OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 21 March 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 March 2017

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HEALTH AND SPORT COMMITTEE
8th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor David Bell (University of Stirling)
Neil Craig (NHS Health Scotland)
Dr Eleanor Hothersall (NHS Tayside)
Professor Gerry McCartney (NHS Health Scotland)
Professor Damien McElvenny (Institute of Occupational Medicine)
Eibhlin McHugh (Midlothian Integration Joint Board)
Fraser McKinlay (Audit Scotland)
Mairi Simpson (Midlothian Integration Joint Board)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Health and Sport Committee

Tuesday 21 March 2017

[The Convener opened the meeting at 10:16]

Subordinate Legislation

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

Under agenda item 1, we will consider two Scottish statutory instruments that are subject to the negative procedure.

Sale of Tobacco and Nicotine Vapour Products by Persons Under 18 (Scotland) Regulations 2017 (SSI 2017/50)

The Convener: On SSI 2017/50, there has been no motion to annul and the Delegated Powers and Law Reform Committee has made no comment.

As there are no comments from members of this committee, do we agree that we should make no recommendation on the instrument?

Members *indicated agreement.*

Sale of Tobacco (Register of Tobacco Retailers) (Scotland) Amendment Regulations 2017 (SSI 2017/51)

The Convener: On SSI 2017/51, there has been no motion to annul and the Delegated Powers and Law Reform Committee has made no comment. As there are no comments from members, do we agree that we should make no recommendation on the instrument?

Members *indicated agreement.*

Preventative Agenda

10:17

The Convener: Under agenda item 2, we will have the committee's first evidence session on the preventative agenda. This is a round-table session, so we will all briefly introduce ourselves, in turn. I am Neil Findlay, convener of the Health and Sport Committee and a member of the Scottish Parliament for Lothian.

Clare Haughey (Rutherglen) (SNP): I am the MSP for Rutherglen and the deputy convener of the committee.

Dr Eleanor Hothersall (NHS Tayside): I am Ellie Hothersall, a consultant in public health medicine at NHS Tayside.

Professor Gerry McCartney (NHS Health Scotland): I am a consultant in public health in NHS Health Scotland.

Donald Cameron (Highlands and Islands) (Con): I am an MSP for the Highlands and Islands.

Professor David Bell (University of Stirling): I am professor of economics at the University of Stirling.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am the MSP for Edinburgh Western and the Lib Dem health spokesperson.

Alison Johnstone (Lothian) (Green): I am an MSP for Lothian.

Professor Damien McElvenny (Institute of Occupational Medicine): I am a statistician and epidemiologist at the Institute of Occupational Medicine.

Neil Craig (NHS Health Scotland): I am principal public health adviser in NHS Health Scotland.

Richard Lyle (Uddingston and Bellshill) (SNP): I am MSP for Uddingston and Bellshill.

Maree Todd (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands.

Eibhlin McHugh (Midlothian Integration Joint Board): I am chief officer of the Midlothian integration joint board.

Mairi Simpson (Midlothian Integration Joint Board): I am a public health practitioner with Midlothian health and social care partnership.

Fraser McKinlay (Audit Scotland): I am director of performance audit and best value at Audit Scotland.

Ivan McKee (Glasgow Provan) (SNP): I am MSP for Glasgow Provan.

The Convener: Thank you. A few people are missing this morning, but I think that they will join us during the proceedings—they are probably having travel problems. I ask Alison Johnstone to ask the first question.

Alison Johnstone: Thank you, convener. How do the witnesses define "preventative agenda"?

Professor McCartney: It is a difficult term to define, as you will have gathered. Different people define it in different ways for different purposes. A working definition that you might want to think about is "spending public money now with the intention of reducing public spending on negative outcomes in the future". That could be defined as primary prevention, in that it prevents negative outcomes such as cancer or a hospital admission from ever happening, or it could be secondary prevention, which is about preventing complications or further negative outcomes occurring after an initial bad thing has happened, or it could even be tertiary prevention, which might be about preventing other negative outcomes in terminal care or other treatments. I do not know whether there is a single definition that everyone would subscribe to, but spending now to avoid negative outcomes in the future is probably a working definition that most people could live with.

Professor Bell: One thing that makes the assessment of prevention extremely difficult is the establishment of what we call the counterfactual, which is what would have happened had the preventative intervention not taken place. Statisticians can spend a long time trying to process what the counterfactual might be. Uncertainty about that clouds the whole prevention agenda and might make politicians less willing to get involved, especially when it can take a long time before the benefits of a preventative intervention are realised.

The Convener: Defining it is one issue, but deciding what we should focus on is another. I think Alison Johnstone wants to add something.

Alison Johnstone: It is unfortunate that Dr Irvine is not here, as she suggests in her written submission that some evidence challenges the perception that preventative initiatives should always be prioritised. She states:

> "employing more district nurses and GPs is necessary to enable them to react to genuine need in the community so as to minimise unnecessary reliance on secondary and tertiary care in the future. That is not preventative medicine as we think of it in public health terms. That is just intelligent, cost-effective health service planning".

So there is another view there.

Some of the submissions say that it is unrealistic to suggest that shifting resources to the community sector will actually save us from negative outcomes in the long term—there is a feeling that shifting resources to where we might see more preventative action taking place will not save us the cash that we think it will. I would be grateful for any views on that.

Eibhlin McHugh: I can speak about some of the things that we have learned on our journey so far in Midlothian in integrating health and social care. Key opportunities have opened up around having a different understanding of what we are dealing with. We are now able to see the whole journey rather than fragmented episodes, whether in hospital or in the community. We also have better data to help us to understand our communities. For example, the level of smoking in areas of high deprivation has been a real shock to us and knowing about it has forced us to confront some realities. There are also opportunities around bringing together a workforce with very different skills. In all of that, the shift in mindset is key.

As we understand the area better, we are able to design new interventions, around building social networks in the community, as alternatives to what previously would have been solo professional interventions. An example is the referral of patients to psychological therapies to address mental health issues, whereas now, increasingly, we have new interventions that look more holistically at the social determinants of people's issues. It is about everyone understanding inequalities and seeing doing that as part of their job.

Shifting resources from hospital to the community is part of the journey, but it is also about seeing the whole picture, being able to make much more holistic interventions, allowing professionals to work together, and having a real understanding of the context and social determinants of some of the presentations.

Alison Johnstone: Some submissions suggest that social determinants are what we need to get at—that if we want to tackle health problems at their root, we need to increase income, improve housing and so on—whereas other submissions suggest that we still need to focus on specific interventions for specific conditions such as obesity or diabetes. Does anyone have a view on that?

Dr Hothersall: That is a false dichotomy. To refer back to your earlier question, it is worth highlighting that the big-picture interventions—those at the social determinants of health and the reducing inequalities end—have a very broad impact. By reducing inequalities, they improve health in lots of different areas, which makes their cost effectiveness harder to measure; it is much harder to see whether widget A produces outcome B when we are looking at the much bigger and broader picture.

I do not think that anyone is arguing that the one is a substitute for the other, but reducing inequalities will have a slow and gradual impact—it is impossible to wave a magic wand and see that impact tomorrow. The problems that we see currently will continue to exist and the people who are developing pathologies today will still be developing them while we are making that broader impact on society. Therefore, trying to separate things out in that way and say that we should focus on one rather than the other is probably unhelpful.

Alison Johnstone: You think that we need to do both.

Dr Hothersall: Yes.

Professor McCartney: We absolutely need to address income, housing and all the social determinants of health, but that will not reduce entirely the need for health and social care services. In the series of reports that he did for the United Kingdom Government a number of years ago, Derek Wanless talked about the need not only to postpone mortality and increase life expectancy but to compress morbidity. We need to reduce the amount of time that people spend in ill health if we are to generate savings in the services, and a lot of the prevention discussion is centred on that. The issue is less about preventing illness and postponing mortality and more about compressing the time in which people need health and social care services, in order to make the system more financially sustainable.

Compressing morbidity is about trying to keep people healthier for longer. To do that, we need to deal with the social determinants of health, such as income, inequalities and housing, but we also need high-quality primary care and preventative services, and specific legislation on things such as smoking, alcohol and food. Compressing morbidity and preventing unnecessary spending on services, to increase the financial sustainability of the system, would be a useful focus for the committee.

Neil Craig: There is a potential false dichotomy between investing in the social determinants of health and investing in things that might tackle behaviours. NHS Health Scotland would argue that we should not generalise about which forms of intervention are necessarily the most effective and cost effective; instead, we should be looking to understand what the evidence tells us about which ways of tackling behaviours and the upstream determinants of health might be the most effective and cost effective.

There is a strengthening evidence base that we can draw on in discussions about prevention. We very much encourage the committee to look at that, to identify which of the broad spectrum of interventions—from upstream interventions to tackle health determinants to downstream interventions to tackle behaviours—will be most effective and cost effective, and potentially most effective in tackling health inequalities as well.

10:30

Fraser McKinlay: To some extent, all public services should be preventative. The Christie report is a good few years old now, but that is where it got to. The danger of talking about "preventative spend" is that it makes it sound like there is money in a pot in a certain place or being spent on specific projects that are designed to prevent stuff, when all the £30 billion or £40 billion of public money that is spent in Scotland should be preventative spend. There is a challenge for us all to refocus our attention on that—although I accept that that is easy for me to say.

Given the general consensus that we need to address housing and the economy—getting people into jobs—and take more specific measures on specific issues, there is a question of money, and that is what Audit Scotland is interested in. I was interested in what some of the submissions say about new models of funding that might be available. It is definitely worth looking at that.

Whichever way one looks at it, there are also some difficult decisions to be made at some point. I was interested in Dr Irvine's submission, in which she talks about the breast screening programme. I know nothing about the rights or wrongs of that—I make no comment on that—but it is interesting that someone in the field is saying, "Here's a thing that everyone's said is a good thing to do, but what about its cost effectiveness?" If there is money to save, the challenge is that that money might be better spent on housing. There is a big question for the Government and the public sector about potentially taking money from one bit of the system and spending it somewhere else. At the moment, that is a difficult discussion to have. To me, we still need to work at having a genuinely whole-system approach.

The Convener: Do you think that enough people are challenging us in that way?

Fraser McKinlay: That is an interesting question. I thought that you got a fantastic response to the inquiry—there were 60-odd submissions and, as I flicked through them, I was struck by the commonality of view. We do not really need to do much more analysis of the issue, as most people are saying broadly the same thing. The question is about what actions on the ground are going to make a difference. How can we tackle the barriers around the use of resources that everyone has mentioned to help colleagues on the

ground, in Midlothian for example, who are trying to make this stuff work? That is where the focus of attention should be.

Alex Cole-Hamilton: I have been hoping to come in on early years preventative work. I declare an interest as I was involved in the early years collaborative during its early stages and as a member of the putting the baby in the bath water coalition, which looked to improve life outcomes for children by investing in services for them in the first 1,000 days of their lives.

We cannot get much more preventative than working with children from birth—in fact, from pre-birth around perinatal mental health, the conditions in which pregnancy occurs and the support that is given to expectant mothers. I am interested in the panel's reflections on how effective the early years collaborative has been in improving health outcomes for children in the early years. I would also like to hear about where we have still to travel, the trajectory that we are on and what work we as politicians should be doing more of.

Fraser McKinlay: I am happy to kick off—if nothing else, I can plug a report that we will be working on over the next couple of years on this very issue.

The Convener: Shameless.

Fraser McKinlay: Absolutely—I take every opportunity, convener.

We are looking at the whole early years agenda, of which the early years collaborative is an important part. In preparation for this meeting, I looked online as a member of the public would and found that it is quite hard to find out how the early years collaborative is doing or has done, although some of the objectives and targets that it set itself were due for delivery in 2015-16. It wanted to reduce the infant mortality rate by 15 per cent by the end of 2015, but I could not find out whether that had been done. It is important to create an initiative, but where is the follow-through, the reporting and the evaluation and monitoring of it?

Alex Cole-Hamilton: That is incredibly interesting. Having been involved at the start of the early years collaborative, I know of the great good will that was afforded to it by the voluntary sector, which was very much an integral part of it and which signed up to the very ambitious stretch aims—as they were called—on health and preventative work. However, cynicism swiftly crept in, because we kept seeing the same money being rebadged and announced as new money, and we did not really see an immediate pay-off from where the investment was going or whether it would create transformational change.

My anxiety is that it is symptomatic of the preventative agenda that politicians' rhetoric, which is all on message about that agenda, is never matched with the delivery. If we do anything in the inquiry, it must be to shine a light on the disconnect between the rhetoric and the reality. The fact that you, who work for Audit Scotland, cannot find online any evidence of what the early years collaborative has done, despite all the investment and all the froth around its inception, is a worrying state of affairs.

Fraser McKinlay: I should say that members of my team are probably watching this session and throwing stuff at the television, because they will almost certainly know the answer to the question. However, I offer my comment as an observation.

Professor Bell: I will put in a plug for the Scottish Government's growing up in Scotland study, which is probably the best source of information on early years. Picking up on that cohort study, which follows over time children who were born in something like 2002 or 2005, understanding the family circumstances of those children and having the complete picture will give us the opportunity to do the best-quality analysis of what effect the programme has had.

The Convener: Are the early years fundamental to everything else in the field?

Alex Cole-Hamilton: At the time, the early years focus was the alpha and the omega of our work.

The Convener: You are not a witness, Mr Cole-Hamilton.

Alex Cole-Hamilton: I thought that you were looking at me.

Professor Bell: A lot of this goes back to Jim Heckman's work on early years intervention in the States and the fact that $10 invested when a child is one or two is far more effective for a range of social outcomes—including, but not only, health outcomes—than $10 spent when they are 15 or 16. That has been used as an argument for rebalancing education spending away from universities towards primary school. The evidence on that is international, so there is strong support for that approach, and it will be good to have evidence for Scotland once it becomes available.

Professor McCartney: The first question was about whether the early years should be the sole focus of preventative activity. It should not be the sole focus for a number of reasons. The first is the timescales. We cannot afford not to prevent all the things that are happening to the current cohorts of people who are in adulthood and old age.

Alex Cole-Hamilton: I do not think that I suggested that early years should be the sole focus of preventative work, but I was keen to distil

things down to the earliest examples of preventative work.

Professor McCartney: Sure. It is important to clarify that the early years cannot and should not be the sole focus, but it is also true that we have greater potential for prevention the earlier we start. However, that depends on what we do. We need to make effective interventions in the early years age group, but there is no point in focusing simply on an age and saying that we should do anything at that age. I know that you were not saying that, but we have to be clear that we are putting in place effective interventions in the early years.

That brings me on to comments about the early years collaborative. In common with many other programmes that we have implemented in Scotland, we do not have an evaluation framework that allows us to attribute a particular set of interventions that can be badged as the early years collaborative to X, Y or Z subsequent impact on health or social outcomes. That has been the case for a number of programmes over a long time; we keep making the same mistake of not commissioning evaluations at the start that would allow us to attribute the impact.

I understand that the early years collaborative has taken an improvement science approach. Improvement science is really good for checking whether known effective interventions have been implemented sufficiently in a local setting, but it is not a good approach for finding out whether interventions are effective. The results will therefore depend on whether the interventions that have been badged as early years collaborative work are already known to be effective. The work that Neil Craig described, which considers the cost effectiveness of a range of interventions—whether they are health, social or broader socioeconomic interventions—and compares their effectiveness is the kind of evidence base from which we want to draw if we want to consider whether interventions have had an impact.

Alex Cole-Hamilton: Professor McCartney has seamlessly brought me round to my second point, which concerns preventative work at the other end of the age spectrum—with older people.

Before Christmas, I had the great privilege of chairing the older people's forum in the chamber. I asked some participants what caused them the most anxiety. I expected the answer to be crime or loneliness, but the biggest thing that they cited was fear of falling, because of the demonstrable link between falls and mortality. They had lots of friends who had fallen and broken a hip, gone into hospital and never come out again.

Members might remember that, when we debated the patient safety programme just a couple of weeks ago, I lodged an amendment that asked for a national falls strategy to build on the work of the Government's falls framework in 2014. I will broaden that out and ask the panel about the issue. In the spirit in which we have just discussed early years, I would say that falls are definitely part of the issue, and perhaps you could reflect on that. What other preventive health measures can we bring to the older population?

The Convener: Are there any comments on that? What is being done in Midlothian?

Eibhlin McHugh: We are doing lots on falls. The approach that we are adopting is to have a shared understanding of the issues and ensure that everyone incorporates them into their roles. Falls provide a really good example of that. We are working with the Scottish Fire and Rescue Service so that, when its staff work in the homes of isolated older people, they do falls checks. They can then link up with us. The position is the same with every other professional who goes through the door.

A lot of public education work is being done with groups of older people to increase understanding. Much of our work is at the secondary and tertiary levels, rather than primary interventions. However, to go back to primary interventions, it is a matter of working through the community planning partnership and examining the houses that we are building, their design and so on, so that the lived environment is a safe environment for older people.

Falls provide just one example, but much of our work is focused on social isolation. We recognise the impact of social isolation on older people's health and wellbeing. We have had opportunities through various funding streams—the change fund and so on—to build capacity across the voluntary sector and across neighbourhoods. One key change that has been particularly important for me has involved professionals recognising the impact of interventions and ensuring that they are well woven into the pathways, so that we are moving away from solo professional interventions to a much more integrated approach that includes an educational approach and a social network approach, with the professional interventions located within that.

Neil Craig: I will address Alex Cole-Hamilton's comment about the ethos around prevention. I think that he used the word "rhetoric" in relation to prevention. In our submission, we stressed the need to think beyond that. There is an adage that prevention is better than cure, which supports the rhetoric on prevention. We suggest that a very strong case can be made for prevention, but it has to be made in a discerning way, because prevention is not necessarily better than cure if it is not effective, if it does not reach the people it

needs to reach or if it is not delivered in a way that ensures the intended impact.

We encourage the committee, in carrying out its inquiry, to think critically about the evidence that is presented to it on prevention so as to understand precisely what it is about prevention that determines whether it is effective and whether it is cost effective, rather than jumping to conclusions about whether broad categories of intervention might be cost effective. We need to be critical and discerning in our use of the evidence that is presented to us.

Dr Hothersall: What the integration joint boards are trying to do is absolutely fabulous, and it very much focuses at the right end but, from a health board perspective, the fixation or obsession is about prevention in the sense of preventing emergency admissions. As far as I am concerned, that is too far down the line to really count. We do not want as many emergency admissions, but that is because we do not want people to have the conditions that require them to go to hospital in the first place.

The fixation on that indicator—the term "perverse incentive" is used in other submissions as well as NHS Tayside's—means that the much more sensible targets or issues, which relate to the big picture again, that should be addressed because they will have a broader impact on older people's health get ignored and underfunded. If we cannot prove that they will reduce emergency admissions next month, nobody is interested.

10:45

Professor Bell: I will make a point that picks up from Neil Craig's last point. We have to be clear about why we are preventing. Are we preventing in order to improve people's wellbeing or to compress morbidity, or are we intervening in order to manage the health budget?

When we are clear about those issues, it is important for the committee to bear it in mind that, even if we prevent a particular adverse event for someone, that does not necessarily reduce the health budget. We might stop them suffering the adverse consequences of diabetes, but they might then develop cancer. The overall health budget will not necessarily be contained by one particular intervention—other things will happen to people and they will die eventually. It is important to be clear about why we are preventing.

Ivan McKee: I thank the witnesses for coming along. I will focus on the data side and on data-driven decision-making processes. I come not from a health background but from a background in which such thought processes are used in a different environment. Almost everybody who we talk to about the health service throws up an anecdotal example of how, if only we spent some money here or stopped cutting something, it would save a fortune over there—there is no shortage of that kind of anecdotal stuff. However, when we start to drill down, it is difficult to find the data.

I understand what Professor Bell said about counterfactuals—I get that and I know that we are talking about big systems. Let us take a simple example, such as knowing that people who smoke will cost the health service more than people who do not. I assume that, with the amount of data that is available, it is not beyond the wit of the people who crunch numbers to factor out things such as age, Scottish index of multiple deprivation aspects and so on and to distil the data to say that the average smoker costs the health service £X and the average non-smoker costs £Y. If we therefore spend £X on stopping people smoking, we can save £Y further down the line, and the same goes for alcohol, obesity, falls—which we were talking about—or whatever. That approach is how I would typically tackle decision making in other environments.

Maybe you will tell me that the data is available but, from what I have tried to find so far, I am struggling to see that those numbers are there. You people take this to the point where you say that you spend £100,000 or £1 million on reducing the number of falls, which saves the health service £10 million in a certain timescale, based on what is known from the huge amount of data that is out there. Does anybody want to comment on that approach and the data that is already available that might help to inform it?

Professor McCartney: I feel obliged to answer that. I am also the head of the Scottish public health observatory and I manage a big team of data people, so we probably have a responsibility to provide those numbers.

A couple of things might be helpful. The first is the triple-I tool—the informing investment to reduce health inequalities in Scotland tool. That allows us to model the impact of a range of interventions on health and health inequality outcomes at Scotland, health board or local authority level. The range of outcomes is limited to mortality and hospitalisation—the tool does not look at wellbeing and other things that we might genuinely be interested in, but that is a limitation of the available data.

Ivan McKee: Do you look at the costs?

Professor McCartney: The tool looks at hospital costs but not at broader health service costs at the moment. I will say a bit more about that in a second.

The triple-I tool is available online on the ScotPHO website. People can play with it and model different levels of intervention, but it is

limited to 11 interventions at the moment. We are consulting on what new interventions we might add to the tool; if there are particular things that have an evidence base, we would love to add them. As ever, the rate-limiting step is the quality of the evidence that allows us to model a particular intervention. Much as it might be interesting and important to do something on falls, we cannot model that; we need an intervention with an evidence base to give us an effect size for falls.

Ivan McKee: What do you mean by an intervention?

Professor McCartney: It can be a policy or a clinical service—it is anything that we can have an effect size for.

That goes back to David Bell's point about the counterfactual. Usually, the best-quality evidence comes from a randomised trial in which one group of people has been given an intervention and another group has not, and we look at the difference in the outcomes of the two groups and see what the effect size is. That allows us to model what the effect would be if an intervention was applied in Scotland.

That is what the triple-I tool does. I am not sure whether I have explained it for you.

Ivan McKee: I will comment on that and I might be right or wrong. To my mind—again, based on what I have done before—it would typically be done as a two-stage process. We would say, "If we do this, that happens." If there is a factor in the middle that allows us to convert from one to the other, it is easier. For example, we know that if somebody falls, it costs X, and if they do not fall, it does not cost that. We know, in abstract terms, how much a fall costs. We could then say, "This policy will reduce the number of falls." We do not need to follow it all the way through; we need to follow it only as far as the intervening factor because, at that point, we know the result because we have already done the work. You are right. There could be thousands of interventions and thousands of outcomes and you are trying to map one to the other.

Professor McCartney: We have done that for some things—for example, employment policy. We were unable to find well-evidenced interventions around what generates employment, but we were able to say what impact employment had on health, so we could model different scenarios. Similarly with alcohol, we can pick the intervention because we know what the outcomes are.

Ivan McKee: Absolutely.

Professor McCartney: We have done that for only a limited number of interventions so far, because it is complex. We are keen to hear what priority interventions people would be interested in us building into the next phase.

Ivan McKee: Is that being used to drive decisions?

Professor McCartney: It is not being used as much as we would like, but that is partly because a limited number of the interventions that we modelled in the last phase are amenable to being done by health and social care partnerships or CPPs. Most of the interventions are at Scottish Government level. They have been the subject of parliamentary debates, and people have used the data. The living wage came out particularly well in the modelling as having a big impact, so it became part of the political discussion when the data was first released. The data has been used to inform some of the discussions. However, to get down to the level of detail about investing in X rather than Y, all the interventions and spending need to be part of the modelling. We are some way away from that, partly because of the limitations of the evidence base.

One or two other resources are available that do that to a varying degree. We are working on the Scottish burden of disease study, which looks at the outcomes—a particular form of cancer, or heart disease or whatever—that drive the burden of disease generically. That includes morbidity and mortality—illness and death. The study also looks at the exposures that would drive that, such as alcohol. The study will be fully published later this year and will help to inform decision making. It will not look at specific interventions but it will allow you to do that midpoint thing and say that, for example, alcohol and obesity are responsible for X.

There is also the assessing cost-effectiveness in prevention study. Neil Craig might want comment on that because he is more familiar with it than I am.

Neil Craig: There are bodies of work that try to do what Ivan McKee has described. I think that the study that Gerry McCartney is referring to is a large-scale Australian study that was carried out about seven years ago. It looked at a huge number of interventions—I cannot remember exactly, but it was something like 200 interventions. Some were treatment interventions but most were preventative interventions. They were modelled in terms of the impact that they had on something called disability-adjusted life years, which is basically an estimate of the extent to which an intervention improves length of life, adjusted for some measure of quality of life over remaining life expectancy. It did a calculation for upwards of 200 interventions and came up with a ranking of the cost effectiveness of those interventions in terms of the cost per disability-adjusted life year generated. It is a measure of

how much needs to be invested in interventions in relation to the health returns.

As other witnesses have said, there tends not to be a good counterfactual about what would happen to people in the absence of an intervention, so the estimates tend to be based on assumptions about what would happen, given what we know about the effectiveness of interventions. The process tends to involve a lot of assumptions. That can lead to differing conclusions because people have built different assumptions into their models. That can present challenges in interpreting the information, but at least there is information out there.

In our submission, we raise issues around how one can interpret and generalise from modelling that is based on evidence from a different country—using the study that I described would involve comparing Scotland with Australia. In a sense, such issues are an occupational hazard, but at least there is a body of evidence that enables us to consider whether the same effect would apply in Scotland if we were to invest in the same array of interventions that have been modelled in another country.

The National Institute for Health and Care Excellence has pulled together evidence to inform its guidance, and it has done modelling in which it compared the impacts of interventions on length and quality of life with the cost, in order to give some sense of what health returns we would get from the resources that we might invest in preventative interventions. The results of those studies show that some of the interventions turn out to be cost saving—to go back to a previous question—while others do not necessarily save money but generate a lot of health benefits for the cost that is incurred to achieve them. Some interventions do not do that, which goes back to our earlier point that prevention is not necessarily better than cure.

There is a body of evidence to draw on. Its applicability to the Scottish context needs to be assessed carefully; we can either draw on it directly or repeat the modelling in the Scottish context to get results that are specific to Scotland. However, there is no short-term fix in the sense of there being a ready-made body of evidence that answers all the questions that we might want to ask.

Ivan McKee: Is the biggest problem that we do not have the data and the modelling, or that we do not have the will to follow through on what we already know?

Neil Craig: As someone who tries to produce that sort of evidence, I would certainly encourage people to make more use of it. There is a will to do so, but there is a capacity issue. As Gerry McCartney highlighted, there is a huge number of potential interventions in which we might invest. We need to prioritise the discussion around areas that we think might offer the biggest potential returns and in which the biggest problems need to be addressed. For example, we might focus our energies on issues such as obesity and try to identify the most cost-effective interventions.

If we simply ask the overall question, “Is prevention effective and cost effective?” we are doomed to fail.

Ivan McKee: Yes—it is a meaningless question, because it all depends on the individual intervention.

Neil Craig: Exactly.

The Convener: Thinking through the process that you are talking about, I highlight as a recent intervention the provision of the baby box for mothers. Did that go through the process that you described for assessing an intervention?

Neil Craig: I do not think that the baby box went through that process, although I might not be aware of work that has happened.

The Convener: Thank you. Does Professor Bell want to come in?

Professor Bell: I could speak about data all day. The first issue is that we do not have enough good people to do the kind of analysis that Ivan McKee is talking about. The second point relates to his example of how much a smoker costs. We have a lot of administrative data—mainly hospital data—through which an individual can be followed, but we need to marry cause and effect. Economists obsess about causal linkages; we need to link the data with social and economic data, and even with genetic data. Some current research is on genetics and epigenetics—where these may be sources of future disease and so on. That is what we are trying to do with our study. We have a questionnaire, which takes an hour and a half to complete, in which we ask people about their occupational history, their health literacy and so on. The effectiveness of preventative interventions depends largely on how people understand the interventions and how they react to the information that they receive. It is important for us to be able to understand whether, in general, people have the capacity to respond.

Scotland is actually in quite a good position internationally with the amount of data that it has, but we have a way to go before we are telling a more complete story—in particular about the social, economic and, maybe, genetic origins of later-life health problems.

11:00

Mairi Simpson: I can talk about the practical experience, in a small area, of looking at local data, including health, social housing and other data. Some of the work in Midlothian that Eibhlin McHugh referred to has been very much about culture change and having a shared sense of ownership when it comes to inequalities. A lot of work has been done on that across the community planning partnership, because having shared ownership is key to dealing with inequalities. The partnership has opted to look at health, economic circumstances and learning. As has been discussed, it is largely about getting a shared and better understanding of local data.

We have enlisted, from the Scottish public health observatory, NHS National Services Scotland and others who are more expert in the kind of things that Ivan McKee talked about than we are locally, support to help us with planning and understanding our local data. That has been really interesting. Previously, people would have said that we had all the data but as we delved deeper and had more expert assistance, we learned much more about our area and our people, which has been really helpful. It has also been helpful to spread the responsibility across housing, planning and other areas.

One thing that we have done as a community planning partnership—led by the IJB—is to look at our gap indicators. We had a tendency to look at our statistics and the trajectories and so on, but not at whether we were closing the gap in certain areas. Having experts come in has really helped us to narrow that down: we have learned so much that will help us with our planning and our interventions. We do not have all the resources and expertise that David Bell talked about, but that work has made a big difference round the table in our planning of services and interventions.

The Convener: How will you use all that data to close the inequalities gap?

Mairi Simpson: The data has been really helpful—I can give a couple of examples. We very much acknowledge that nothing will change in the next year or so as a result of getting the data from the CPP. That is difficult because some elected members' terms will be finished before we see results. People need to be committed to the longer-term view.

On a day-to-day level, some of the information that we got about mental health prescribing has been really helpful. It is helping us to look at where we position services and how we ensure that services are attractive and applicable to people in certain SIMD groups and certain areas. The data has helped us to plan and design our services. That is on a small scale, but it has been helpful to have that information. We are also looking at school attendance. We have realised that there is massive variance in school attendance between areas and between social groups.

The data is helping us to hone our interventions and it is helping people to see things from a different perspective. As I said, there is also shared ownership across services and agencies.

Colin Smyth (South Scotland) (Lab): Fraser McKinlay made the point that there is quite a lot of commonality among the submissions. Most of the submissions argue that primary and early interventions are key to decreasing demand for acute services. However, some of the submissions argue that it is unrealistic to believe that moving resources to community services will, on its own, reduce demand for acute services, and that therefore we will still have crisis intervention in both sectors. Is the aim of shifting resources from one sector to another in order to reduce demand for acute services possible or realistic in a world where, in effect, we do not have the funding to do both? Is the panel aware of any major disinvestment decision that has released resources for effective prevention work?

Dr Hothersall: I will start with a general point. There is a Nuffield Trust report about moving services into the community, which says that the idea that simply moving things into the community will save money is not proven. That ties in to the earlier point that talk at that high level covers everything, from things that will almost certainly not deliver what we want them to deliver and that we do not have any evidence for, to things that will deliver.

In Tayside, we have had an early community support model up and running for the past few years. It targets frail elderly people who are at high risk of admission to hospital, and builds a community support team around them in order to prevent them from being admitted to hospital. We estimate that, in its first winter, that support model saved us more than £100,000 by preventing emergency admissions and delayed discharges.

Continuing evaluation across our patch has shown that that pattern of preventing emergency admissions has continued in some areas, but in other areas it has not been realised in quite the same way. We do not know, because it is hard to unpick, whether that is due to differences in the population, differences in implementation of the model or something even subtler—for example, that what we see in one bit of the country does not necessarily translate easily to elsewhere in the country.

The model has certainly given us hope that some bits of moving care into the community will

have a concrete impact. It is just that we have not got to the end of that experiment, if you like.

Eibhlin McHugh: The Midlothian IJB is still at an early stage, but I echo the evidence of the previous witness. I can give two concrete examples. Up to now, the Midlothian IJB has used Liberton hospital—at times, we have used 40 beds—but from 1 April, we will make no further admissions there. Instead, people will be better supported at home or have rehabilitation in a more local hospital in Midlothian. We have also developed the hospital at home service, which supports frail elderly people to avoid hospital admissions.

We are getting a better understanding of the frail elderly and where they are on the pathway. We can then target community services in a more co-ordinated way in order to meet their needs and better support them in the community. With the work that we have done, hospital admissions for that group are starting to come down for the first time, so there is some encouraging evidence.

We need to be careful not to assume that there can be a straight shift from hospital provision. We need to do things radically differently in the community. It is about understanding our population and working in a much more co-ordinated way, but it is also about new models of care. If we do not take a much more proactive approach to the use of technology, and if we do not use our care resources in a much more targeted way than we have done up to now, there is a risk that some people's care in the community could be more expensive than care in the congregated setting in hospital. As an IJB, we therefore need to be thoughtful about what we are doing and we need to test things constantly.

There is not always a straight link between what we do in one intervention and an impact. Often, a shift is due to a range of interventions. What is harder to evaluate is a different culture around how we use resources, which is about really understanding what will make a difference to individuals' lives. It is all those things together that make our work very complex. We need to be constantly alert to what is working, and to be testing things.

Professor McElvenny: I am not a specialist in public health—my background is in occupational and, to some extent, environmental health—so I speak with some trepidation, given all the public health experts in the room. However, I get the impression from the discussion that we know a lot about what needs to be intervened on in order to reduce ill health in the community. The discussion seems to be about how best to configure interventions.

Also, we do not necessarily know everything that we need to know about what might be effective as an intervention. In particular, we do not know a lot about the causes of some diseases on which we might want to intervene. For example, with the ageing population, there has been a huge rise in the number of people with neurodegenerative diseases; we just do not know what causes the vast majority of those diseases—genetics, diet or whatever. As well as interventions, therefore, I would encourage thought being given to understanding better the causes of the diseases that we want to intervene on.

Colin Smyth: A number of witnesses have given examples of disinvestment, and other examples have been outlined in the written submissions. I appreciate that Dr Irvine is not here, but I note that number of the submissions talk about ceasing mass screening programmes. Do the witnesses have any views on those interventions?

Professor McElvenny: The International Agency for Research on Cancer recently evaluated breast screening and found that, on balance—I stress "on balance"—it is still beneficial.

The Convener: Do you want to come in here, Fraser?

Fraser McKinlay: I was just going to make a more general point about disinvestment. The example that has been highlighted is a good one. Mr Smyth might have missed it, but I said earlier that although I make no comment on the specifics because I do not know the rights and wrongs of the issue, it seems to me that we need to have a conversation with the public and our communities if services are to be changed, no matter whether we are talking about a screening programme or an acute hospital, or a bit of it, being closed or changed. Such conversations are very difficult, but if we are to achieve the genuine transformation in the provision of care such as colleagues from Midlothian have been talking about, we need to have them.

I am delighted to hear mention of the community planning partnerships in Midlothian. After all, if we are trying to do this just in our own little bits of the public sector—for example, if a council and a health board are trying to make decisions in isolation from each other but with an integration joint board in the middle—it is just not going to work. If community planning partnerships are there to do anything, it should be to reduce inequality in their local areas, so they need to add up how much collectively they have to spend—which, in some places, is a very big number—and what they are spending it on, and they need to figure out how they can better use their people, their

buildings and their money in order to target their collective resource at reducing inequality in all the ways that have been described.

Of course, the danger is that, as the financial pressures on the individual bodies increase, it becomes tempting to retreat into one's individual organisation and to make decisions on its behalf when that is the point at which we should actually be opening things up and having a much better conversation with communities and using local knowledge and the available data to make the genuinely strategic decisions that we need to make for the next however many years.

To come back to the question, going into all this with the aim of saving money is not, I think, the right place to start. We should be talking about how best to improve outcomes for communities. The evidence suggests that, if we do that, we will find better and more efficient ways of working, which should certainly save some money in the future.

Professor McCartney: Mr Smyth asked two specific questions, the first of which was about evidence on whether disinvestment releases savings. I remind people that there are other ways of prevention that do not involve any services but which are about legislation, regulation and taxation and which are often very effective ways of improving outcomes. A very quick list of such things would include reducing paracetamol pack sizes, installing suicide barriers on our high bridges, introducing alcohol minimum unit pricing, the ban on smoking in public places and the ban on alcohol discounting. All those measures use regulation of some sort and are very effective at improving outcomes without giving rise to any great on-going spending requirement. There are other preventative interventions that are worth keeping in mind, aside from services—which are, of course, really important.

On the specific question about breast screening, I think that it all depends on the outcome that you are interested in achieving. The Cochrane Collaboration, for example, gathered together all the international evidence from randomised breast cancer screening trials. The outcome that it looked at was all-cause mortality, and it found very little effect from breast screening. However, when Michael Marmot and his team at University College London were asked to do similar work, they took breast cancer mortality as their outcome and found a 20 per cent reduction.

You will notice the disparity between the two results: the question, therefore, is whether breast cancer mortality or all-cause mortality is the right outcome to look at. On the one hand, if competing causes of death are important, as somebody mentioned earlier, we might want to look at all-cause mortality. However, if we are worried that the effect of breast cancer screening might be diluted by looking at all causes, because we would expect only a small proportion of all deaths to be due to breast cancer so it therefore provides an insensitive measure, maybe looking at breast cancer mortality gives a better outcome. That is where the debate lies around breast cancer screening, and it is why there is so much debate and discussion about the effectiveness of screening.

11:15

Professor Bell: I want to pick up on Fraser McKinlay's point. I am a bit concerned that we are learning, in different parts of the country, lessons that may be of general applicability, but we do not have the mechanisms in place to roll them out. The roll-out of an intervention is an issue that has to be thought through very carefully.

I am on the board of a body in England called the economics of social and health care research unit, which is looking at pretty big pieces of research including a randomised control trial about whether telehealth interventions prevent emergency admissions, in which two fairly large populations are being compared. I might be wrong, but I do not think that Scotland is in that business—I do not think that we have yet captured the notion of how we can identify and then spread out best practice.

The Convener: Clare Haughey has the next question, then I will come to Maree Todd, who has been very patient.

Clare Haughey: I want to expand on a point that Mr McKinlay made about disinvestment and changing services. We have heard lots about how we need to change services, work in different ways and look at things in the round, particularly with the integration joint boards. However, as politicians, and as health board and council members, we are often contacted by members of the public who are very concerned about changes to services, such as the closure of hospitals or other buildings, centralisation of services and so on. If the professionals are saying that that is the direction in which we need to go, how do we bring the public along with us?

The Convener: That is a good question.

Eibhlin McHugh: We do that through engagement and communication. It is about respecting people's views, and acknowledging and working through some of the differences.

In Midlothian we have what we call a hot topics group that local politicians and members of the public come along to, and we put the most difficult things on the agenda for that meeting. At the moment, because Midlothian is such a fast

growing area in terms of its population, there are issues around access to general practices. That group is where we come together and talk about the issues. GPs talk about the challenge that they face in meeting the needs of the local population, and about the strategies that they have introduced to manage that. Members of the public tell the GPs how annoying and difficult it is, when they have been trying all day to get through on the phone, that there is a triage system, so the GPs go away and look at what they can do to improve their triage system. There is no shortcut; we cannot do enough communicating.

It is also about professionals working together. When members of the public are unsure, professionals must be clear and must have a shared understanding of the risks, be explicit about that and share it openly.

One of the things that we are constantly challenged about is the changing of well-established services. Assumptions are made about the evidence behind things that we are all familiar with and we are challenged about the evidence. There is very little, or very poor, evidence about the effectiveness of many of the things that we have done for a long time, but because they have been happening for a long time, people feel safe and secure. We need to work through that openly. There is absolutely no doubt that we need to have between the public and public services more conversations in which there is shared ownership of what is happening, in order to help people to understand the challenges.

Neil Craig: There was some interesting evidence to that effect in the national conversation: there seemed to be a willingness on the part of respondents to engage in some debates.

I reiterate what Eibhlin McHugh said about the need to involve people over the longer term. There is some evidence that when people are engaged in discussions and information is shared with them about the choices that officials and service providers face, they are willing to embrace the challenges that those decisions present. They face up to the opportunity cost of doing something in the way that it is currently done, which may not necessarily be the best way of doing it, even if there is local support for that method. If people are offered alternatives for which a good case can be made in terms of effectiveness and better ways to meet needs, they might embrace those alternatives, even if they went into the discussion with a different view. Conversation can work, but it is not a short cut—it needs to happen over the long term.

Maree Todd: I will pick up on something that Gerry McCartney said. Perhaps we could all explore another politically slightly tricky area: the reluctance to use the most effective—and very cost effective—options of regulation, fiscal control and legislation, which do not contribute to health inequality. There is a tendency for politicians to fall back on individual interventions, education and behavioural change, for example, which are much less effective and contribute to health inequality.

Professor McCartney: I agree. At times, those kinds of interventions can be more politically challenging, even though they are often cheaper, and they can be seen as antilibertarian. For example, limiting sales of alcohol or the areas where people can smoke, or regulating the food industry, would be unpopular with a lot of stakeholders. However, those are very effective ways to improve health and reduce health inequalities because, as you suggest, they do not rely on individual agencies or people having to opt in to things—they just remove the risk from the context in which we live. They are very effective, and very cost effective, for that reason.

Maree Todd: Are there examples from around the world? My colleague Alison Thewliss has introduced to the UK Parliament a bill on advertising formula milk. The UK has the lowest breastfeeding rate in the world, and I know that there are, around the world, various regulatory systems on advertising of formula milk and that type of thing. Are there examples of that sort of legislation that we could follow?

Professor McCartney: I suspect that that would be effective, but I am not sure of the exact evidence. Perhaps Neil Craig could tell us whether breastfeeding was included in the ACE—assessing cost effectiveness in prevention—study; I cannot remember.

Neil Craig: I am trying to remember. The ACE study that I mentioned earlier certainly included a number of regulatory interventions and found that they tend to be cost effective—they are low cost and effective. Although the risk for each individual may not reduced by a great amount, the interventions reach the whole population. Small risk reductions can have a big effect, which, when set against the low cost of such interventions, makes them cost effective.

Richard Lyle: I have listened intently to the points that have been made, and I have a couple of questions. A number of years ago, women were concerned about breast cancer, so there was a breast screening programme. Now we are told that the programme is ineffective and costly. People are told that if they have a cough for three weeks, there is something wrong with their lungs and they should go to the doctor quickly. The point is, are those programmes worthwhile and effective, or are we just wasting our money?

The Convener: Who would like to answer? Professor Bell? I see that he is looking away and looking at the floor. Does anyone have an opinion on that? Helene Irvine might have, but she is not here today.

Richard Lyle: Right. I will be controversial again. We have just heard, "Smokers—it's all your fault." Well, I am a smoker, and I cannot remember the last time I saw a doctor, so it ain't all the smokers' fault.

I want to go back to a comment that Fraser McKinlay made earlier. People hammer individual national health service boards because there is a postcode lottery, but should we not tailor programmes for local people, local areas and local problems?

Fraser McKinlay: I can have a go at answering that, but maybe not the bit before it.

The Convener: Not the bit about smoking?

Fraser McKinlay: No—I would not like to comment on Mr Lyle's smoking habit, one way or the other.

Richard Lyle is absolutely right that we need to be very careful about the phrase "postcode lottery". We are interested in unexplained variation. If a health board, council or community planning partnership can demonstrate why it is doing things differently to meet local need and that that is making a difference, that is absolutely right and proper. Quite a lot of the time, when we ask why things are different in one place from how they are in another, people do not actually know. That is the point at which it is legitimate for us to ask the question and to challenge. We absolutely should not talk about postcode lotteries, but should instead consider unexplained variations between places or between populations or communities. That is kind of what inequality is all about. These days, with data such as colleagues have described, we should absolutely be able to get under the skin of things.

We have done some work on education. Places like East Renfrewshire and East Dunbartonshire will always come out top in educational attainment scores, and people can say that that is because of the sorts of areas they are. There is a bit of that, for sure, but they are also the most improving parts of the country. Even given the deprivation impact on educational attainment in other places, other local authorities are accepting that East Renfrewshire Council and East Dunbartonshire Council are doing something in education that they should go and look at. That is absolutely legitimate.

Richard Lyle: My last question should be very thought provoking. Do we have too many targets? What should be retained and what should we dispense with? Which programmes are cost ineffective and should be abolished? We have really got down to the nitty-gritty. What is the best and what is the worst? What do we get rid of?

The Convener: That is an easy question. Are there any takers? No?

Richard Lyle: So, do we get rid of nothing, then?

The Convener: Maybe we could hold that and go round at the end to ask people what we should be doing and what we should get rid of. That will give people a bit of time to think.

Richard Lyle: Also, what should we amend?

The Convener: Yes.

Helene Irvine says in her written submission that

"the task of quantifying preventive spend"

is onerous

"because we have been determined to substitute the right solution ... which is reducing the opportunity/income/wealth gap ... with a ... wide and expanding range of alternative solutions that provide a suboptimal return on our investment."

I am very much of the school of opinion that we need to address the social determinants, and I have been for a long time. Is Helene Irvine right that that is what the whole focus of Government should be? My view is that, unless all ministers, including the ministers for fishing or anything else, are equally responsible for health and health inequality, we will not see a cross-Government approach. Actually, the First Minister should have as his or her target reducing the health inequality gap. Is that where we should be going? Rather than have all these individual small things that we want to measure and assess, should we assess the top line, which is whether the gap is decreasing?

Professor McCartney: The Government has the national performance framework, which has a relatively small number of high-level outcomes that it is aiming to improve. There are a number of health outcomes as well as economic, housing and other outcomes; it covers all areas of Government. That is useful, because it gives a picture of whether we are making progress. Underneath that, there are more detailed indicators, and then each department has more detailed indicators and targets below that. As long as that is framed in an outcome-focused way so that we can say that, if we address one specific outcome, it will make a contribution up the chain to the overall national outcomes, that can be useful and it can help to divide up the tasks.

11:30

If we have just a single outcome to improve life expectancy by X per cent, that is great, but people in health boards, housing departments and elsewhere will think, "What do I do? What is my role?" We have to divide up the tasks so that everyone can see what contribution they will make to the work overall. Things need to be linked together in an outcome-focused way, which should drive people to consider what the most effective interventions are to deliver the outcomes in their area.

Often, as others have said today, we do not know what the best interventions are and it is just because of history that we have ended up where we are. We should challenge each other more to test what we are doing to see whether it is the most effective way of doing things, and we should consider whether we can make changes and evaluate changes robustly to see what difference they make. If we find out that the original way is the best, that is fine and we can go back to it, but if we find that there is a different and better way, let us do it.

The Convener: Are we seeing evidence of a substantial and significant shift of resource to the areas of most need in order to close that gap? My assertion would be that we are not seeing that shift, that in many ways the rhetoric is not matched by the reality on the ground and that what we are actually doing is scratching the surface.

Professor McCartney: I think that there is some truth in what you say, but the situation is complicated by the fact that the areas that perhaps have the highest life expectancy also have the oldest people, so they also tend to have high health and social care needs. Shifting that resource is challenging. The nature of prevention is that we have the need now that has to be met, and another need to shift resources to redress future demand, but also to reduce inequalities. That is tricky when we have to spend money on the existing demand for services, as is the case now. There is a genuine challenge there that is quite tricky.

Neil Craig: Your initial question, convener, was about where we should be investing our resources and the extent to which we should be tackling upstream causes. NHS Health Scotland's strategy is very much about supporting the tackling of the social determinants of health, given their role in driving health inequalities, and the evidence on the cost effectiveness of prevention—

The Convener: Can I ask you to evidence that statement?

Neil Craig: Sorry—to evidence which statement?

The Convener: Your statement about where the focus is.

Neil Craig: I am saying that our strategy is focused on reducing health inequalities and highlighting the need to tackle the upstream drivers of health inequalities.

The Convener: That is the strategy. Where is the implementation of that on the ground, and the evidence to back that up?

Neil Craig: Sorry—I did not wish to comment on that.

The Convener: Right. So we have a strategy.

Neil Craig: Yes. I was going to make the point that the evidence on the effectiveness and cost effectiveness of preventative measures in terms of their potential to improve health and reduce health inequalities suggests that there are many upstream interventions that are effective and cost effective. In our previous publications on the economics of prevention, we have highlighted the case for investing in upstream interventions on the grounds of cost effectiveness and the potential of such interventions to reduce health inequalities.

The Convener: I accept that that is in the strategy, but it is more difficult to follow that through and see where there is intervention and investment on the ground that is actually backing up that strategy. Audit Scotland might be able to assist us with that.

Neil Craig: I would not wish to comment on that without further analysis of the balance of spend and how that has changed in recent years, but it is certainly a productive line of inquiry for the committee.

Fraser McKinlay: I do not think that, at the top level, we have seen a significant shift, and the report attached to the inquiry—"Changing models of health and social care", which we published last year—says that. The principle of moving more care into the community is a long-standing one; it is not something that has been invented recently. In fact, the principle has been supported by Governments of all different colours over the years, but we are not yet seeing, at scale, whole-system change.

In the report, we tried to evidence that lots of really good stuff is happening. To come back to David Bell's earlier point, the challenge is how we make more of that happen in more places more of the time, with it becoming more of the starting point. If it is difficult—and it is—to turn off a tap in acute and stick it into preventative or primary stuff, we need to have a conversation about whether there are different or innovative funding models that will help investment.

There have been goes at that: we have had the change funds and we currently have the attainment fund in education. I absolutely agree with the point that Gerry McCartney made earlier, which is a point that we repeatedly make; the evaluation of those initiatives needs to be designed and built at the outset. When we ask five years later what we got for the money, we do not want the answer to be that it is difficult to tell. We need to figure that out at the start and know what we are trying to do, and we need to measure it as we go to have a sense of whether it has worked. For me, that is a gap in how we do such things.

Alison Johnstone: I have a question specifically around GPs and health inequality. I am missing Dr Irvine this morning because a lot of the evidence came from her, but I know that you are all experts in the field.

Dr Irvine's work supports the view that, in areas of deprivation, we do not support general practice well enough to tackle unmet need and health inequalities. She also says:

> "We should consider funding a high quality GP service with continuity as the aim rather than disable general practice and then hope to solve the many problems ... by adding a series of fragmented problem-specific programmes aimed at patching up the inadequate primary care service that results."

I am interested in your expert views on whether we are funding GP services adequately, particularly in those areas of need.

Dr Hothersall: General practice funding is part of the issue; the underpinning fragmentation and difficulties in general practice are another aspect. My perception of general practice, from various perspectives, is that the difficulties are part of one of the biggest public health problems that we are about to endure, which is our inability to deliver the services that we want to deliver through primary care because of a lack of workforce and other facilities. We say that we want something, but then we cannot have it on the ground because we do not have the people or the facilities available, because of systematic disinvestment over a very long time at every level and the increasing unattractiveness of the job. I am really sorry to say this—don't shoot me—but we have a recruitment crisis in general practice at every level because it is not a great job to have a lot of the time.

What we want—the whole philosophy underpinning moving care further into the community—puts much more pressure on primary care at a time when we have less and less ability to deliver the services there in the first place. Some of that is about money, but lots of it is about culture, emphasis and value, in the other sense of the word. Unless we can fix that bit, just bunging some more money in that direction is not going to solve the problem.

Clare Haughey: I draw members' attention to my entry in the register of members' interests—I am a registered mental health nurse. I want to ask a question specifically about mental health, which we have not really touched on except very briefly with Alex Cole-Hamilton's question about perinatal mental health. How do the witnesses see the preventative agenda in relation to mental health and mental health services, and how does that feed into better or more accessible services? I throw that open to everyone on the panel.

Eibhlin McHugh: Mental health is one of the areas where we are starting to feel more confident about the progress that we are making, particularly around the role of the GP and what is happening in the primary care setting. Picking up on the previous question, I think that one of the things that we absolutely must not do is create a more fragmented service. Much of our challenge, and the point at which we get the poorest return on our investment, is when we deliver fragmented services that are very episodic and which respond to individual things that happen, with an intervention that is then left sitting until another thing happens. For me, the key is to have really well joined-up services, with the GP at the heart of delivery, supported by a team around him or her that complements their skills. I think that we will deliver services best when everyone works to the top of their skills in a respectful and well joined-up way.

We have been very alert to the number of presentations to our GPs in which there is an underlying issue to do with mental health and wellbeing. We have piloted a wellbeing service, in partnership with the Thistle Foundation and using the house of care approach. That has been very well received by our GPs, who have rolled it out in eight practices. In some ways, the service is very simple. It is about skilled workers working with individuals who are referred by their GP because they have underlying issues. It is about focusing on the outcomes that the individual wants by having an hour-long conversation and helping them to make connections and use a range of different supports that enable them to take control of their lives. We are engaged in an evaluation of the pilot—Mairi Simpson is directly involved in that—and the early results are very positive.

The idea of making mental health visible and highlighting where there are underlying mental health issues is key for us. We use a range of responses, many of which involve being clear about the outcomes that the individual wants and the range of interventions that are available. There are professional interventions, which are complemented by opportunities for learning so that people are better able to manage their conditions. Our approach also involves people using the strengths around them, with much more peer

support. There is an organisation in Midlothian called Pink Ladies 1st, which is focused on people using their own experiences to support one another. A whole range of different community responses is available. Underlying all that, we need to be mindful that many of the issues that cause poor mental health are to do with income and access to housing so that we are able to deliver our service in a joined-up way. We are encouraged by that area of work, and we are starting to make some progress on it.

The Convener: Does anyone else want to comment on that?

Clare Haughey: Sorry—can I come in?

The Convener: Very briefly, because we have only a few minutes left.

Clare Haughey: When the committee was out in Drumchapel a few weeks ago, we met some of the link workers who work in the deep-end practices. The link worker scheme is going to be rolled out across the country. Eibhlin McHugh talked about people who present at GP practices being supported through their mental health difficulties. Have other areas been looking at doing that?

Eibhlin McHugh: I cannot comment on the level of activity in all the IJBs across the country, but locally—as I said—we have been doing work on that. The model that we use is very similar to the link worker model.

The Convener: The final question is from Miles Briggs.

Miles Briggs (Lothian) (Con): I want to pick up on the questions from Clare Haughey and Alison Johnstone and bring them together. Some of the GPs whom I have met do not have a huge amount of confidence when they deal with mental health issues, and there are very few tools available to help them. I asked one GP what was available on ALISS—a local information system for Scotland—for them to use, and they replied that they did not use it. The growth of social prescribing should be a huge opportunity to build more preventative opportunities in the health service, but it does not seem to be happening. I would be interested to hear whether there is any work going on in the field, or where you think that there needs to be a change.

Mairi Simpson: I agree with you. Whenever anybody mentions developing a new directory, I start to twitch a bit, because that is not what is needed in a 10-minute appointment. GPs do not have the time to look through a directory and say, "What about this organisation?" That is where the link workers are ideal. A link worker can take an hour and explore what is going on for someone, and physically support them into a local service. Most people do not need a psychologist. Tier 2 community-based support—often run by the voluntary sector—is ideal for a lot of people. Having those workers to support GPs is really important.

We have also developed a local mental wellbeing drop-in, so that GPs can refer people or encourage them to go. A person qualified in mental health sits with them, looks at their immediate needs, does an assessment and physically supports them to go to the likes of Pink Ladies 1st, Women's Aid or group work at the Orchard centre, which is our main voluntary sector health and mind organisation.

I agree that a 10-minute consultation is really hard for GPs. If they do not know about Pink Ladies 1st—what the organisation is, what it does and how it operates—they are unlikely to refer people there, whereas an intermediary can make a big difference to the person. Often people who go to a GP do not want a prescription. The approach looks at social support, but an intermediary is needed.

11:45

The Convener: I promised Richard Lyle that we would do a whirl round the table at the end, to ask whether there is one policy area in this field that witnesses would like to introduce or expand, and whether there is one that they would reduce or get rid of. I know that that is simplistic, but we are looking at where the committee will take the inquiry, so it will be food for thought for us on where we go. I start with Eleanor Hothersall.

Eleanor Hothersall: I get the hard job.

The Convener: You get the best one. You have all the choices.

Eleanor Hothersall: I am now going to completely ignore your instruction—

The Convener: Sounds familiar.

Eleanor Hothersall: —and reflect on what Mr Lyle asked earlier. I have had time to think about his question, and I have reflected on how so much of what happens at the moment is chasing targets. Dr Irvine's submission mentions the four-hour target in A and E as an example; the target for breast screening is another. It feels as if we have sacred cows that nobody is willing to unpick. Rather than telling you what to do more of and what to do less of, I give you my mandate to unpick targets a bit more, and perhaps set aside the political motivations for some of them and go back to the evidence.

Professor McCartney: On what to introduce or expand, I would use more regulation of the food industry and food chain to improve health. On

what to reduce, we have heard proposals looking for various interventions for which I am not sure about the evidence base. I would reduce the drive to find novel, unique and new interventions that are not evidence based. I urge you to stop always looking for the novel. If we are going to try something new, let us do it in an experimental context to find out whether it really works.

Professor Bell: I agree with what Gerry McCartney has said. To expand my brief a little, I note that top of the list in the national performance framework, which Gerry mentioned, is sustainable economic growth. We have talked a lot about trade-offs; those get a lot easier when we have more tax revenue, so a key issue for the compression of morbidity is to have more older workers in the workforce. Scotland has had a huge expansion in the number of people aged 55 and over who work—it has been a great success story in the past few years. The health system can lend support to the sustainable economic growth that in turn will relax the hard trade-offs between acute care and social care and so on that we discussed.

Professor McElvenny: I echo my earlier point that, as well as interventions, we should learn to increase our evidence base and understand more about what causes certain diseases.

Neil Craig: I support what Eleanor Hothersall and Gerry McCartney have said; my emphasis would be to look at the cost effectiveness and effectiveness of preventative interventions, and to consider their potential to reduce health inequalities rather than make savings, given all the issues in relation to savings that we have discussed. To pick up Richard Lyle's point, we need a review of the current regime of targets and indicators to ensure that they are consistent with an evidence-based preventative agenda.

Eibhlin McHugh: I will say two things. First, let us make sure that we are still paying attention to the messages in the Christie report about collaboration at local level and that we focus on the needs of communities and work together, with honest conversations about prevention. Secondly, let us recognise the limitations of working in professional silos; we need holistic approaches that embrace people's social circumstances as well as the things that professionals can do to support them.

The Convener: Does Mairi Simpson have final comments to make?

Mairi Simpson: Oh, sorry—that was a joint comment from Eibhlin McHugh and me.

The Convener: And I never even saw your lips move.

Fraser McKinlay: I do not suppose that I will get away with saying, "Everything that the other witnesses have just said," convener. I have a simple suggestion; it is a plea to people not to use jargon all the time. The language that we use around all this is problematic, particularly when it comes to engaging with the public. That is something for all of us to bear in mind.

My second suggestion is about the money—that is not surprising, coming from me. We need to renew and redouble the expectation that public sector partners at local level should figure out how much money they have, what buildings they have and what skills they have, and then make much better use of those, collectively, for the good of their communities, rather than continuing to operate individually.

The Convener: Thank you. We can expect Audit Scotland reports to be jargon free from now on. That is excellent.

Fraser McKinlay: I will try.

The Convener: Good luck with that.

The next step in our inquiry will be a committee debate in the chamber, in which all members can take part. After that, the committee will consider how we take the inquiry forward. If people have not already done so, I urge them to respond to our call for evidence, which would be helpful.

Thank you all for your attendance.

11:51

Meeting suspended.

11:56

On resuming—

NHS Governance

The Convener: Item 3 is an opportunity for members to consider the main themes that arose during our informal session on NHS governance this morning.

Ivan McKee: I heard a lot this morning, and probably three issues stuck out—I am sure that members will come up with others. First, there was a feeling that the complaints process is, in many cases, unresponsive. People said things like, "As soon as they hear there's a complaint, the walls go up and you cannot get through to them."

Secondly, people talked about person-centred care and the need to think about the broader picture of the patient, rather than just considering the specific medical condition and what is wrong with them. People felt that there had been some progress on that, but there is still a long way to go.

Thirdly, variability of service seemed to be an issue. There seemed to be a lot of variability between health boards and between services within a health board.

Alison Johnstone: On the point about complaints, people in the group that I spent time with were clearly seeking a middle way, or a different way. They said that, in many cases, they just wanted someone to speak to who could fix the problem that they faced; they did not want to go through the complaints system. That was their great frustration: there was a problem and, instead of someone being available to talk to them, they had to go through the complaints process. That came over loud and clear.

Several people had experienced a review of medicines when things had got to the acute stage. One person said that they had gone from having 17 tablets a day to five, which had had a positive impact, although it had taken a long time to get a review. There were cases of people being on medication for almost two decades that they subsequently discovered they should not have been on or did not need. That also came over loud and clear.

The Convener: There seemed to be a lot of frustration about complaints and the process of accessing the system, finding out who to speak to and getting an answer. One of the participants said, "You've more rights and ability to complain about a tin of peas than you have to complain about your healthcare," which I thought was a telling comment.

People also talked about boards' decision making, in particular about service change. They described the secrecy with which boards operate and thought that boards might attempt to confuse people by hiding decisions in 600-page agendas that go before committees. Someone talked about trawling through 600 pages to find out what the board was trying to cover up, which was another telling comment. Board governance and operation was certainly a theme.

Individuals raised a number of points about how their care was addressed. If people have multiple conditions and multiple appointments, they have to go back and forward to the hospital, rather than going in and getting all their issues addressed on one day. The co-ordination of that is difficult.

12:00

A further issue was about the centralisation of services. People felt that they were excluded from having a say in the development of services and that there is a lot of tokenism in the process. People felt that they did not have a genuine say in what happened.

A load of other issues came up about good practice at certain health centres and general practices where people felt that they were getting good service. It was not just a group of patients complaining; they were being constructive in their comments and I found the discussion helpful.

Clare Haughey: I also picked up on that. People need to hear that we are listening to their difficulties, but I asked each group what areas of good clinical care there were, how they could be expanded on and what made a good episode of care or interaction with the health service. Everyone across all the groups said that it was about the one-to-one aspect—being heard, being listened to and feeling that the healthcare professional had time for them. That was telling, because those people had had interactions with lots of different parts of the health service, not just one particular department.

Miles Briggs: I will make a wider point. From the limited time that I have been an MSP, I have found it quite shocking that we need to build people's confidence that they can influence the health service when changes are happening. It is sad that, too often, people feel that the health board is judge and jury, that it has decided what will happen and that it will make the facts fit an argument.

I have been involved in the campaigns against the centralisation of Edinburgh's cleft lip and palate surgery unit and the closure of the centre for integrative care in Glasgow. It is sometimes difficult to reconcile the evidence that campaigners put forward with the decisions that the people on the health board make. We need to focus on changing that in NHS governance so that people

have confidence in the health service. There are huge changes to make in the health service in future, but we need to get that right so that people are sure that their voice is not only listened to but heard.

The Convener: A number of us have scribbled notes. I have loads here that I will pass on to the clerks so that we take account of people's comments. We also had Parliament staff taking notes so we will capture all of what people said at this morning's informal meeting. I put on record our thanks to the people who came in for that meeting. It was not easy for many of them to travel but it was much appreciated and very helpful.

We agreed at a previous meeting that we would go into private for the next item, so that is what we will do.

12:03

Meeting continued in private until 12:23.

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