OFFICIAL REPORT
AITHISG OIFIGEIL

# Health and Sport Committee

**Tuesday 9 May 2017**

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 9 May 2017

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## HEALTH AND SPORT COMMITTEE
**12th 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)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Julie Carter (NHS National Waiting Times Centre)
Emilia Crighton (NHS Greater Glasgow and Clyde)
Mike Higgins (NHS National Waiting Times Centre)
Dr Helene Irvine
Dr Una MacFadyen (Royal College of Physicians of Edinburgh)
Dr Margaret McCartney
Mark McDonald (Minister for Childcare and Early Years)
June Rogers (NHS National Waiting Times Centre)
Jill Young (NHS National Waiting Times Centre)

**CLERK TO THE COMMITTEE**

David Cullum

**LOCATION**

The James Clerk Maxwell Room (CR4)

# Scottish Parliament

## Health and Sport Committee

*Tuesday 9 May 2017*

*[The Convener opened the meeting at 10:00]*

## Preventative Agenda

**The Convener (Neil Findlay):** Good morning and welcome to the 12th meeting in 2017 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones have been switched to silent. You can, of course, use them for social media but not for taking photographs or filming proceedings.

Agenda item 1 is an evidence-taking session on the preventative agenda. I welcome to the meeting Dr Una MacFadyen, a consultant paediatrician at Forth Valley Royal hospital and a fellow and member of the college council of the Royal College of Physicians of Edinburgh; Dr Margaret McCartney, a general practitioner; and Dr Helene Irvine, a consultant in public health. We are due to be joined by Emilia Crighton, the head of health services in the public health directorate at NHS Greater Glasgow and Clyde.

We move directly to questions, the first of which is from Alison Johnstone.

**Alison Johnstone (Lothian) (Green):** Good morning, and thank you for joining us. I see common themes emerging from all our witnesses' written submissions. For example, in Dr Irvine's submission, she says that, as a result of the demand that we are facing, we need to prioritise and that

"no area should be exempt from scrutiny or regarded as sacred".

Indeed, the breast screening programme is discussed in those terms in the submissions from Dr Irvine and Dr McCartney. How is evidence that counters current practice discussed in Scotland, and how are decisions either to continue or to discontinue programmes that might not be cost effective made?

**Dr Helene Irvine:** That is a very good question. With regard to the breast screening programme and, indeed, most of the other major screening programmes, the decisions are really made by a United Kingdom-wide screening committee and are then implemented by Scotland. In a bigger piece of work that I carried out on data that is routinely collected in Scotland, in which I voiced my concerns about how we were adopting policies from England, I highlighted the same issue and expressed my fear of our sometimes implementing policies that are decided south of the border. I suspect that, when it comes to the breast screening programme, we do not review all the evidence in Scotland and then decide what we are going to do; instead, we follow the UK National Screening Committee.

**Alison Johnstone:** Is that your view, too, Dr McCartney?

**Dr Margaret McCartney:** Yes, I think so. The UK National Screening Committee is a very good organisation, but one might almost say that it franchises out parts of its remit to look at evidence. There is, for example, an advisory committee on breast cancer screening. However, what I am concerned about is that, for some time, there has been no good cost-effectiveness analysis, particularly with regard to opportunity costs—in other words, the amount of time that we spend doing one thing when we could be doing something else of more value.

The other big question is how good we are at sharing decision making with regard to not only breast cancer screening but all forms of screening in Scotland. After all, the matter is devolved. I do not think that we do this work well or thoroughly enough, and I do not think that we do it with the attitude that, if we find that something is not working, we should interrogate the evidence and ask whether we should simply stop doing it. For example, there is quite a lot of evidence that says that the keep well health check programme does not work, does not improve quality of life and does not extend life. I would therefore ask why we are spending so much money on that when we could be spending the money on other things that we know really do work. Opportunity costs are a huge issue, because if there is a limited amount of GPs and GP time and you ask them to spend money on stuff that does not work, that means that we are not doing the things that work and which really make a difference to people's lives. As I have said, that is a huge issue, and it has been sailing under the current without being interrogated properly for decades now.

**Alison Johnstone:** Obviously stopping such a programme would be a politically difficult decision. I see that it has been questioned in other countries—I note, in particular, your evidence about Switzerland—and I know that there is a view that it just got past the last UK review, which was carried out by Sir Michael Marmot. If we were to look at the matter more discretely and with a Scottish focus, might we come to a different decision?

**Dr Irvine:** I do not see how a Scottish perspective on the matter would be any different from an English perspective. It should be looked at, and anyone who looks at it objectively will

conclude that it is not a good idea to do it at a universal level.

Targeted screening should be considered for high-risk women, because the return for the effort is higher and the risks incurred are lower, and therefore the cost benefit ratio is better. I do not think that a Scottish analysis would be any different, other than that, in terms of the statistics, it would be about 11 per cent of the UK figure. The beauty of the UK-wide approach is that we are looking at a bigger sample size. If we did it at the Scottish level, we would be looking at a much smaller number of women screened and lives saved and so on. I think that it should be looked at UK-wide. It would be odd if Scotland went ahead unilaterally and tried to scrap the programme, leaving England carrying on with it. It is one of those very sensitive issues where it would be awkward to try to go it alone.

**Alison Johnstone:** There is some evidence in the submission about how the programme originated in the first place, under Margaret Thatcher's Government.

**Dr Irvine:** Can I add something about that? In 1989, I did the master of public health course at 1 Lilybank Gardens in Glasgow with Professor Jim McEwen. We studied all the reports in detail and, even then, many of us on the MPH programme had major concerns about the screening programme. In fact, that same year, Maureen Roberts, a breast physician from Edinburgh who had spent 10 years looking at the subject and had advocated going ahead with the screening programme, wrote in *The BMJ* that she suspected that it had been an error of judgment. That was published posthumously. I have those papers with me and the material from Maureen Roberts makes compelling reading from the dead—the fact that a woman who had devoted her career to breast screening and breast pathology died from the disease and then wrote in the last months before she died that it had been a mistake to advocate a national screening programme. She cited all the criticisms of the programme. That was 1989—just one year after the decision was made by the Tory Government of the day to go ahead, possibly because it would be a vote winner among women. It worries me that there was a political dimension to the programme, and then one of the Scottish experts expressed concern about it in the months before she died from the disease.

**Alison Johnstone:** You spoke about having a more targeted approach and making sure that we are seeing high-risk women. Concerns are raised about the worried well and the amount of resources that are used inequitably. I would like to understand how we make sure that we reach the high-risk women. You say in your submission that any new model is doomed to fail if it does not have GPs at its heart. I suppose that GPs are essential. We have heard concerns from GPs at the deep end about the inequity in funding. Will you expand on that, please?

**Dr Irvine:** Let me answer your second question first. I have done a major piece of work on the funding of the various components of the national health service, and the amount of money that we are spending on hospital consultants, GPs, district nurses, social care, the elderly and so on, and I have major concerns about the disinvestment in general practice. I believe that, at the moment, the entire NHS is at risk because of progressive and on-going disinvestment since 2006. I do not see how we can expect GPs to pick up early signs of cancer in patients who already have the disease. I do not see how GPs can promote health and discourage patients from smoking and drinking too much and so on—all the things that we know would have a high return on investment. We know that people are more likely to listen to such messages from their GP than they are from anyone else. It is bizarre that we spend vast sums of money on something like breast screening, which exposes all women aged 50 to 70 to radiation every three years, generates a huge false positive rate and has a very high screening-to-life-saved ratio, yet we disinvest progressively in GPs. The breast screening programme is one of many public health programmes. You may think it odd that a public health doctor would question some of those initiatives, but we need to review all of them and see what we are getting for the money, what potential harm we are causing and whether we are contributing to health inequality, which I believe we are.

On the first part of your question, I am not an expert on breast screening and how you would go about targeting, but it would probably involve genetic markers. You would identify the women who have family history and are positive for breast cancer markers. If you focused on those women, you would get a better return on any kind of routine screening.

**Ivan McKee (Glasgow Provan) (SNP):** I thank the panellists for coming.

Taking a wider perspective, I am a wee bit concerned that we talk about prevention but we jump straight in and start talking about screening as if screening equals prevention and vice versa. To my mind, prevention goes much wider than that. Dr Irvine makes that point in her submission, but she also says that

"preventative medicine as we think of it in public health terms"

does not include what I would consider to be the main part of prevention, which is what GPs do—in other words, the upstream stuff. Therefore, I am

bit concerned about the terminology. I think that we need to refocus on the wider concept of prevention, which is about doing stuff earlier to stop other things happening later.

I want to focus on the cost side and to find out what data and mechanisms we have for judging the effectiveness of interventions. You use words such as “huge”, “substantial” and “considerable” to describe the costs. You have included some data—from a quick look at that, we are talking about a spend of £250 million. That sounds like a big number, but it is less than 2 per cent of the total health service spend in Scotland, so it is not a big number in the overall scheme of things.

I also want to explore Christie’s idea that 40 per cent of public sector spend is potentially preventable if we take action upstream. I want to find out what mechanisms are there that allow us to do data crunching that enables us to say, from a financial point of view, “Doing this works,” whether we are talking about screening, investment in GPs, investment in primary rather than secondary care or whatever. That is the nub of the issue. What tools and mechanisms are there to allow us to make proper, quantified, evidence and data-driven decisions on preventative spend in the wider sense?

**Dr Irvine:** Are you asking me?

**Ivan McKee:** I am asking anyone who wants to answer.

**Dr Irvine:** Does anyone else want to have a go at that?

**Dr McCartney:** The committee asked which areas of preventative spending it would be most useful for it to investigate, and I addressed that in my submission. I am interested in putting resources where they work. If we do not have evidence-based policy making in the NHS, we are sunk. I am worried that we are throwing good money after bad again and again. You might say that it is only 2 or 3 per cent of the health service spend, but those small numbers add up and make a big difference.

For example, when it comes to the general practice service, how can we do more work in the community when we simply do not have enough hands-on staff to do that? If we do not have the number of district nurses that we need, we cannot allow people to have a good death at home. The existing district nurses cannot simply multiply their number. Our health visitors are now working horizontally across practices. We are putting at risk the primary care team, which we know has had huge benefits with regard to vaccinations and so forth as a result of women and families having long-term relationships with the staff in that team, whom they know and trust.

You asked where the data is. There is a lot of data, but there is a lot of data to tell us that we are doing stuff that does not work and which wastes money and causes harm. With breast cancer screening, for example, the big issue is overdiagnosis. Early diagnosis sounds so attractive. The idea of having a health check and picking up on something early so that we can make a difference is incredibly attractive. It is a political vote winner—over many generations, politicians from many parties in many areas of the world have used it, but the problem is that it is not possible to get full information about the process from a soundbite.

**Ivan McKee:** I understand that. You say that we need to be data driven in our decisions, but you say that we are not. I want to get at the data on where you would spend the money. If you say that we should spend it on nursing or whatever, what data do you have to show that that works from a preventative spend point of view? What analytical mechanisms are in place to understand where we should spend the money?

**Dr McCartney:** Are you asking about randomised control trials or systematic reviews?

**Ivan McKee:** I am asking about evidence on spend.

**Dr McCartney:** There are good Cochrane reviews that show that people who live in high-quality housing that is not damp and cold have fewer asthma exacerbations.

**Ivan McKee:** Can you point to the financial evidence for that?

**Dr McCartney:** I would need to go back and look at the Cochrane review. You can google it; I think that it involved studies that were done primarily in New Zealand, but some were also done in England.

**Ivan McKee:** A lot of people say that we should do this rather than that, but I am trying to find out what data-driven analysis is available that says, “If we spend X hundred million pounds on nurses, we will save X billion pounds in that area.” Where can we find those numbers?

**Dr McCartney:** You need a health economist to answer those questions. If you wanted that kind of answer it would have been useful to have the questions framed like that. Then I would have spent more time doing what you wanted and giving you the data that you were looking for—it is completely possible to do that.

**Ivan McKee:** Okay. That is fine.

10:15

**Dr Irvine:** Can I try to answer now?

**Ivan McKee:** Of course.

**Dr Irvine:** You did not think that the sums of money that we are currently spending are very big, because they are not a large percentage. I think that what we are spending is a lot of money if it is not giving us a sufficient return on the investment. The evidence for that is the rising index of inequality—the fact that the gap between rich and poor in terms of life expectancy is increasing every year. Mortality rates are falling for both rich and poor, but the gap is getting wider every year.

One obvious failing of our current strategy is that we are spending that £250 million but we are leaving the poor behind. The most cost-effective way to improve public health is to reduce the gap in income, wealth and opportunity between the rich and the poor. I am sure that most of you will have read "The Spirit Level" and the subsequent book by Richard Wilkinson and Kate Pickett. I do not want to seem simplistic, but that really is the essence of public health.

If we reduced that gap deliberately, we would improve on hundreds of parameters. We have to focus on that. Once we remove the focus from that gap and start introducing a myriad of other approaches, we get distracted and we create a lot of false positives. The hospital is focused on dealing with all the breast lumps that have been identified and all the false positives in that cohort, and we lose sight of what needs to be done, which is ensuring that the gap is minimised.

**Ivan McKee:** Suppose that we had nothing that was on that list—pandemic flu, health screening, tobacco control, alcohol misuse, health protection and the whole lot—what would you spend the £250 million on and what difference would that make?

**Dr Irvine:** I would not just cancel a lot of those things. I would also look at the huge wastage in what is spent on responding to unnecessary admission to hospital. Because we have starved general practice, district nursing and social care of the elderly, we have a much higher emergency admission rate than we should have, we are having to pour money into more accident and emergency physicians, acute physicians and staff for the hospital, and we do not see that. It is obvious; all we have to do is plot the data—the emergency admissions and the compliance failures in A and E—and we will see that those coincide with clusters of very old patients. The reason why the old patients are pouring into A and E is not demographics—it is because we have cut back on GPs, district nurses and the social care of the elderly. That is data driven, and I can absolutely demonstrate it.

**Ivan McKee:** Are you able to quantify that? If we spent another £100 million—

**Dr Irvine:** I did not show you that data because you were asking me about preventative spend. I chose the breast screening programme as one example among others that we need to review to see whether we can liberate some funds. The big money is being spent in the hospitals, and we could shed a lot of that if we reduced the demand for it by providing a strong community-based service, which we do not have.

**Ivan McKee:** There are two parts to that. One is about screening; if we stopped screening, how much money would that save?

**Dr Irvine:** Whatever is spent on the screening, which depends on which programme it is. However, I am not suggesting that we cancel all the screening programmes.

**Ivan McKee:** So you do not have a number for that.

**Dr Irvine:** I am suggesting that we review every one of the screening programmes to see what we are getting for the money—its cost effectiveness—and, if that does not stack up, we should consider toning the programme down.

**Ivan McKee:** But you do not have any numbers on how much that would save.

**Dr Irvine:** No. If you look at my submission, I said that we need to review the programmes.

**Ivan McKee:** Right—so you are taking a view on that without the data.

**Dr Irvine:** I am looking at the data. I looked at the Marmot inquiry, which reported that it is estimated that, in the whole of the UK, screening would save 1,300 lives from breast cancer. At least 200, but up to 1,000, women would need to be screened to save each life, but three—or, according to other studies, up to 13—of those women would have an unnecessary mastectomy or lumpectomy, with or without other treatment. It depends on the studies that are looked at. I think that those numbers need to be examined; they are not good enough and I do not think that that is a public health approach—it is an interventionist approach.

**Ivan McKee:** Coming back to preventative spend, you do not have any data on how much we would save if we did not run the screening programme.

**Dr McCartney:** Part of the problem is finding out what things cost. I have published material recently on health screening, and we found wildly different answers from different health boards giving different figures. Part of the problem is that the data is so fragmented—the costs are not fully inclusive. For example, opportunity cost is hardly ever examined—pharmacy time, patient time and, in particular, patient burden. Gathering data on

this would be a PhD thesis in itself. The data is almost impossible to find—that is one of the problems. I emphasise again that opportunity cost is almost never examined. You can state the cost of the drugs and the cost of supplying a certain number of staff for a certain time, but the distraction that is caused is a fundamental problem, and that is not examined.

**Ivan McKee:** Some 160,000 people are employed in the health service, and we spend £13 billion on it. It is concerning that we cannot find someone to do the number crunching that would enable us to understand where the money is being spent. That looks like a problem to me.

**Dr McCartney:** It is difficult to get the data. You will find that academics, probably working in their own time, have published writings about small areas. However, it is remarkably difficult to get coherent numbers across the whole of Scotland. The other problem concerns cost-effectiveness analyses, which are rarely done independent of the organisation that is funding the work.

**Emilia Crighton (NHS Greater Glasgow and Clyde):** In terms of assessing the cost of programmes, they have been designed to be embedded into delivery of the NHS, which means that it would not be difficult to find out how much we spend. As a screening co-ordinator, I know exactly what staff we employ to deliver what we do, so finding the data is not impossible.

The UK National Screening Committee is tasked with reviewing evidence—it commissioned the Marmot review. If there are any issues, it is up to the National Screening Committee to go back to the evidence and look at cost effectiveness.

Helene Irvine identified the value of the lives that are saved through screening and, through the National Institute for Health and Care Excellence, we have information about value for money in terms of how much it costs to get any outcome, whether it is a life saved or an improvement in the quality of life.

We have seen, particularly through screening programmes, that the way in which humans are designed means that if we save a person from one disease they will simply get another one. For example, California has saved coronary care beds through preventative measures on coronary heart disease, but now people there are finding that they have to do more joint replacements because degenerative conditions kick in as people age. It is up to us to decide what is worth doing. Certainly, it is worth our while to extend life by preventing people from dying young from diseases that are highly preventable. However, having grown up in communist Romania, I can say that the fact that we were all equal has not stopped us from smoking and drinking excessively and from dying young as a result of preventable diseases. We have to strike a fine balance.

**The Convener:** Could you provide the committee with the data that you have on costs?

**Emilia Crighton:** We can send that to you.

**Dr Una MacFadyen (Royal College of Physicians of Edinburgh):** I would like to add a small point to pick up on Ivan McKee's question about prevention versus screening, and to mention some positives that have been shown in respect of prevention. In relation to breast cancer, there is a positive in terms of breastfeeding. You will see from the Royal College of Physicians's submission about early intervention that there is good evidence to show that breastfeeding reduces the risk of breast cancer. That evidence includes data from the Unicef "baby friendly" initiative. Breastfeeding could be viewed as a preventative measure against breast cancer that costs nothing but the mum providing milk for the baby.

We could reduce the risk of people developing a disease by pushing positive messages rather than the potentially negative message that says that we will catch people when they show early signs of a disease. A number of initiatives that are not specifically related to screening programmes could be positive preventative measures.

Another point to make about data collection is that there is little uniformity among health boards in terms of how data is collected. If you are going to ask a question that covers the country, it is important to ask the right question so that you not trying to draw data from answers that were provided for different reasons. It is also important to make collection of data easy and part of what is done routinely so that we do not employ people just for data collection, and that the information technology facilities that ensure that that happens are provided. Differences between health boards' IT systems interfere with the reliability of data.

**Dr Irvine:** Breastfeeding is much more likely among the privileged classes, which is another reason to try to improve the economic welfare of the people at the bottom end. In my view, it is a bit cheeky to expect people who are really struggling, who are not well educated and who are not employed or do not have meaningful employment to adopt healthy lifestyles and to breastfeed. Anyone who has done it knows that breastfeeding is not easy. It is inconvenient at times, and if someone is trying to breastfeed fully their husband cannot just give a bottle. Having breastfed two children myself and having witnessed my daughter doing it recently, I know that it is something to which one has to be really committed. It is also very difficult to combine it with having a job. The idea that we can just get everyone to breastfeed when people are struggling and have major

financial worries and housing problems is, I think, cheeky and unrealistic.

**Alex Cole-Hamilton (Edinburgh Western) (LD):** Good morning, panel. I am glad that Dr MacFadyen made that observation, because it feels slightly incongruous to me that we are looking at screening as part of our preventative agenda. For me, screening means catching things after they have happened, although it is early intervention. In political circles, we often conflate early intervention and prevention and think that they are the same thing; actually, we need to get to the issues before they get out of the traps. I guess that some screening could pick up DNA profiles that might show that people are more susceptible to certain conditions, which could be preventative.

My question relates to health inequalities. Dr Irvine articulated the issues well when she talked about communities in which breastfeeding is less likely because of social deprivation and various factors around that. I would like to explore the uptake of screening opportunities. We do not screen everybody: it is voluntary and nobody is mandated to be screened. As a result, the demographics will include a heavier weight of the worried well than of people from populations that are perhaps more at risk of some conditions, given their lifestyle factors. How do we fix that? A lot of time, energy and resource are spent on checking people who keep themselves pretty well anyway, who probably know how to check themselves for lumps and who are fine, whereas a nucleus of people in deprived communities, who do not necessarily open their mail and who do not see that there is an opportunity to be screened, do not take up the opportunity.

**Dr Irvine:** Are you basically asking me to advise how we could increase uptake of screening programmes among those who are at highest risk?

**Alex Cole-Hamilton:** Yes.

**Dr Irvine:** I suppose that I would backtrack and say that I do not want to promote screening generally unless there is a very sensitive and specific test. That brings us to the breast screening programme. In my opinion, it is not good enough. It creates some false negatives and a lot of false positives, so spending even more money, time and effort on trying to target the quarter of the population in which there would be a better return is not the way that I would go. I would emphasise primary prevention. Alex Cole-Hamilton hit the nail on the head when he said that screening is picking up disease that is already there, so it is what we call secondary prevention. That was outlined in the submission by my health board, NHS Greater Glasgow and Clyde. By the way, I need to remind everyone that I am not representing the views of my health board today, but am here as a consultant in my own right.

I would not want to go down the route of promoting screening; I would want to promote a healthy diet. I would not do that by telling people repeatedly what to eat and what not to eat, which is not working; I would do it by having a public health protective policy on, for example, trans fatty acids in chip fat. I would even regulate the amount of salt that is allowed to come out of the salt shaker in your chippy and I would regulate the amount of salt, sugar and fat in junk foods. We have far too many types of junk food to choose from and far too many types of alcohol that are available too close to us physically—we can buy it anywhere. People spend too many long hours in the pub. When the licensing laws were changed to make it easier to drink at all hours, I thought that that was one of the most bizarre things that the Scots could do. Given the existing problematic relationship that the Scots have with alcohol, why would we make it even easier to drink?

I believe in primary prevention, but I do not believe in relying on health education, which we know is not working because we can see the inequality gap getting wider. I believe in reducing the gap proactively using taxation and a range of other fiscal policies. There is a report by Chik Collins—"Working-class discourses of politics, policy and health: 'I don't smoke; I don't drink. The only thing wrong with me is my health'"—which is about people who are unhealthy because they are poor and stressed. That approach is the way to go; I absolutely fervently believe that, and I am not going to change my mind.

10:30

I have been in public health for 26 years. In 1989, I was doing my master of public health degree, and I had been in the UK for five years, having left Canada. I despaired when I heard the plan for Scotland in 1989—to hire an army of health improvement officers who would have no contact with patients and who would produce boxes of leaflets to be distributed to people who would not read them. The leaflets sit in general practice surgeries and often do not even get used. I despaired because I knew that the solution was meaningful employment, not complex benefit systems—meaningful employment through which people could live on the wage that they were paid. It is as simple as that.

You do not need to hire consultants like me; you just need to reduce the gap and everything will improve, including mental health and physical health. If you read "The Spirit Level", you should be persuaded. If you have not read that book, you need to do so.

**Alex Cole-Hamilton:** Wow! Thank you for that. That was very compelling. It is very much grist to the mill of members around the table who would like the committee to produce an obesity bill to tackle some of the practical issues that you describe.

As I said, your evidence is very compelling and I find that I have been educated by what you said about how, in some cases, screening may be a false flag. It may be a comfort blanket for politicians and the wider public to be able to say that decision makers are doing something about breast cancer when, actually, we are not. We are just spotting cancer in a few people; we are not preventing it in anybody. That was really helpful. Thank you.

**Dr Irvine:** I will just say one more thing about something that has bothered me slightly. When I looked at the routinely collected data for my health board, the most common medical elective diagnosis—that is, reason for admission—in all the medical elective work was breast cancer. It may only be 2 per cent of all the medical elective admissions, but we are talking about tens of thousands of admissions, of which the commonest was the medical elective for breast cancer. To me, that is a symptom of our focus on the breast screening programme and the general obsession with lumps. Unfortunately, breasts are lumpy, so if you become obsessed with trying to prevent every death from breast cancer, you end up treating a lot of lumps that do not need to be treated. You then get what I have just pointed out—breast cancer ends up being the commonest medical elective admission.

I submit that it will be difficult to measure the actual cost of the breast screening programme because you have to measure the cost of the lady coming in and being worried about it, having a lumpectomy that she does not need, taking time off work and so on. There is also the fact that it is difficult to feel the breast thereafter because there is a big scar on the breast where the lump has been taken out. All those costs are impossible to measure. That is why, overall, I concur with Margaret McCartney: apart from the financial costs of the screening programme, you have to measure all the other unforeseen costs, and there are impossible-to-measure costs.

**Dr McCartney:** I worry—in respect of breast screening and the health checks programme—about exactly the point that Alex Cole-Hamilton made. People who are at low risk present themselves—the healthy-attender effect—so we automatically think that we are doing some good, because we pick up stuff early. However, that would have happened anyway; people would have had good treatment. The problem with breast cancer screening and, to a certain extent, health checks, is overdiagnosis. Bona fide cancers that would never have progressed to being invasive cancers that would have done harm are diagnosed through the breast cancer screening programme. The problem is that if that effort is focused on women who are well-off and already have long life expectancy, you are putting into that group more resources that can then never reach other groups in society.

What was said earlier about true preventative healthcare is exactly right—it is outside healthcare. It is about social justice, fair food laws, tobacco laws, active commuting, being able to play outside with your kids knowing that you will not be run over by a car, safe places to work, fair laws and fair employment laws. It is about fair play from Atos Healthcare and the Department for Work and Pensions: the absolute carnage in the benefits system has created so much stress and hassle for my patients that I am daily heartbroken by its effect on people.

All those things have a profound effect on health, but I am unable to influence them as a GP. I am happy to come to the committee and tell you about them, but I would love to see the committee take flight and start to say that to get real preventative healthcare, we need far more than the NHS.

**Emilia Crighton:** On discrepancies in uptake in screening and picking up on Helene Irvine's point about education, I say that affluent people understand the health messages that we put out. In Glasgow, we developed campaigns to promote screening programmes, including the cervical cancer screening programme, which we tested on the least affluent people. What happens time and again is that there is lower uptake among the people who most need the programmes. There are wider influences at play that prevent the least affluent people from engaging with the programmes that we promote.

The only way to be effective is to have policies that make the right choices easy choices. With regard to breast screening, for example, we know that obesity is a factor that drives breast cancers, that breastfeeding is protective against them and that a number of cancers appear because of the amount of alcohol that women drink. There are, therefore, primary preventions or interventions that can be made. However, even if we have effective obesity policies that involve people having the right foods with reduced calorie density and the right nutrients, we will still in 20 years be arguing about whether it has made a difference, or about how much money we have spent, because if something does not appear, we cannot count it and we do not know what made a difference.

The reality is complex because it is hard to attribute causality to a lot of interventions. Aside

from in the breast screening programme, we have seen that in screening programmes including triple A—abdominal aortic aneurysm—screening, for which we had randomised controlled trial evidence on its effectiveness. We put that programme in place in Scotland, but because of the changes in how we dealt with cardiovascular disease and the preventative agenda, we did not find the number of cases that we expected, luckily: the world had simply moved on.

The issue is how we get smart and understand that the world is constantly moving on, and that what we believe will deliver might not deliver in a new context, or might give us something very different to what we expect. We need a constant process of reassessing what we do and adjusting our efforts.

**Dr Irvine:** Can I add a point?

**The Convener:** Very briefly.

**Dr Irvine:** Ivan McKee focused on data-driven evidence. Although I spend most days analysing data—more so than most consultant colleagues, because I am particularly focused on data analysis and routinely collected data—I would accuse him of being excessively impressed by a data-driven approach. Some of this is just plain common sense. If we made it harder for people to eat rubbish and drink alcohol, a whole range of things would improve; for example, there would be less ischaemic heart disease and there would be lower incidence of about 15—maybe even 25—types of cancer. We also know that tobacco use causes about 25 to 30 different types of cancer and that obesity is a major risk factor for breast cancer, as Emilia Crighton has just said. If we reduce the ability of the public to eat rubbish and high-fat foods, we will improve health and reduce the incidence of a range of diseases. There would be no chance in heaven of measuring perfectly, or even remotely closely, what the impact would be, but if we were to improve the obesity situation, we would improve the situation in a range of diseases, including diabetes. I do not need a data-driven approach.

**Ivan McKee:** But we know that stuff only because the data tells us it.

**The Convener:** Ivan.

I sense that you have seen the committee before, Dr Irvine.

**Dr Irvine:** Sorry.

**Tom Arthur (Renfrewshire South) (SNP):** Good morning. I have a supplementary question on a specific matter. I very much appreciate the points that you are making, Dr Irvine, but do you not agree that unhealthy lifestyles that involve a propensity to drink excessively and to eat poor food are in themselves symptoms of economic inequality, low pay, alienation—to use an old-fashioned word—and the dehumanising effect of precarious work? Simply removing access to cheap alcohol and food would not take away what motivates people to pursue those things. Can you comment on that problem and tension?

**Dr Irvine:** First, I point out to you that middle-class people also pig out and drink too much alcohol—and are doing so increasingly. It is therefore not just a problem of the poor and the unemployed. However, I agree generally, because I have always focused on the poverty issue first because it is about social injustice. That is why I keep banging on about “The Spirit Level”. We have to examine why living in this world is stressful and why a substantial minority are being left behind. That is how we should really tackle public health.

On top of reducing the gap between the rich and the poor as regards income, wealth, opportunity, education and so on, we also have to introduce a protective public health policy, which is why I am very proud of the Scots for beating the English in banning smoking in public places. That was a fantastic piece of legislation, and we did it first in Scotland.

We have to use a number of approaches, including good-quality health education that is available nationally, and GPs promoting healthy lifestyles and identifying high-risk patients. However, our priority has to be reduction of the gap in income and wealth, and we must never forget that. If we do, we will end up going off at a bunch of tangents—which is what we are doing at the moment in having lots of different initiatives that give us a low return on our investment.

**Dr MacFadyen:** I am interested in the bias towards screening programmes and interventions. As a paediatrician, I am a glass-half-full person and have a lot of faith in children. We have seen preventive health initiatives that have worked because children and young people have adopted them. Taking the approach that, as well as the state helping and supporting them, everyone can help themselves, has a lot of potential.

The so-called “worried well” often miss the risks and benefits of the decisions that they make. Margaret McCartney commented earlier on giving people facts about the risks of interventions and screening programmes as well as about the potential benefits. From my perspective as a paediatrician, I see worried parents of children who are in various states from wellness to illness. Very often, giving facts on the benefits and risks of an intervention is important—and not just going for the programme that offers an intervention itself.

The Scottish initiative of the daily mile in schools has been an enormous success and has applied

to all children in all social groups. I see children and young people for whom giving them the respect to make the right decision for their own needs has had a hugely positive impact on their self-esteem and self-confidence and, in turn, their potential to be peer supporters of other young people to make change happen from the inside out. An example from some years ago is what Bathgate academy's pupils did in changing the attitude of their entire school to keeping themselves fit, because they owned the programme and took it forward for themselves. There are a lot of areas in which a different attitude towards preventive health could reap benefits for possibly a lot less cost than some of the major programmes that are in place at present.

**Emilia Crighton:** I want to pick up on the argument about environment and poverty driving people to drink excessively. As regards alcohol consumption, the most affluent people drink just as much as the least affluent people, yet we know that a male in the least affluent decile is 16 times more likely to die from that than is a person in the most affluent category. Unhealthy behaviours are pervasive in society.

It would be remiss of me not to mention the problem that we have in Glasgow with drugs including heroin and the new psychotropes. People who are fairly close to me have experienced the deaths of very young people in their families. From looking at the evidence, I say that what works is offering young people alternatives. Una MacFadyen mentioned giving people the choice to do something different. If we look at the example of Iceland, we can see that the authorities simply engage families and children in alternatives that they are interested in—for some that might be sport and for others it might be cultural activities. We need to create an environment that engages people in something that they care about and in which they really want to participate. Food needs to be the right food and not the junk that people get at counters, and alcohol has to be more expensive. Through the school survey in Glasgow, we have seen that the least affluent children now buy less alcohol, because they do not have enough pocket money. Therefore the approach is about having the right policies as well.

**The Convener:** We are extremely tight for time this morning, so I ask for short and sharp questions and answers.

10:45

**Maree Todd (Highlands and Islands) (SNP):** I am interested in the tension between data-driven, evidence-based medicine and the "intuitively sensible" approach, which I think is an issue throughout medicine but particularly in public health. A number of people have questioned the flu vaccine, and a Cochrane review a few years ago asked how much difference it had made to our health, but Helene Irvine said that the programme is "intuitively sensible".

Why would we take an approach to a vaccine that is different from our approach to a screening programme, about which lots of questions have been raised? Is it because the costs of vaccination are less? There is the cost of the drug, but little clinical harm is done to people who get a flu vaccine unnecessarily. There is also an opportunity cost to giving the vaccine. Does Dr Irvine or Dr McCartney have any thoughts on that?

**Dr McCartney:** The flu vaccine is different from a vaccine such as the measles, mumps and rubella vaccine, because flu changes every year and we have to predict what the flu outbreak will be like—

**Maree Todd:** And sometimes the vaccine is not at all effective.

**Dr McCartney:** That is right, and that is the problem. Vaccines such as MMR are highly effective, but there are legitimate questions to be asked about flu vaccination. There is high-quality evidence that people with significant underlying lung disease are far more likely to benefit from vaccination—a person who has really bad chronic bronchitis is very likely to benefit. However, the group that I worry about is healthy adults who just happen to be older. I worry that GPs get payments for hitting vaccination targets, as opposed to offering an informed choice about vaccination. It should be the GP's job to say, "Here's an intervention, and these are the pros and cons; what would you like to do?" We should not be paid to do more, when some people do not want the vaccination, for all sorts of reasons.

The decision that has to be made outwith the general practitioner's person-to-person discussion is about what the Scottish Government is willing to fund and whether the best use of resources is an intervention for everyone, or our doctors and nurses doing something better with their time.

Like many GPs, I start early and finish late, to give a little more time to every patient, and I want to use that time to talk to the patient about what is important to them. I want a dialogue, as opposed to a directed approach, where I have to say, "It's time for your vaccination now." A person might say, "I just want to talk about the death of my father", "I am worried about this symptom" or "I am concerned that my depression is coming back".

It is hard to capture that kind of nuance when we are talking about opportunity cost, but I am worried that we are almost turning general practice into a factory setting where everyone automatically

gets the same thing, rather than a high-quality choice.

**Maree Todd:** A couple of people said in their submissions that the accident and emergency four-hour target had directed attention at A and E. When Harry Burns came to talk to the committee about targets, we all agreed that there are problems with some of the targets. However, that particular target seemed to be quite useful. It is a kind of canary in the mine: it tells us something about what is happening in the A and E, which also tells us about the health of the whole system. For example, it tells us who is coming in for unscheduled care, how many such cases appear and where in the hospital people are moved on to. The four-hour target seems to me to be reasonably useful, compared with some of the other targets. What are the witnesses' thoughts on that?

**Dr MacFadyen:** The four-hour target seems rather illogical on its own. That takes me back to the issue of knowing what question one wants to answer, which is important. If we do not set the questions beforehand, the data from the four-hour target simply tell us how many people are seen within four hours. If the people who are seen did not need to be at A and E in the first place, having a four-hour target is meaningless. If we work back from there, we can ask, "Is the target all that we need or is there something more to that?"

I work as a hospital doctor, and I see many people who could have been seen in another way, which has led me to ask how people are advised to find help with their health. We have been hearing a lot about GPs; there are other people who can answer some of the questions that end up with someone coming to an emergency department. Someone might say, "I have a headache but no paracetamol" and then go to the hospital for their paracetamol, which seems completely illogical until we realise that that is the only place where the person knows that they can get help when they do not feel well.

We must ensure that young people—I am talking about young people again—are aware of how to look after their health and deal with their symptoms. That might be an important aspect of looking at the ED four-hour target. I do not know why four hours is seen as the magic number. As a doctor, I think that clinical priority is much more important than the number of minutes or hours for which somebody waits to be seen.

**Emilia Crighton:** We know that when emergency departments are busy, the mortality rate among people who attend hospital increases. We need to find a balance by providing the right venues for people to attend when they need care.

Targets are set arbitrarily. If we have targets, we tend to find ways to manage the target rather than the patient. We need to take a whole-system approach, as Una MacFadyen said, to ensure that we see the right people in the right place rather than just being mindful of our target.

**Dr Irvine:** The four-hour target was introduced in 2007. It was useful at that time because it attracted attention to unscheduled care and to A and E in particular. It encouraged hospitals to invest in their A and E service, to hire more staff and so on. The quality of the service improved and the waiting time experience improved dramatically.

Between 2007 and 2010, compliance performance in Scotland, including in our health board, was excellent, but thereafter it deteriorated. In our health board, it deteriorated markedly, with extremely low troughs—going down to 70 per cent, for instance. Now we are starting to go back to those really appalling statistics.

The collapse of the four-hour A and E target reflects the inadequacy of community-based services. If you ignore the alarm bells when they keep going off intermittently, and every winter in particular, and you do not address the inadequacy of social care for the elderly, district nursing, GPs and other community-based services, what is the point of continuing to measure progress against the four-hour target? You are not addressing the root cause of the problem; you simply hire more A and E consultants, as we have been doing for many years. I am not a fan of the target any more—it has outlived its usefulness.

**Maree Todd:** My final question is on breastfeeding, so I am delighted that Una MacFadyen raised the subject. Breastfeeding has been implicated in preventing many of the illnesses and conditions that we have discussed today, including breast cancer and obesity.

When the topic of breastfeeding was raised, I immediately thought of the graph in the NHS Greater Glasgow and Clyde submission that highlights lifestyle drift. Interventions tend to focus on education and on telling people that they should breastfeed, rather than on addressing the issues that may prevent us from creating a culture in which breastfeeding is easier, as it is in some of the Scandinavian countries where the regulation of marketing is tighter and economic inequality is less acute. I would be interested to hear your thoughts on whether we could take action other than in the field of education to improve breastfeeding rates.

**Dr MacFadyen:** There are a lot of things that we could do. I work in neonatal care, so I see a lot of babies and their mums, and I believe that it is imperative that one-to-one support is provided for a mum who is trying to breastfeed. That is the

intervention that makes the biggest difference. That leads us on to think about health economics and the need to have people who can support mothers in the community: not only professional health visitors but peer supporters.

In Scotland, it has been quite a challenge to change the culture. In wartime, women were encouraged to go out to work and to bottle feed with national dried milk. That culture is now two generations old, and it takes a long time to change. At that time, the media—which are now involved even more actively in the debate—promoted formula feeding because women were needed at work. To move away from that, and to see that formula is not the best way to feed a baby, means a whole culture changing its beliefs. There is a great need for that.

We should not accept social discrimination between different income groups as a given. A lot of women in lower socioeconomic groups would love to breastfeed if they were given the support to do so, and we should be targeting those groups. It is like the daily mile initiative: if we assume that one group of people will not breastfeed, they will not do so. We may need to look at targeting through extra input to encourage the positive benefits and to let people enjoy breastfeeding their babies, which is what it is all about. Those babies will be the next generation, who we hope will be healthier and less obese, which will improve the Scottish economy.

**The Convener:** We have to move on. We have five people waiting to ask questions and five minutes left.

**Tom Arthur:** Given the prominence of false positives in screening, in the discussions that occur between screening and intervention, to what extent is realistic medicine being practised? Could you comment on the cultural drivers of demand within healthcare and the preventative agenda? What role in altering those cultural demands do health boards and the Government have?

**Dr McCartney:** Is that question for me?

**Tom Arthur:** It is for anyone.

**Dr McCartney:** I am concerned that the invitations and adverts for screening always emphasise the importance of attending screening. They do not encourage shared decision-making. They do not encourage people to make a decision that is based on their values and what they would prefer to do. That is the biggest cultural problem. GPs are trained to believe in patient autonomy and in giving people good information on which they can base their decisions, but the invitations are sent from a central agency with my name on them. Invitations essentially say, "Dr McCartney says that it is time for your cervical screening and you have to come along for it now" without giving people information about the potential for false positives and overtreatment.

Women who want to have cervical screening should absolutely be supported to do so, but we have to be respectful of people who, for whatever reason, have decided that they do not want to have it. I do not think that that is embedded in the current system.

**Dr MacFadyen:** I have a comment on the "Realising Realistic Medicine" report, which is a positive document that has been positively received, in relation to antibiotic treatment. You asked about the pros and cons about how information is presented. There is huge potential to change people's demands on the health service by allowing them to truly understand the benefits and the risks of the treatment that they might think would be right for them. People can change their attitudes, but it takes time and it takes person-to-person interaction. One-to-one contact, with media back-up, is an effective way to go. Media alone will not be enough. If someone asks for an antibiotic and they are told that it might give them a tummy upset and cause resistant organisms, and that they probably have a viral illness that will not respond anyway, most of them go for not having an antibiotic. However, it does take that brief discussion to make sense of it. How would anyone understand if we did not give them that explanation?

**Dr McCartney:** There is good evidence that someone who has a continuous relationship with their healthcare professional is more likely to be satisfied with their care and less likely to increase costs. Their care is cheaper because they have fewer interventions and, overall, people prefer it.

**Dr Irvine:** There is some wonderful material in the "Realising Realistic Medicine" reports, but I am concerned that there is a bit of a conflicting message, in that the Government has encouraged the concept of screening generally and encouraged people to go and see their GP at the drop of a hat, including if they have a cough for more than three weeks. I have had a cough for something like eight weeks. I get it every winter, I have had it for many years now and I certainly do not go the GP about it.

I worry that, with one voice, we encourage people to become a little bit health neurotic and look for disease and worry that every time they have a lump or a bump or a sniffle, there is something seriously wrong with them, and then we issue a document that says that we need to start practising realistic medicine. It is a bit late now. We have a huge cultural demand that will be hard to put back in the bottle. Governments have to take some responsibility for that, particularly south of the border, where they encouraged people to screen for depression and we saw an increase in

the prescribing of antidepressants. We encouraged people to screen for prostate cancer and get prostate-specific antigen tests done when we know it is not a good idea to screen the general male population for PSA. The Government has to be consistent now and in the future, otherwise we will not get away from the problems that we are experiencing.

**Jenny Gilruth (Mid Fife and Glenrothes) (SNP):** One of the things that has come out of everyone's submissions this morning is the need for behaviour change around preventative medicine and the agenda of preventative healthcare. Dr Irvine highlighted meaningful employment and how that could help to solve the problems that we are facing. Obviously, the education system has a key role to play in giving kids the currency to trade in the marketplace through their qualifications. Do we need to reconfigure our understanding of health education, and do we need to look at behaviour change in the education system to help close the attainment gap between the poorest and the richest kids?

11:00

The daily mile, which Dr MacFadyen highlighted, is all well and good, but we need to join up physical activity in schools, whether that is physical education or whatever, with the theory behind it. We might, for example, use modern studies to look at social inequality and link behaviour change with that, and we could also look at food education. Does the panel have any views on whether the education system can play a role in the preventative agenda?

**Dr MacFadyen:** I was looking at curriculum for excellence just before I came to this meeting, and I think that there is huge potential to incorporate in the curriculum more about keeping your own health as it should be. Certain big topics, such as sexual health, will be presented in a number of ways, but the one-to-one approach—I guess that it would be called respect for the individual—is very important in relation to health.

Indeed, in a recent survey that they carried out with the Scottish Government, young people themselves identified their mental health as a concern. That population is saying, "I want help", and we should be ready to address that and go with what people feel they want. After all, behaviour change happens when you want to be helped, and that brings us back to listening to users as much as seeking to impose a service on people from the outside. I think that Emilia Crighton, too, talked about addressing the issues that people want to know about.

**Emilia Crighton:** With regard to the role that education can play, we must have the right environments, and they must be in place very early on. We carry out vision screening in children's pre-school year and the orthoptics people came back from the east end of Glasgow and said, "You know, there are children who can't name common objects." How do we ensure that children who reach school age have the cognitive ability to engage with the education system? The answer is to have a pre-school system that is available to all children, particularly those from the least affluent backgrounds; we need them to get bedtime stories, for example. We need to engage and give support to families very early on, because by the time the children are 10 or 11, it is a bit too late.

**Jenny Gilruth:** I suppose that my question is whether there is a role for the health service, GPs or someone from the healthcare industry to come into schools and speak more readily to children about accessing the appropriate healthcare professionals. After all, one of the key points that has been highlighted this morning is folk going to A and E when they do not need to. If we want to change behaviour, is the answer not to get to the next generation and to teach those behaviours accordingly? If so, do you think that there is a role for the healthcare industry to have more of an input? For example, Medics Against Violence goes into secondary schools in Glasgow and across the country to speak to pupils about its work, and that helps to develop understanding. Is there a case for having a better link between health and education in that respect?

**Dr Irvine:** In theory, yes. You can teach children to do anything you want. However, you have to remember that the curriculum is already very tight. As you will have read in today's *Herald*, there are difficulties in teaching, what with the pressures with regard to budgets, achievement and so on, and I think that it is a bit utopian to think that we can teach the general public at a very early age how to use the NHS.

As for the abuse of A and E, Tayside has cracked that issue with its redirection policy. People who go in get triaged by a nurse, who might say, "You are not really supposed to use the A and E for this. Go and use the pharmacy instead—this is where it's located at this hour." They might be told to go and see their GP the next morning, and the GP will be geared up to take them. As a result, the A and E attendance rates in Tayside are a fraction of those in our health board.

You therefore do not need to teach all children at school not to abuse A and E; with a redirection policy, you can teach the patient themselves the very first time that they do so. In fact, I believe that that is the direction in which Scottish A and E departments will increasingly be moving—out of

necessity, it has to be said, because we simply cannot cope with unnecessary attendances.

**Dr MacFadyen:** Just to add—

**The Convener:** Please be very brief, because we have to move on.

**Dr MacFadyen:** Instead of young people waiting to go to A and E, school nurses are a force that could be utilised to help young people feel confident about using health services. I think that it is unfair on young people to expect them to know how to use the NHS in what we would see as an appropriate way either by instinct or through following what their parents have always done.

**Donald Cameron (Highlands and Islands) (Con):** Following on from Jenny Gilruth's questions about education, I wonder whether we can look at methods of communicating preventative health messages to the public. A range of things have been done; we all remember the striking and powerful national advertising campaigns and we all know about the posters in GP surgeries and the use of social media. In a sentence, can you tell us what we are doing right and what we are doing wrong, particularly in reaching the unworried unwell in perhaps highly deprived communities who might not have access to the internet or ready access to broadcast media?

**Dr MacFadyen:** I would always say, "Use the children." For example, our smoke busters programme in Stirling was the most effective force in stopping smoking in public places before the legislation that banned it came in. If children know and believe a message, they will get it to their parents, so perhaps one way of doing this is to start young.

**Emilia Crighton:** What we do right in Scotland is have the right policies. We have been brave enough to ban smoking in public places and to support minimum alcohol pricing, so we have to be brave enough to say, "These are the right foods that you need to eat". The industry will follow. We have already seen the readjustment of the sugar content in soft drinks on the back of the sugar tax. What we need is policy that affects everyone instead of having to rely on the intelligent processing of information that has to be available and then enabling these things through behaviours.

**Dr Irvine:** I actually think that most people know that they should be eating, say, more fruit and vegetables, but they do not like them or they are not used to eating them; their parents never gave them any, so they do not have the palate for them. We encourage people to consume more healthy food by making it cheaper and making not so healthy food more expensive. We should be taxing junk food and subsidising fruit, vegetables and, indeed, wholemeal bread. Imagine how many people would eat wholemeal bread if it cost 15p and white bread cost £1.20.

**Dr McCartney:** We need evidence-based policy making, which means doing some things right and some things wrong. Everything should be driven by evidence, and we should get rid of stuff that does not work. The staff in the NHS love working there and are driven by their vocation, but that keeps getting subverted by our being asked to do stuff that is wrong and ineffective.

**The Convener:** In response to our question about the preventative agenda, Dr Irvine says in her submission:

> "The implication in the question is that there are wonderful initiatives out there that prevent ill health and premature death but we simply can't measure their cost-effectiveness and we need to try harder to demonstrate their existence and their value for money. The truth is that the wonderful initiative is staring us in the face: equalise opportunity and reduce the income/wealth gap. Use existing powers to do so."

I could not agree with that more. All the issues that lie outside health—structural change in the economy, fair work, fair pay and all of that stuff—are the very ones that we have to tackle. Have you seen any evidence of that happening?

**Dr Irvine:** No, and I am distressed by how little people talk about it. I feel ostracised and a bit of an oddball for raising the issue, but I feel that it is my job to do so and I am not going to stop doing it for the rest of my career. This is an absolutely essential point, and my fervent belief comes from being brought up in Canada under Pierre Elliott Trudeau in the 1960s and 1970s—I was born in 1957—when the gap between rich and poor was very narrow. I will never forget Canada in those days and how it changed as we went into the 1980s, which is when I decided to leave and come to the UK. We have to reduce that gap and show commitment to young people.

I am a product of that attitude. I do not think that I would be what I am now if I was born in Canada today, because it is now much more like America, with a bigger gap between rich and poor. Reducing that gap is the way to go, and if we continue to tolerate huge accumulations of wealth by a tiny minority, we are just going to have more and more problems. We do not have enough millions of pounds available in the public sector to rectify that situation, and you cannot solve it through health promotion or health screening. None of that will work, but reducing that gap has to be the priority.

**Emilia Crighton:** It is a very difficult question. Despite our best efforts, we are not closing that gap. However, what we in an equal society can do to narrow it is to provide education very early on, and there is good evidence that neighbourhood-

based education in the first years of life promotes social mobility. That is the one thing that we can do.

**The Convener:** Is that you abandoning any willingness to have redistribution?

**Emilia Crighton:** I sincerely hope that that will come. Some measures have been put in place, but we need to be bolder. It is not the final solution, because we will require vaccination programmes and many other things in addition.

**The Convener:** Finally, would you still get rid of screening even if money was no object?

**Dr McCartney:** Yes.

**Dr Irvine:** Yes, but we should keep targeted screening for higher-risk women.

**Dr McCartney:** The problem, though, is that you would still be creating avoidable harm, which is something that we want to get rid of. We can always spend the money on something better.

**Dr MacFadyen:** Screening for babies is a different issue. Please do not take all screening away.

**Emilia Crighton:** Many screening programmes are worth while, and I would continue with them even if there were not a lot of money.

Let us say that we allowed individuals to do whatever they pleased. In the States, there are huge disparities because the wealthy think that, on balance, they can afford to have their mammograph every year as opposed to the three-yearly programme that the UK offers; actually, most countries offer mammography every two years. We need to be critical of what we offer and to whom we offer it, but allowing a free-for-all would widen the inequality gap even more.

**The Convener:** Thank you very much for your attendance. I really welcome this session, because having these kinds of challenging submissions and discussions is healthy.

I suspend the meeting briefly to change the panel.

11:10

*Meeting suspended.*

11:13

*On resuming—*

## NHS National Waiting Times Centre

**The Convener:** Agenda item 2 is an evidence session with the NHS National Waiting Times Centre. Some committee members had the benefit of visiting the Golden Jubilee national hospital back in September, and we thank the centre for hosting us.

I welcome from the centre Jill Young, chief executive; Julie Carter, director of finance; Mike Higgins, medical director; and June Rogers, director of operations. Jill Young will make an opening statement.

**Jill Young (NHS National Waiting Times Centre):** My statement will be brief. I am sorry that I was not there for your visit, but I am delighted that it was useful to see what we do.

**The Convener:** I am sure that you enjoyed your holiday.

**Jill Young:** I did—thank you.

I will tell you about the unique nature of our health board, which is different from any other health board in Scotland and, indeed, the UK. We are delighted that, next month, we will celebrate our 15-year anniversary in the NHS. We believe that they have been 15 very successful years.

11:15

We started as a national waiting times centre that was set up purely to address elective waiting time targets—for example, because someone could have been waiting many years to have a cataract operation. However, we have changed radically and significantly over the years; hence, we are now more commonly known as the Golden Jubilee foundation.

Although we provide a range of services for the people of Scotland, we have three core specialties. Our heart and lung centre is one of Europe's largest cardiothoracic centres, and it provides a range of services from west of Scotland all-adult cardiac surgery—we treat not just elective patients but all the emergency heart attacks that come by blue-light ambulance or helicopter to be treated at the Golden Jubilee hospital—to our national heart and lung services, the best known of which is the heart transplant service for the whole of Scotland, which is based at the Golden Jubilee hospital.

Our second core specialty is our orthopaedic department, which is one of the best-known such departments in Europe and one of the largest. It

undertakes pioneering work that is being replicated not only across Scotland and the UK but further afield in Europe. Twenty-five per cent of all hip and knee replacements in Scotland are carried out at the Golden Jubilee hospital, with tremendously successful outcomes. That is not just about the activity in numbers; it is about the clinical outcomes, the performance and the satisfaction of patients. The department is now moving more into telehealth and telemedicine in orthopaedics, and it is providing outreach clinics up in the Highlands and Islands as well as in Fife, for example.

Our third core business is the cataract procedure, which is quite short. It takes about half an hour in theatre to have a cataract removed and replaced with a lens, and the work is done almost totally as day-case work. We carry out 18 to 20 per cent of all cataract procedures. People travel to the Golden Jubilee hospital from all over Scotland—even from the Highlands and Islands—to have their cataract procedures. That is partly because of the excellence and expertise of the team that we have and partly because of the clinical outcomes and the speed at which we can deliver the service for people.

I will finish by briefly mentioning two other dimensions that we are unique in having as a national board, which are critical in underpinning our success. We have our own four-star conference hotel, which is unique not just in Scotland and the UK but in Europe, and our own research and innovation institute. Our research department is running about 80 research projects with international interest and input to benefit the patients of Scotland. We have also completely refocused the hotel's business so that it is a conference centre of excellence that provides residential training conferences with highly specialised equipment for healthcare and the public sector—we have gone beyond the NHS.

What has made us so successful in our performance over the past 15 years is our staff. Their dedication, enthusiasm and commitment to constantly go the extra mile and to look to improve at every turn and make things better have been tremendous. We underpin that by providing training in human factors, values and culture as well as training on the professional side for doctors, nurses and allied health professionals. It is down to them that we provide such high-quality services and continue to improve and innovate.

**The Convener:** Thank you.

**Ivan McKee:** Thanks for coming along. I enjoyed the visit to the Golden Jubilee hospital last year.

We have some data in front of us—I assume that you will agree with it—that compares the cost per in-patient case at the waiting times centre with the costs at a range of other hospitals. Your cost is significantly higher, so I would like to unpick that a wee bit to understand whether we are comparing apples with oranges, given what you do. I would also like to understand how you get linked up with demand from other health boards, whether your underutilisation impacts on costs and whether we should be leveraging that more.

Why are the numbers that we have in front of us significantly higher?

**Jill Young:** I will start and then hand over to Julie Carter, who will be able to give you the detail. What we do is complex. For example, the national services are completely different, so we are not comparing apples with apples. That is the first point.

We try to change pathways of care so that we do not bring patients down to the Golden Jubilee on unnecessary journeys. We provide alternative ways of treating them with outreach. For example, we send our ophthalmology team up to Orkney and Shetland and up into the Highlands to treat patients, which is an additional cost to us but a saving to the local health board and the local community and population. For those reasons, you are not comparing apples with apples.

I hand over to Julie Carter for the detail.

**Julie Carter (NHS National Waiting Times Centre):** I reiterate that. The committee is absolutely looking at comparing apples and oranges. In orthopaedics, for example, all our work is on joints, and the average cost of the implants that go into the joints is £1,500 to £2,000. In comparison, a lot of the work of other health boards is on fractures and does not involve joints. That is one of the big differences.

We are unique in that our work is 100 per cent elective. We do not have any accident and emergency work coming through.

**Ivan McKee:** That is fine. To take that to the next stage, is there data on what you do that compares apples with apples?

**Julie Carter:** Yes.

**Ivan McKee:** How do your costs compare on that basis?

**Julie Carter:** Very well. We compare our costs for work on joints and so on. Because our average length of stay is only three days, whereas the average length of stay across Scotland is about five days, our costs come out really well. We are extremely focused on that because we have to be. We are an elective factory, so we have to be extremely efficient and look all the time to make things better.

**Ivan McKee:** That is what I expected. The model should work in that way, and the big advantage should be that it is a lot cheaper. You say that that is the case and that you have data that shows that you are cheaper than other health boards when doing similar processes.

You do 25 per cent of hip and knee operations and 20 per cent of cataract operations for people from across Scotland, but you have underutilisation of capacity—it is at 60-odd per cent. Given that all your work is planned, your use of capacity could and should be a lot higher than that. Why are you not more fully loaded? Are health boards resistant to giving you more operations to carry out? Does something in the costing system make it look cheaper than it really is for them to do operations in house? What are the issues behind that?

**Jill Young:** Maybe I can tease out what you mean by "underutilisation", because at the moment we are full. On our capacity, in terms of the hospital and the board's resources, we are absolutely full. Indeed, we are working six days a week in some specialties, and part of the reason for the expansion plans for the new elective centre is to accommodate more orthopaedics and take the numbers 25 per cent higher.

**Ivan McKee:** It is just that we have data that says that you are at 68 per cent occupancy versus a target of 73 to 85 per cent.

**Jill Young:** That is occupancy in some wards.

**Ivan McKee:** So that figure is not for operations and we can leave it to one side.

To go on to the next stage, what would need to happen for you to do more work, given that it is cheaper for you to do it than for other health boards to do it?

**Jill Young:** It is also of higher quality.

**Ivan McKee:** Of course.

**Jill Young:** It is the quality that drives the efficiency, rather than—

**Ivan McKee:** I am taking that as a given.

**Jill Young:** The point is important, because I have never seen a finance target deliver high quality, but I have seen targets for high quality deliver efficiency.

We need expansion. We are running six days a week and we are exploring running some services seven days a week. We do seven-day working in the physiotherapy and occupational therapy departments but, to get the theatres running seven days a week, we need more staff, more resources and more supply. We are exploring that in order to squeeze out every part of our current resources, but the Golden Jubilee would need to be expanded, and that is in planning.

**Ivan McKee:** We also have data on cancellations. The figure came in at just under 3 per cent. Do you recognise that? It is higher than the figures for pretty much every other health board but, again, you might tell me that we are not comparing like with like.

**Jill Young:** It is a bit of both. A number of our patients do not come to us for their first out-patient attendance, whereas the other boards count such appointments in the cancellations, so we are not comparing apples with apples.

The 3 per cent figure is not acceptable and we are working hard to bring it down. Perhaps June Rogers can tell you more, as she drives some of the work to do that. The figure relates partly to the distance that patients have to travel and whether they deem the time to be appropriate given their circumstances. We tend to get cancellations from people who live further away.

**Ivan McKee:** Can I squeeze in one last question, convener?

**The Convener:** Yes.

**Ivan McKee:** There is clearly a strategic intent to replicate elsewhere what you do. You might not want to answer this question directly. Given that what you do involves planned and elective procedures and given that you are pretty good at it on your site, if you had to consider where it made most sense to invest the money, would it be in starting from scratch and building up expertise to do the work at other locations round the country or would it be in investing more in what you are doing and doubling or even trebling your capacity?

**Jill Young:** We are looking at both aspects. The elective-capacity expansion plan is looking at how much we can expand and do on the Golden Jubilee site and what is best to be delivered locally. Certain procedures should be done locally so that there is no need for patients to travel to us. We have to consider the resources—not just the physical resources and money but technology, equipment and the recruitment of staff. Sometimes that can be quite challenging on smaller sites.

To go back to the point about what we are doing, the model of care in planning the new elective centres is the Golden Jubilee model of care. We have been asked to take a lead role in that to make sure that, even if there is expansion in other areas around Scotland, those centres will be run and operated on the same model of care as we use.

**Ivan McKee:** Very finally, if everybody did what you are doing, how much would we save across the health boards? You might not know the answer to that and might want to get back to me.

**Julie Carter:** We would save lots.

**Ivan McKee:** If you got back to me with some analysis, I would appreciate it.

**Julie Carter:** The only thing to add is that we work closely with other health boards—it is not a matter of them and us. We share models with them and, if we can do things better, we share that with them. We work very much on a cohesive basis.

**Donald Cameron:** It is good to see some of the panel again after the visit last September. I will concentrate on cancelled operations, which Ivan McKee raised and which are a problem. With the exception of a couple of months last year, you were above the Scottish average for the whole year on the number of operations cancelled for capacity and non-clinical reasons and, as has been said, your figure was the second highest in Scotland. What is the reason for that high rate of cancelled operations?

**June Rogers (NHS National Waiting Times Centre):** There are a couple of things. The cardiac programme is included in that, and cases are often cancelled because more urgent cases come in, such as transplants.

We also have a general surgical service that is run by visiting consultants, which mostly involves things such as endoscopy and minor general surgical procedures. On occasion, or maybe more than occasionally, we have to cancel lists at fairly short notice because those consultants have been held back at their host boards to carry out more complex procedures.

Additionally, over the past year we have had equipment issues with ophthalmology. That affects large numbers of patients in one day, which inflates the percentage.

What you are looking at probably relates to orthopaedics and to endoscopy, where there are up to 14 procedures in a day, so it does not take long to rack up 3 per cent of cancellations. We have been more concerned about cardiac cases, which are being postponed to make way for more urgent procedures, rather than being cancelled.

**Donald Cameron:** A lot of what you do is elective surgery, for which I presume by its nature that it is easier to plan, and you rightly have a reputation for quality, as the gold standard and a national centre of excellence. Given that, do you accept that you will have to sort out the issue of cancellations to maintain your reputation?

**June Rogers:** We are acutely aware of the areas that need to be fixed. The areas that we have typically concentrated on are orthopaedics and cataracts, as Jill Young said, and we perform in the upper quartile on both those services. That has been evidenced in peer reviews. We work really hard not to cancel patients' procedures and, if we have to cancel, to give patients a new date on the same day as we cancel them, so that they are not waiting for longer than their waiting time guarantees. We are still able to treat them. The 3 per cent is not a great number, but we are working really hard and we are focused on what we have to do.

**Colin Smyth (South Scotland) (Lab):** Can I touch on the point that you made about the challenges of consultants? We have a national shortage of consultants in almost every area, and yet you are looking to expand. Given the numbers of cancelled operations, which Donald Cameron touched on, how challenging will it be to make that expansion when you have issues such as a shortage of consultants, as you mentioned?

**Jill Young:** I will start and then hand over to Mike Higgins to give you the detail. We are doing a number of things. The expansion is three to five years away; it will be two years for phase 1 and then three to five years for phase 2, if we assume that the plan will be approved.

We have set up our own training academies for theatre operating staff and radiology, which have been successful. We are taking people in and training our own staff so that they will be ready when the new expansion happens.

11:30

Services in a number of areas are delivered only at the Golden Jubilee, so when we recruit, we are not taking staff away from other areas of Scotland; we are advertising and marketing in the UK, Europe and further afield internationally to recruit into those areas.

We have spent the past 10 to 15 years building our reputation and credibility as the place to come and work in order to get experience and high-quality professional career progression. We have skills shortages in a couple of areas, but we tend to have a number of candidates coming forward when we have a vacancy. To date, I think that there has been only one specialty in which we have not been able to appoint someone to fill a vacancy—I am talking primarily about doctors.

**Mike Higgins (NHS National Waiting Times Centre):** The challenges that we face are the same ones that are faced by the rest of the NHS and, broadly speaking, the solutions that are put in place to address those challenges are the same solutions that are being put in place across the rest of the NHS.

We have looked at what consultants do and we try to use them in a way that means that they only do tasks that consultants need to do. For instance, we have undertaken major redesign in the

ophthalmology service so that the parts of the cataract procedures and outpatient appointments that can be done only by consultants are done by consultants, and we have used optometrists to take over many of the tasks that do not need to be done by a qualified eye surgeon. That redesign is on-going. We have reached a point at which we have made major efficiencies and improvements, but we would like to take the work much further, and that process is in place.

Our orthopaedic service has also grown. When I came to the Golden Jubilee in 2008, we had six or seven full-time orthopaedic consultants, and we now have 15 or 16, depending on how you count them. Before we grew the service, there was some scepticism about whether a centre that concentrated on a relatively small number of elective procedures could attract people who were interested in a professional career. Because we made the job intrinsically attractive by concentrating on high standards and ensured that our recruitment process was highly focused on non-technical skills, team working and non-technical competencies rather than simply involving a one-hour consultant interview, which made it harder in some ways for people to be appointed, we have found that the centre has become an extremely attractive place to work, and that there are people out there who want to come and work in the Golden Jubilee.

On a wider scale, if those consultants are being attracted from elsewhere in the health service, it is important that, when they are working in the Golden Jubilee, they are working to maximum efficiency so that their input to the health service is maximised. I think that that works very well.

As Jill Young pointed out, in some specialties, there are super-specialised areas in which there is a tight international market, as is the case in heart transplantation. Our Scottish pulmonary vascular unit and adult congenital cardiac care, both cardiological and surgical, is in an area in which there is not only a UK shortage of skills but an international shortage of skills, so we are playing in an international market. We have a number of international and European appointments to our jobs in the Golden Jubilee.

**Colin Smyth:** You make the point that you sometimes compete with other parts of the health service for staff, particularly with regard to more routine types of operations. Like other members, I represent some rural areas that are quite some distance from the Golden Jubilee. Patients want to go to where they can get the best treatment, but they would also like that to be in the local area, if at all possible. Given that you are competing with other parts of the health service for consultants, how do you think the expansion of the Golden Jubilee will impact on local health services in other parts of Scotland?

**Mike Higgins:** It should be a win-win situation, and we will work very hard to ensure that that is the case. There is a sense in which any appointment anywhere in the health service is in competition with appointments elsewhere in the health service. What we should do is to provide the maximum benefit from those appointments, wherever they are. That relates partly to efficiency—as Colin Smyth mentioned earlier in relation to the use of consultants—and partly to being creative. For instance, we have been looking at having split appointments under which consultants might spend half their time in one of the surrounding geographical board areas and half in the Golden Jubilee. That is one useful and practical solution.

One of the issues with our anaesthetic team is that, because we do a fairly limited range of operations and much of the work is focused on regional anaesthesia—in which patients are not put to sleep but part of the body is numbed in order to carry out the operation—there is a worry that people's skills in putting patients to sleep are being diluted. One solution that we are looking at is joint appointments under which people will have a general anaesthetic workload in one board area and, say, an orthopaedic workload with us.

There are some simple practical things that we can do. As Julie Carter mentioned, it is important that we work collaboratively with other boards and do not set ourselves up in competition. We want to create win-win solutions to such problems.

**Colin Smyth:** So you do not think that the expansion will impact on local services.

**Mike Higgins:** We work hard to ensure that all the services that we set up are what we might call win-wins. It is not possible to give a global answer to the question. Broadly speaking, we hope that we will not impact on local services or work to their detriment. We take a global view on how to provide the best treatments at the best place so that both patient experiences and patient outcomes are optimised, and we work with other boards in order to do that.

**Jill Young:** I can give a brief practical example. NHS Dumfries and Galloway has experienced challenges in recruiting ophthalmologists while we have been looking to expand, so we have been working closely with it to see whether we can make a joint appointment. A surgeon would spend some of their time working down in Dumfries and Galloway, treating patients locally where they could do that, and where patients require more intensive or complex operations, the same surgeon would come up and work with the team in the theatres at the Golden Jubilee. We are

genuinely trying to work closely so that we do not remove local services but, where there are challenges, collaborate.

**June Rogers:** In recognition of the issues in Highland and in the rural boards that Colin Smyth mentioned, we send consultants, who are orthopaedic surgeons, up to Raigmore hospital three times a year—in each visit, they see at least 100 out-patients—and patients who require surgery come to the Golden Jubilee for their treatment. It is all agreed and arranged in advance. Patients know that, if they see our consultants at the clinic, the expectation is that they will go to the Golden Jubilee to have their procedure carried out and they will have their follow-up arrangements carried out using a telehealth link. We have monitored that process all the way along to make sure that there is patient and clinician satisfaction with the service that we provide.

We have replicated that in Shetland, also for orthopaedics, and we have an ophthalmic surgeon who goes to Shetland three times a year. We are in close contact with every board in Scotland to make sure that we make it as accessible and simple as possible for patients to come to us. When surgeons go and do such clinics, patients have their pre-op assessments at the same time. We send up an administrator from our hospital to talk to patients about what their experience will be when they come to the Golden Jubilee, where a relative can stay in the hotel and what their transport arrangements will be. We have recognised that there is a gap and tried to fill it. It is a very collaborative arrangement that we have with every single board.

**Clare Haughey (Rutherglen) (SNP):** I want to pick up briefly on something that Mike Higgins said in reply to Colin Smyth about current staffing and having staff from the European Union. How does he see Brexit impacting on the recruitment and retention of staff at the Golden Jubilee?

**Mike Higgins:** I think that we have a small number of EU staff. Like everyone else, we are waiting to see what will happen about the EU, so the simple answer is that we do not know, although at the moment we do not expect any major difficulties that we will be unable to cope with.

**Jill Young:** When the Brexit decision was taken, we did as detailed a review of the situation as possible given the information that was available, and we took it to our board as a risk paper. We examined all the dimensions that were involved including export—which we do not really do—workforce and procurement. On that last point, it is important to note that a lot of the highly complex equipment that we have for magnetic resonance imaging is built and bought from abroad, and the value of the pound could have an impact on us in that regard.

We took that paper to our board for it to decide whether the risks should go on to our risk register and what mitigating actions we could take with regard particularly to recruitment, but also to expansion if we go ahead with the purchase of two new pieces of MRI theatre equipment. We are lucky that we have national procurement in Scotland so the procurement is done once for Scotland, resulting in the best deal that we can get. However, the outcome of Brexit will determine much of what we are talking about.

**Clare Haughey:** Was Brexit put on to your risk register?

**Jill Young:** It was not, because it was determined to be a low risk at that point. We use a matrix to determine risk, which involves the impact of the event and its likelihood. After full discussion at the board level, it was determined to be a low risk, so it did not go on to the board register. However, we still monitor it.

**Clare Haughey:** Most of the MSPs round the table will have been approached by constituents when their experience of the NHS has perhaps not been as good as they would have expected it to be or when they have not had the level of service that they wanted. I am therefore keen to discuss the data from your latest in-patient survey, which found that 98.7 per cent of patients had positive engagement, with 94 per cent rating your service as excellent, and that the board delivered more than its planned activity for in-patient day cases and diagnostic examinations, with activity being 12.5 per cent higher than in the previous year. You are to be congratulated on achieving that.

What learning is there for other hospitals from the experience of the Golden Jubilee and your positive engagement with your patient group?

**Jill Young:** There is a lot in that question. Those of you who managed to visit the hospital will have seen the presentation of our quality framework. For the past six years, we have been working hard to establish that quality is about being an exemplary employer for our staff because they are the ones who deliver the front-line care to patients and their families and carers; that it is about looking at the pathway of care for the patient and ensuring that it is of the highest quality; and that it is about what matters to the patient and not what is the matter with the patient.

That last point is important, because the two things are quite different. If you ask someone who is having a hip replacement what matters to them, they might say that they want to run the next 10km race, or they might say that they just want to go out and dig the garden or take their kids for a walk without being in pain.

We have done a huge piece of work around training our staff and looking after them in order to raise their satisfaction, and that contributes to the satisfaction of patients because it results in high-quality care and good communication. That communication starts before they come anywhere near the Golden Jubilee, as it involves a phone call, once they receive their appointment letter, to explain to them what will happen all the way through their treatment.

We look constantly at the indicators, the targets and the hard facts around them—the number of infections, the number of complaints, the average length of stay and the rates of cancellation and DNAs. DNA stands for "did not attend". We triangulate the staff experience, the patient experience and the targets, and we use apps, which are in every ward and department and on all the board members' iPads and laptops, to feed into a live digital platform that people can look at—on any day, at any hour, from wherever they are in the world—in order to monitor quality.

We also encourage patients to give feedback in a range of ways before, during and after the treatment. For example, people in the orthopaedic department found that patients were grateful for the treatment but would simply say that their treatment had been wonderful as they were leaving, because they just wanted to get out the door and go home. The department found that it was not until seven to 10 days after the operation, once the patient was home and had talked things over with their family or carers, that they were able to truly reflect on what their treatment had been like. Therefore, those patients now get a phone call seven to 10 days after they have gone home to ask them about their wound, their mobility, how their operation went and, more important, whether we could have done anything better to improve their satisfaction.

**Clare Haughey:** The committee has also considered staff governance. You mentioned that you are an "exemplary employer" of staff. How have you rated that? What engagement have staff had, particularly through things such as the national staff survey for the NHS?

11:45

**Jill Young:** We get a tremendous response from staff in the staff survey. I am looking at my notes, but I think that there was 84 per cent satisfaction with our employee engagement. Our staff satisfaction rating was one of the highest in Scotland, if not the highest, which is tremendous.

The other indicators that we gather for our quality framework include things such as turnover. We have one of the lowest turnovers of staff. Sometimes it is good to get fresh eyes and to have new staff coming through but, over the past 10 years, we have been expanding every single year, which gives us the freshness of new staff coming in with new ideas.

We constantly offer staff the opportunity to tell us when things are going well and we include them right at the start. Our partnership forum has its own values, which we table every time the partnership and the staff side and the unions meet with management, and we do a 360° review at the end of those meetings to ask how our behaviours are, how the workplace is and what more we could do to improve things. There are a whole range of ways in which we ask staff for their views.

There are also confidential contacts—there is a board member whom staff can approach directly if they have any concerns, and we have a whole team in the human resources department.

We have provided human factors training to 60 per cent of our staff—that is, over 1,000 staff—in the past year. That is a basic exercise to allow them to find a voice so that, if they feel that they are in any way being bullied, intimidated, harassed or put under pressure with workload, they have the words and the training to raise that and do something about it. We made a commitment just over a year ago—about 18 months ago—that we would train every member of staff. Indeed, we are all trainers. That allows them to question it when things are not going well but, equally, to tell us how to improve things.

**Clare Haughey:** Can I just check something? When you mention your staff, are you referring to staff right across the estate—to your hospitality, nursing, medical and facilities staff?

**Jill Young:** It is everyone. All members of staff are employed by the Golden Jubilee Foundation. However, we take it a bit wider than that, as we include our volunteers and some of our young people. With the investors in young people gold award, we have a lot of interaction with schools, and when young people come in for work experience or volunteer work, they are included in the staff governance.

**The Convener:** Related to that, what about the level of use of agency and bank staff, and the private sector?

**Jill Young:** There are no private sector staff. We are trying to repatriate all the private sector work for the NHS. We do have bank staff. Julie Carter can give you the detail on agency staff. We did quite an intensive piece of work, as all the boards in Scotland did, to reduce the use of agency staff. First, there is the high cost, but secondly, we could not give the assurance of the clinical governance and the expertise and skill levels of staff coming in to work at short notice. Agency staff tend to be used in highly intensive

areas such as operating theatres and MRI scanners rather than as lower-grade staff in the wards. I do not think that we have used any agency staff.

**Julie Carter:** Use of agency staff is really low—

**The Convener:** Can I pick up on that? Are you saying that that is because you could not verify the skills?

**Jill Young:** No. It is because we are not aware of their level of experience. If we had an agency nurse who was at band 6 with intensive care training, we could not plan on the assumption that they would have the necessary experience for, say, a heart transplant patient who had just come out of theatre. That is quite a dedicated role within what we do.

**The Convener:** If you have to employ bank or agency staff for those niche posts, is it massively expensive?

**Jill Young:** Agency staff are expensive, but we do not use agency staff for that. We have our own bank, which comes under our training. We make sure that anyone in our bank who comes in to work in those areas has been trained by us.

**Julie Carter:** As I said, our use of agency staff is very low across Scotland, and we are keen to keep it like that.

**Alison Johnstone:** Following on from that, I know that when NHS boards cannot provide a service locally, they can opt to send patients either to you or to the private sector. We know that in 2015-16, boards spent £81.8 million on using the private sector for NHS patients. That exceeded your income from boards, which I believe was £50.4 million. Has there been any analysis of that spend in the private sector and of whether there are any gaps that you could be filling? Are people going to the private sector because there is something that you cannot pick up on? Has there been a look at that?

**Jill Young:** Yes. Both things that you have highlighted are happening. As we do not do certain specialities, they cannot be picked up by us, but they could be picked up by other hospitals and boards around the country.

We are also, within reason, trying to repatriate from the private sector all the specialty work that we do, but in order to do that, we need the expansion that I referred to earlier. We have done predictions and projections up to 2030 of the demand for orthopaedics and ophthalmology in NHS Scotland and the rising elderly population and have translated that into how many operations will be required. We have also looked at the history of the work that has gone to the private sector, particularly with regard to those two specialties. We know how much work has previously gone there and what we will need in the future, and we are using those as our planning assumptions for the expansion.

**Alison Johnstone:** So you hope that the private sector spend might decrease over time.

**Jill Young:** Absolutely. That is the key purpose of the expansion.

**Alison Johnstone:** I read in our committee papers that you are

"funded through a combination of Scottish Government funding and payments"

due to referrals from other health boards. Your annual income from such boards is £50.4 million, but there seem to be reports of a few boards—Grampian, Highland and Greater Glasgow and Clyde—no longer referring to you. At the time of writing, however, the Scottish Parliament information centre could not confirm the position regarding those referrals. Will you comment on that? Are some boards or specialties not referring, or is that incorrect?

**June Rogers:** No, that is not correct. You mentioned Grampian, Highland and—

**Alison Johnstone:** Greater Glasgow and Clyde.

**June Rogers:** All of them have an allocation capacity at the Golden Jubilee, and have done forever.

**Alison Johnstone:** So they continue to refer to you at the moment.

**June Rogers:** Yes. We have a three-year contract with all the boards. We have referrals from every single board in Scotland now, which has taken some time—over a number of years—to achieve, and under our three-year agreement with them, they can within their allocation choose to send whichever patients they want, no matter where they are on their waiting list, or make new referrals.

We have what are referred to as see-and-treat referrals, which are of patients who have never seen a consultant in their home board area. They come to us, see our consultant and stay in our system. We also have treat-only patients, who have already been diagnosed, are existing patients on a waiting list elsewhere and come to us just for surgery. People come into our system in a variety of ways, but every board has an allocation of capacity depending on its particular needs.

**Maree Todd:** As someone who represents the Highlands and Islands, I have a wee supplementary to that question. Might there be particular cases that are not being referred? Earlier this year, the press reported the high-

profile case of a young woman with a cataract who had waited a year to be seen by NHS Highland. When the press made inquiries, NHS Highland said that, since the previous September, it had no longer been referring people to you.

**June Rogers:** I know about that lady. NHS Highland had an allocation of ophthalmology capacity at the Golden Jubilee. We talked to it at the time about whether it was appropriate for patients, who are generally elderly, to travel down to the Jubilee for what is often a half-hour procedure, but it needed the capacity and we were happy to take the patients. However, given that 30 per cent of those patients do not proceed to surgery, we talked to it about how we might refine things through a pilot in which the initial consultation would be carried out by telehealth link in order to avoid unnecessary travel. Highland did not manage to make that happen, because an optometrist or a specialist nurse was needed at its end to conduct the consultation and tell the consultant what they could see; after all, the consultant can see only a certain amount. NHS Highland then passed its capacity to Fife, which is now carrying out that pilot in the hope that we can then take it back to Highland as a done deal—if we can call it that. It looks as though we have found a way forward, but at that point, NHS Highland was unable to use the ophthalmic capacity that we had given it.

As for orthopaedics, however, Highland has been sending us those patients for three years now. We do outreach clinics for them, with follow-ups by videoconference. I hope that we can get back to helping out NHS Highland with ophthalmology. The lady to whom Maree Todd refers was quite an unfortunate case, and I did hear about it. Had NHS Highland phoned us to ask whether we could have taken the lady, we would have taken her.

**Maree Todd:** NHS Highland has severe recruitment difficulties in that area, so it is not as though it is providing a service there anyway.

**June Rogers:** Absolutely—and that is why we send one of our ophthalmic surgeons up to do the Shetland clinic, which used to be done at Raigmore. We are trying to help as much as we can, but I hope that we can get back to doing a bit more for Highland.

**Jill Young:** As we highlight to all the boards, not just at board level but to the clinical teams and GPs who refer to us, the management and redesign of pathways and the work that June Rogers has described should never impact on an individual patient's care. A patient should not have to hear about how we are redesigning things or moving them around and how we are working with other boards. In such cases, people just have to lift the phone—they all have our number; it is the direct number to June Rogers—and we will fix them. The patient in question should not have been caught up in the middle of that situation.

**Miles Briggs (Lothian) (Con):** Good morning. I want to press the question of how aftercare for patients is monitored, specifically when they return to their health board areas; I am thinking, for example, of access to physiotherapy. From the monitoring that you say that you have been doing, are you aware of specific boards where this is a problem and where the pathway is not being put in place for people? That seems to have been the case for constituents whom I know in Lothian. Do people returning to their own health board areas face a postcode lottery?

**Jill Young:** I am not sure that it is a postcode lottery. Before patients are admitted, we pre-arrange their discharge; we would not bring in patients who did not already have that agreed and in place.

We have never had a delayed discharge at the Golden Jubilee for more than 10 years now. That has not happened by accident—it has taken a lot of hard work and planning. If a patient was fit and well to go home, but had their discharge delayed because they needed physio or occupational therapy or some sort of stair lift or toilet aid, that would block the bed and the next patients would not be able come in. That is obvious. We have negotiated with health boards that the next patient blocked from coming in as a result of that will be theirs, which will breach their targets. We have worked extremely hard on this, and we have contact with every social work department in Scotland, whereas most boards only need to have that partnership with their local social work department. As I have said, we have not had any delayed discharges.

I have to say that we have not had a huge amount of feedback saying that what had been agreed up front was not in place when patients went home. We need only look at the care that is received now—and which Mike Higgins has outlined—especially for orthopaedics, where patients do not get general anaesthetic, control their own pain and are up and walking the same day. They get their hip replacement in the morning, they are up and walking in the afternoon and they are back home two days later. As a result, the majority do not require additional care in the community, whereas before they would have had to spend 10 days in hospital and then would come back home with perhaps a wound drain or a big dressing that needed a district nurse and aftercare. The number of people who need that has reduced dramatically. As I have said, I have not had a lot of feedback in that respect, and we look at all the feedback that comes in.

**June Rogers:** Do your constituents have an issue with one particular specialty—say, orthopaedics?

**Miles Briggs:** I do not have the authority to speak about the specific case, but I can say that it was a hip replacement.

**June Rogers:** That would be unusual. Lothian sends us more than 4,000 cases a year; it is one of our highest referrers—in fact, it is the highest—so I am almost pleased to hear that we are talking about only one case. One is bad enough, though.

**Miles Briggs:** The complaint does not seem to be about you, but about access to physiotherapy, if that is needed, once a person gets home.

**June Rogers:** That is generally organised in advance. Most patients do not have any specific post-operative physio when they go home. When they come to hospital for their pre-op assessment, they go to what we refer to as the joint school and leave with a video, book and phone number. They are encouraged to do their exercises at home; if they have specific problems, they call us and we call their GP practice for additional support, but that does not tend to happen very often.

**Jill Young:** Access to seven-day services in local areas in the community would improve that dramatically for everyone, but that is not available everywhere at the moment.

**The Convener:** We have seen the amount of delayed discharge across the country. Does the planned nature of your work prevent that from happening to you?

**Jill Young:** Yes, indeed.

**The Convener:** So you are in a unique position that others are not in. You know when people are coming and can arrange services way ahead to ensure that there is no bed blocking.

**Jill Young:** Absolutely, but there is another side to that. The innovation and new technology that we have put in place mean that patients do not have to go back to nursing homes, some other hospital or some other form of care in the community. As a result, we do not have to make all those arrangements; patients just go back to their homes and their families.

**The Convener:** Can you give me an example of that technology?

12:00

**Jill Young:** With enhanced recovery, which has been rolled out across Scotland, no general anaesthetic is used and no urinary catheters are inserted, so patients are not discharged home with a catheter that would require care from a district nurse. Because patients are up and walking in three days, they do not get chest infections; as a result of that, they do not need antibiotics and do not need to visit a GP. Complex discharge arrangements that had to be made five or 10 years ago are no longer required. We have all the evidence behind that.

**The Convener:** In that regard, are you doing stuff that others can learn from, or are they already doing it? If they are doing it, why has delayed discharge not been eradicated?

**Jill Young:** Enhanced recovery has been rolled out and is being used by all health boards in orthopaedics. We have spread it into our cardiac and thoracic surgery. It is a principle of care—it does not apply purely to one speciality. We have shared the approach; indeed, our team has gone round the country, training people in it.

**The Convener:** Thank you very much for your attendance this morning. I now suspend the meeting.

12:00

*Meeting suspended.*

12:05

*On resuming—*

# Subordinate Legislation

## Registration of Social Workers and Social Service Workers in Care Services (Scotland) Amendment Regulations 2017 [draft]

**The Convener:** Agenda item 3 is consideration of an affirmative Scottish statutory instrument. As is usual with affirmative instruments, we will have an evidence-taking session with the minister and his officials, and once all our questions have been answered, we will have a formal debate on the motion.

I welcome to the meeting Mark McDonald, the Minister for Childcare and Early Years, and from the Scottish Government Diane White, senior policy officer, office of the chief social work adviser; and Ruth Lunny, principal legal officer. I invite the minister to make a brief statement.

**The Minister for Childcare and Early Years (Mark McDonald):** Certainly, convener. Thank you for the opportunity to introduce the regulations, which are made under sections 78(2) and 104(1) of the Public Services Reform (Scotland) Act 2010 and amend regulation 5 of and the schedule to the principal regulations, which are the Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013.

Regulation 5 of the principal regulations, read with the schedule thereto, requires social service workers within the scope of registration to register with the Scottish Social Services Council. Specifically, the regulations require all new workers commencing employment for the first time in any of the groups within the scope of registration to achieve registration within six months of commencing that employment. Where persons are already working as social service workers, the dates specified in the schedule are the dates by when those workers must achieve registration.

The draft regulations before you relate to the latest groups of workers for whom registration with the SSSC will commence in October 2017—support workers working in care at home and housing support services. In fact, they are the last groups of social service workers within the current scope of registration who will require to register with the SSSC. The 2017 regulations amend the schedule to the principal regulations to specify the two additional descriptions of social service worker requiring to register with the SSSC—a support worker in a care-at-home service and a support worker in a housing support service—and to set the date by which existing workers in those services must achieve registration with the SSSC as 30 September 2020.

In summary, the regulations maintain and fulfil the policy intention, which has commanded support from all parties, that registration with the Scottish Social Services Council is a prerequisite of employment and continuing employment as a social service worker. They also provide the final dates for the achievement of registration for those final groups of workers.

**The Convener:** Thank you. Is there any evidence about who pays the £25 annual registration fee? Does all of it fall on individual staff members? We know that staff in this field are some of the lowest paid and that their employment is among the most precarious of many of our public sector workers. Do they have to pick up that fee themselves, or is their employer paying it for them?

**Mark McDonald:** Individual workers usually pay their annual registration fee to the SSSC. As you have identified, the fee for the groups concerned will be £25, which, apart from the fee for social work students, is, I believe, the lowest charged by the SSSC for registration. It is worth noting that individuals can claim tax relief against their registration fee, which would reduce the cost from £25 to about £20.

**The Convener:** Do you have evidence that any employers are picking up that fee?

**Mark McDonald:** I am not aware of employers who are paying it—I do not have the kind of comprehensive information in front of me that would make me aware of that. There might be some employers who choose to pay it, but I personally am not aware of any.

**The Convener:** Do any members have questions?

**Alison Johnstone:** I realise that registration is a requirement of the SSSC, but has there been any Government consultation on the issue raised by the convener? If so, what feedback did you receive? We are desperately trying to recruit more people into the profession and although the fee itself might not be a lot to some people, it might be a barrier for others. Has there been any discussion of a waiver for those who find it to be a barrier that they cannot overcome?

**Mark McDonald:** It was not the Government's role to consult on the matter. It was the SSSC that consulted with the sector; it contacted more than 90,000 individuals and received 3,813 responses, which is a 4.2 per cent response rate. Undoubtedly some individuals will be unhappy that the fees are going up across the piece, but if you

look at the general trend of monetary increases, you will see that the uplift for most of the lower-paid end of the spectrum is very small. I have also asked SSSC to look at the possibility of introducing an income-related system for registration fees in the future, and it is considering that suggestion.

**The Convener:** For an average care worker, the fee is probably equivalent to three hours' pay, which is quite significant.

We now move to agenda item 4, which is the formal debate on the affirmative SSI on which we have just taken evidence. I invite the minister to move motion S5M-05208.

*Motion moved,*

That the Health and Sport Committee recommends that the Registration of Social Workers and Social Service Workers in Care Services (Scotland) Amendment Regulations 2017 [draft] be approved.—[*Mark McDonald*]

*Motion agreed to.*

## Regulation of Care (Social Service Workers) (Scotland) Amendment Order 2017 (SSI 2017/95)

**The Convener:** Agenda item 5 is consideration of a negative instrument. No motion to annul has been lodged and the Delegated Powers and Law Reform Committee has made no comment on the instrument.

If there are no comments, does the committee agree to make no recommendations?

**Members** *indicated agreement.*

**The Convener:** Thank you. As previously agreed, we will continue the meeting in private.

12:13

*Meeting continued in private until 12:44.*

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