices, with how the indicators are set.

Professor Collins: Okay.

Emma Harper: Good morning. I am interested in how we apply budgets to the national performance framework. I asked the previous panel about how we manage the cross-portfolio aspects of the NPF, such as housing, wellbeing, the economy and care, which we have talked about previously. Those aspects are all intertwined, but how do we make sure that we assign the correct budget to them, whether we are talking about single-year or multiyear—which Carol Calder spoke about—funding? What is the best way to fund the various items in the national performance framework in order to achieve the outcomes that we need to achieve?

We also need to think about the fiscal constraints that we face and the impact of austerity, which we have spoken about. We cannot separate the fact that, here in Scotland, we do not have full fiscal levers, which affects our ability to deal with aspects of drug law in order to tackle alcohol and drug harm. Given that we do not have the ability to take ownership of everything, what do you suggest we do with regard to applying budgets to each of the various items under the national performance framework?

Carol Calder: I think that it comes back to making the outcomes the umbrella under which all decision making is made. It is a case of thinking about what you are trying to achieve in your decision making and how that will deliver the outcomes. It is a question of making a clear connection between the decisions that you take and the outcomes. We are not in an environment in which all those outcomes can be improved all the time, so, as my colleague Professor Collins said, it is a question of prioritisation. We need to think about what we are trying to achieve. If we salami slice the budget without thinking about the impact that that will have on the outcomes, we are missing a trick. There will be a disconnect between what we are saying we want to achieve as a country and how we are delivering that.

This is really hard to do, but I think that the outcomes need to be considered as part of the decision-making process. We need to be transparent about the fact that the decisions that are taken will mean that we have to prioritise one thing against another. If we try to go forward on all fronts when we are fiscally constrained, perverse and counteracting actions will end up being taken by different parts of Government. Therefore, it is a question of creating coherence, and the outcomes give us the framework to do that. They tell us what we are trying to achieve, but we need to think about what that means for the individual budget lines for different parts of Government.

The NHS does not deliver all the various aspects of health: as you said, that involves work by other parts of Government. I hate the term “a golden thread”, but it is important that we think about the impact on the outcomes when we make decisions that will change how services are delivered, such as the cuts that Professor Collins described in mental health funding. We need to ask, “What impact will that have on that outcome? Is that an acceptable change that we can tolerate because we are focusing on these other outcomes over here?” We need to have coherency of decision making, with the outcomes acting as the umbrella under which decisions are taken. At that point, it is question of thinking about where the spend goes and trying to unpick, to an extent, the delivery across the various delivery bodies within Government.

Another issue is the delay. We can work towards the positive social determinants of health that Professor Collins described, but we will not see the result of that until years down the line. It is very difficult to do such long-term planning in the parliamentary cycle, but we need to think about the future, have a long-term plan and do the three-horizons investment, so that we can deal with what we need to deal with on a day-to-day basis, while embedding the outcomes in decision making and providing the incentives and the accountability for the various agencies that implement the policy.

Professor Collins: I think that recasting the national performance framework in terms of wellbeing probably helps, because it provides a fulcrum around which we can have a discussion about relative prioritisation. Health and wellbeing is a good way to see it. If we want to achieve a nation where there is wellbeing, health is obviously a core aspect of that.

Ultimately, however, we are not talking about a technical exercise across the Government. It is part of a political process in a democracy in which a range of voices will compete to set the relative priorities. That is how we want it to be, but we want that process to produce a rational outcome with regard to the wellbeing outcomes. We need to have an overt national-level discussion that connects with a wider public—a discussion about where we are, the trends that we are seeing in health and wellbeing, and how acceptable those are to our society. We also need to think about the social and economic burden that we are building up for our generation—never mind future generations—to carry.

To illustrate that, I will pull out a statistic from the health and wellbeing survey in greater Glasgow and Clyde. In 2008, 20 per cent of the population of greater Glasgow and Clyde had a long-term limiting condition or illness. That figure is now 30 per cent—30 per cent of the population have a long-term limiting condition or illness. In the poorest parts of Glasgow, healthy life expectancy is down in the mid-40s. If we allow that to continue to grow, to develop and to build up, what burden are we building up for the future?

We talk about national missions. Maybe that mission could articulate with the national performance framework and provide a wider discursive framework within which we could have a more grown-up national discussion about what we are trying to achieve and how the relative prioritisation of portfolios and social determinants of health would feed into that.

However, to begin with—this goes back to how well we record our progress against the indicators—there needs to be honest, up-front recognition of where we are at and how we got here. In public life—this is the case not simply in Scotland but in other places, too—we have developed a culture whereby it is really good to be positive. Recently, I have been at events at which people who have made presentations have felt the need to apologise for accurately describing reality in case it made people feel a bit upset.

We need to begin by engaging with the reality that we are dealing with in population health terms and the unprecedented nature of those developments, and then try to make that the basis for the national discussion that we need to have—in my opinion and in the opinion of the Glasgow Centre for Population Health.

Emma Harper: If we are talking about wellbeing and supporting a wellbeing economy through the national performance framework, do you think that the public know what "wellbeing economy" means? We have been talking about it for a few years now. There is the Wellbeing Economy Alliance, and there are lots of experts out there who produce paper after paper, which we see, but do the public know what it means to have a goal of a national performance framework that supports a wellbeing economy?

Stephen Boyd: My instinctive response to that is that I do not think that they do.

Emma Harper: Do they need to know what it means?

Stephen Boyd: I think that it would be helpful if they did. "Wellbeing economy" is a phrase that is very widely used in the policy community, and there is a general understanding of the outcomes that we are hoping to improve by having the wellbeing economy as our goal, but beyond the policy community, outwith this building, there is a huge variety of understanding of what the phrase "wellbeing economy" actually means. I am not sure that it is entirely helpful in serving as a guide for policy, although it is a legitimate aspiration.

11:30

With regard to how we go about improving understanding, I think that the Scottish Government needs to articulate very clearly what it believes a wellbeing economy to be, and it has not managed to achieve that in the past. Its current economic strategy does not align particularly neatly with most people's understanding of what a wellbeing economy would be. Therefore, there is a huge job of work to be done there.

I would like to quickly go back to Emma Harper's previous question, which was about the budget. I do not have anything particularly clever to say about how we connect the national performance framework outcomes with the budget-setting process, but in relation to health and social care, the main takeaway has to be that

if we want to maintain quality, never mind achieve improved outcomes, health budgets and social care budgets will have to rise year on year at a higher rate than the whole-economy rate of inflation. We are talking about labour-intensive personal services. We know that, in all countries and at all times, the cost of delivering those services rises at a higher rate than the whole-economy rate of inflation. At some point, we will have to engage with that reality, which must inform our future taxation policies.

Carol Calder: I think that your question prompts a wider question about what the public's expectations are when it comes to public services. What can we do? What can we deliver? I think that there needs to be a change in culture and that a conversation needs to take place that involves setting out how difficult it is to deliver public services and the fact that we cannot continue to have the services that we have had in the past.

If we project forward the increase in the health budget, in time there will be no budget left for anything else unless something changes, because the health budget is going up year on year. We need to have honest conversations with the public, and difficult political decisions need to be taken that will involve doing things that the public do not like. It is a case of explaining why those decisions need to be taken. I realise that this is a health committee, but we need to ask whether we can continue to empty everyone's bins once a week or once a fortnight, or to put tarmac in the holes in the roads. Can we continue to do all the things that we have come to expect? No, we cannot.

Therefore, we need to start to have a conversation about whether free prescriptions is a sustainable policy. I know that that is a small element, but we need to have such conversations. I still hear people in GP surgeries say, "You shouldn't buy that. You can get it free on the NHS." I am talking about prescriptions for things with low-level charges, such as paracetamol and Calpol. There is a culture of thinking, "It's free. We've already paid for it through our national insurance, so we should get it." However, I do not think that the public have been engaged in the conversation about the difficult choices that need to be made right now. We need to make a shift to supporting the most vulnerable people, rather than trying to provide universal services across the piece.

The Convener: I call Tess White.

Tess White: Convener, do I have time for two questions or just one?

The Convener: If you are concise—and if the answers are concise—you have time for two.

Tess White: That is great. I will ask two questions then.

Both are for Carol Calder. Audit Scotland has highlighted the concerns about the lack of clarity in budget documentation on the impact of specific budget interventions on long-term health outcomes. In your opinion, how can the NPF improve transparency and ensure that budgetary decisions are closely linked to achieving measurable health improvements?

Carol Calder: It is all about being specific in that respect, about the transparency of the decisions that are made and about being clear about roles and responsibilities. You have to set the expectations with regard to what you are trying to achieve and then give the responsibility for delivering that to the individual agency, to ensure that those agencies have a clear line of sight with regard to what they are doing to contribute to individual outcomes.

Tess White: Thank you.

A lot of what you have said this morning about prioritisation versus salami slicing and fiscal prudence has resonated with me. Some talk about austerity while others talk about fiscal prudence; however, they are at different ends of the scale. What you are saying is that we cannot go on unconstrained.

Let me give you a specific example. In the financial year 2022-23, more than 661,705 bed days were lost due to delayed discharge. That is the highest figure ever reported, with an annual cost to Scotland of a staggering £1 billion. As the IPPR has emphasised, it is a key example of not meeting the needs of our older people and, indeed, of depriving them of dignity.

A decade ago, this issue was a major priority for the Scottish Government; indeed, it basically pledged to eradicate delayed discharge. So, it was high priority; it was one of the top few things that had to be done, and the focus was on that. My question, therefore, is this: how, in your opinion, can the NPF finally ensure that funding is used effectively to address the negative outcomes that we are seeing for Scotland's older people?

Carol Calder: Through accountability.

Tess White: Accountability of what?

Carol Calder: It is through accountability of the individual agencies for delivery against the outcomes. At the moment, there is no clear link to the outcomes for all the different agencies that deliver public services; there is collective accountability, but what that means is that nobody is accountable. There is no clarity on the intended or expected impact of the funding that is given to public bodies, and if there is no accountability, spending happens in a way that is not necessarily aligned with the outcomes.

I do not think that I am being very articulate about this—what I am trying to say is that the NPF is your vision, or mission, and to deliver that mission, everyone needs to be on the same page. Decisions need to be made with that in mind. That is the ultimate target, and the work that is done should be aligned with that.

The fact is that delayed discharge has gone up. It has not gone back to the level that it was at before Covid, although I should point out that there were times when delayed discharge was really low in particular local authorities. I know that the NHS is doing work to understand the variability across Scotland, because the determinants will be different. It might have to do with social care or the ability to put people in the right step-down care, or it might be about getting into people's homes and making adaptations, but it might also have something to do with taking a multidisciplinary approach to assessment of a person's need, with clinicians and social care people coming together to make an assessment of individuals in order to reduce delayed discharge.

At the moment, we know that those are all factors, but we do not know why there is such variation across Scotland. I know that the boards are doing work to try to find out what the issue is; we will probably report on that in next year's overview of the NHS, looking at the trend in that respect and the work that has been done on the matter.

Tess White: So the issue is accountability and aligned targets—that is, NHS boards not having aligned targets with the IJBs and the IJBs having split accountability.

Carol Calder: We need to declutter the system a little bit to ensure that there are clearer links to the outcomes and that the impact can be measured.

Tess White: Thank you.

The Convener: Sandesh Gulhane has a brief supplementary.

Sandesh Gulhane: Professor Collins, I want to go back to what you said about people apologising for being upset by the reality. I was quite upset and shocked to hear that healthy life expectancy in parts of Glasgow is now in the 40s and, indeed, is still falling. What can we do to try to reverse that specific trend in Glasgow, which I should say also has the highest rates of drug deaths?

Professor Collins: We recently addressed this question to a degree in the context of a wider set of questions that was asked by the Scottish Government. There is no point making the sort of recommendations that we would have made in an economic and fiscal context that is very different to the financial situation that we have at the moment, so our recommendation was to try to get resources as directly as possible into a network of local community organisations that would be able to respond to local needs, drawing on the experience of some of the great responses that we saw in the early stages of Covid.

Some of those organisations exist, and there is capacity to develop them in other places, too. That would be something that, in the short term at least, could make some impact in those local environments to slow the decline and, I hope, begin to reverse it, especially as we move into a context where we can begin to get some of the bigger more resource-demanding policy levers working to support those local interventions.

Sandesh Gulhane: Thank you.

Professor Collins: You are welcome.

The Convener: Before we move on, I want to ask a brief supplementary, too. You have mentioned twice now, I think, that we are in unprecedented times in terms of population health and that you could trail that back to the start of austerity 14 years ago. We are being told by the new Labour Government that things are only going to get worse in a financial sense. What impact will that have?

Professor Collins: I will just say what I said earlier. Perhaps I can give you an analogy: when you pump carbon out into the atmosphere, the earth warms up. When you reduce people's access to positive social determinants of health, often through cutting public expenditure and often in ways that impact on more vulnerable groups, population health suffers and population health inequalities widen. You do not get to buck that science.

Although there are interventions that can be made in local places—and lots of local community organisations are doing incredible, indeed unbelievable, things that would make you greet, if I can use that word, and are having a dramatic impact and really improving lives. Those organisations are barely able to do that even at the level of the size of settlements that they are in. Some great work is being done in Kilmarnock, for example, but is it impacting on the overall population health trend in Kilmarnock? It is really just having an impact on the limited section of the population going to those places.

We should never forget this. Of course, we should never let gloom and doom overtake us, but we must remember what the science predicts and use that to inform our understanding of where we are at and the things that we need to be doing. Not only that, but we also need to remember how important this is. It is important not just in the ethical or moral terms in which people might often phrase it; we also need to remember the economic

and social costs and, indeed, the future burden, which will hamper the future development of our economy and society. After all, no society really wants to be trailing such a burden behind it—it will definitely hamper it.

The Convener: Thank you. I call David Torrance.

David Torrance: How can the national performance framework be more effectively integrated into the decision-making process to ensure that it actively influences both national and local health and social care policies? This is all about looking ahead, I guess.

Carol Calder: I am happy to go first, although I will probably be repeating myself.

We require our public sector leaders to be accountable for delivering against those outcomes—or for their part of the contribution to those outcomes. I keep talking about accountability, but that is what this is all about. If a chief executive of an NHS board or a local council knows that they will be held to account for what they have done to contribute to outcomes and the work that they are doing in that respect, they will corral their information and activity to be able to demonstrate that. What gets measured—and what you are held to account for—is what gets done. I am repeating myself, but we need to require all public sector leaders to demonstrate how they have contributed to the outcomes.

Stephen Boyd: I guess this morning's conversation is taking place based on the assumption that the national performance framework is the guiding star for public policy in Scotland, but I am not entirely sure that day-to-day practice in the public sector reflects that reality. Having just come from eight years in the Scottish Government, I think that the extent to which the national performance framework influences policy development is very patchy between different areas and how it has been disseminated to different parts of the public sector has been very patchy, too. If we really want public sector leaders to grasp the nettle in terms of the national outcomes, a much stronger signal has to go from this place, and from the Scottish Government, that the national performance framework should, indeed, play that role of guiding star.

11:45

Professor Collins: I agree with both my colleagues to a degree, but I struggle with the diagnosis that the main explanation for what is not happening in terms of achieving outcomes is that we have an implementation gap. That is the permitted explanation, and I think that it tends to displace responsibility from this place on to other places. It is always quite an easy thing to say: if we just held more feet to the fire in local authorities, in the NHS and in various other agencies and organisations, we would kind of get there. Of course, that is what we have been arguing for some time now.

However, I wonder to what extent we are dealing with a policy implementation gap and to what extent we are dealing with an actual policy formulation gap. That gap has been well described by Audit Scotland; indeed, I wrote what it said down—if I can just find the relevant bit of paper.

Audit Scotland said:

> "there is a major implementation gap between policy ambition … and ... delivery".

I highlight that it talks there not about policy, but "policy ambition". It seems to me that the NPF describes policy ambition. Are we doing enough to translate policy ambition into implementable policies that have resources attached to them and which can be delivered by the agencies that we expect to deliver them?

That is probably another part of the explanation. This would not be the first time that people have said, "The problem is an implementation gap and the answer is accountability"—and when the next cycle comes around, the explanation is still the implementation gap and the need to hold more feet to the fire. You get a lot of burnt feet, but not a lot of progress.

I am just offering that as a view. This is not a particular area of expertise for me, but it seems to me that it is the recurring trope—if you like—that requires some critical interrogation by policy makers as well as policy implementers.

David Torrance: My next question is for Professor Collins, first of all. What role should the public play in shaping the future development of NPF? How can public engagement with setting national outcomes be improved?

Professor Collins: I think that Oxfam commented on the limited amount of public engagement that there had been on this matter, describing it as "disappointing". Could—and should—there be more? I think that this brings us back to an earlier question: do people know what a wellbeing economy is? If they do not, whose fault is that? Whose job is it to strike up that dialogue and establish that relationship between what the Government is trying to do and what people are actually talking about? A wellbeing economy does not seem to me to be something that would be a particularly hard sell for a great majority in society to understand and commit to. All we have to say is that, instead of pursuing GDP and numbers, we are going to run the economy in a way that supports and delivers wellbeing, greater equality and greater happiness.

It is all about trying to crystallise for a wider public the actual relevance and value of these discussions and to invite them to join the discussion in ways that are meaningful and accessible. I am not exactly sure how you would do that, but if there were some concerted attempt, I guess that we would learn from it and might do it better in future cycles.

Carol Calder: I agree. I think that we need to show the connection between what the ambition is and what is actually happening. The ambition is all about what you want the country to be like, then the public want to know how you will get there and what choices are being made to achieve that ambition.

It is all about making it real, as I think Professor Collins was saying, and how you will do it. I do not think that anybody would disagree with the outcomes and the ambition as they are, but as I have said, the devil is in the detail. How will we deliver these things? Indeed, what does that mean for what we are not going to deliver, so that we are able to deliver whatever we set up? What does it mean for, say, our taxation policy, so that we have the resources to deliver these things? That is where the conversation is important—it is all about the next level of how you make it happen.

Stephen Boyd: Something that I was struck by when I was looking through the documents over the past couple of days was that there does not seem to have been a huge effort to engage the public on this. Most of the organisations that responded were the usual suspects that respond. If you are going to have participative democracy—and if you are going to do it well—you need to understand it, you need to be creative and you need to spend a bit of money, too.

I recently attended a Save the Children session in Stirling with a panel of ordinary members of the public. At the moment, it is testing out public attitudes to measures for addressing child poverty in Scotland, and it is taking that group of 40 people through, I think, eight different sessions before it settles on a set of recommendations. It was a really good session; people were highly engaged with the issues, and it will be a robust piece of work. However, quite a lot of resource had been spent on that kind of participative work. To do it properly and effectively, you do have to spend a bit of time and a bit of money.

David Torrance: I have no further questions.

The Convener: I thank the panel for their evidence this morning. It should certainly help the committee in its work and its scrutiny of the national outcomes.

At next week's meeting, we will take evidence from representatives of NHS Greater Glasgow and Clyde and NHS Lothian on the independent review of gender identity services for children and young people, followed by the first of a series of oral evidence-taking sessions as part of the committee's further scrutiny of stage 2 of the National Care Service (Scotland) Bill.

That concludes the public part of today's meeting.

11:51

Meeting continued in private until 12:10.

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