OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 6 February 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 6 February 2018

CONTENTS

HEALTH AND SPORT COMMITTEE

5th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Annie Anderson (University of Dundee)
Dr Christine Campbell (University of Edinburgh)
Geoff Huggins (Scottish Government)
Fraser McKinlay (Audit Scotland)
Gregor McNie (Cancer Research UK)
Dr David Morrison (NHS Information Services Division)
Dr Euan Paterson (Royal College of General Practitioners)
Janice Preston (Macmillan Cancer Support)
Shona Robison (Cabinet Secretary for Health and Sport)
Professor Bob Steele (University of Dundee)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 6 February 2018

[The Convener opened the meeting at 09:30]

Preventative Agenda

The Convener (Lewis Macdonald): Good morning, and welcome to the fifth meeting in 2018 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are switched to silent. I will do it myself, as an exemplar. Devices may be used for social media, but please do not record or film proceedings. We have our own people to do that, and all the recordings are publicly available.

Agenda item 1 is a round-table evidence session on the detect cancer early programme. The session is part of our wider preventative agenda inquiry.

I ask everyone around the table to introduce themselves, please. I am the convener of the committee and a North East Scotland MSP.

Ash Denham (Edinburgh Eastern) (SNP): Good morning. I am the deputy convener of the committee and the Scottish National Party MSP for Edinburgh Eastern.

Janice Preston (Macmillan Cancer Support): I am head of services for Macmillan Cancer Support in Scotland.

Miles Briggs (Lothian) (Con): I am a Conservative MSP for Lothian and the Conservative spokesman for health and sport.

Dr David Morrison (NHS Information Services Division): I am a consultant in public health medicine and director of the Scottish cancer registry.

Alex Cole-Hamilton (Edinburgh Western) (LD): Hello, everyone. I am the Liberal Democrat MSP for Edinburgh Western.

Gregor McNie (Cancer Research UK): I am the head of external affairs with Cancer Research UK.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I am the constituency MSP for Mid Fife and Glenrothes.

Emma Harper (South Scotland) (SNP): I am one of the MSPs for the South Scotland region.

Alison Johnstone (Lothian) (Green): I am a Lothian MSP.

Professor Bob Steele (University of Dundee): I am a co-director of the Scottish cancer prevention network, and I also chair the United Kingdom National Screening Committee.

Professor Annie Anderson (University of Dundee): I am director of the Scottish cancer prevention network and a professor at the University of Dundee.

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

Dr Christine Campbell (University of Edinburgh): I am a reader in cancer and primary care at the University of Edinburgh.

Brian Whittle (South Scotland) (Con): I am a South Scotland MSP and the Scottish Conservative spokesman on health education, lifestyle and sport.

Sandra White (Glasgow Kelvin) (SNP): I am the MSP for Glasgow Kelvin.

Dr Euan Paterson (Royal College of General Practitioners): I am from the Royal College of General Practitioners in Scotland and was a general practitioner in Govan for 30 years.

David Stewart (Highlands and Islands) (Lab): I am an MSP for the Highlands and Islands region.

The Convener: Thank you very much. I warmly welcome all our guests.

I will start the questions by asking about the rationale for the detect cancer early programme, which clearly—at least, in part—relates to late diagnosis and late presentation in Scotland compared with diagnosis and presentation in other countries. What contributes to that late diagnosis?

Professor Steele: There are a number of reasons for late diagnosis. It is partly about many people delaying going to see their general practitioners with symptoms, and it is partly about the fact that, in some cancers, symptoms are not good early indicators of disease. That is why we have screening programmes for breast, cervical and colorectal or bowel cancers. There are two main issues.

The Convener: Why does Scotland show a relatively greater tendency to late presentation and late diagnosis than comparable countries?

Professor Steele: There are various issues to do with levels of deprivation. We also have to think about the causes of cancer. Scotland traditionally has had behaviours that are not conducive to cancer suppression: diet, smoking habits and lack of exercise have contributed to the high incidence of cancer.

Gregor McNie: I can speak to a couple of points that Professor Steele has raised about what we describe as “the patient interval”, which is the time from when a patient first spots symptoms to their presenting at their GP. That interval can be months, or even years.

The convener asked about Scottish differences. International evidence points to UK differences that are grounded in our relationship with the national health service. There is a unique UK view that plays out in a lot of the evidence, which is that we do not want to overburden a system that we all hold in very high regard.

On more Scotland-specific issues, a lot of public-opinion testing has discovered that a strand of fatalism exists in deprived areas in particular. A healthy level of fear of cancer is required in a population; we want people to hold it in some fear so that they present. However, when fear drifts into fatalism, it becomes disabling and we hear concepts such as “the big C”, “cancer means curtains” or even “I’d rather not know.” Those concepts are particularly prevalent in deprived areas in Scotland. The DCE programme has made some efforts to challenge those concepts, but there is a long way to go.

Dr Paterson: I will add a general practice perspective, having worked in Govan for many years. The issue is not just the absolute deprivation but the gulf that exists and is increasing between the haves, who include people like me, and the have nots, who include a lot of the people whom I was trying to serve. Not only does that induce fatalism, but it leads to a loss of purpose, a loss of hope and people asking, “What’s the point?” which can be extremely frustrating and very difficult to overcome. We struggle to get people who have been diagnosed with cancer to go back for review—it is that big a problem. I suspect that global inequalities underlie a lot of the issues; we see that writ especially large in countries including the UK and the United States.

Dr Campbell: I would reiterate what my colleagues have said. Literacy and health literacy are related to that. We deal with the wider contexts of people’s lives, too, so when we try to address fear and fatalism through information and awareness campaigns, it is very important that we use appropriate language. DCE efforts have, in different ways, tried to give messages in such a way that people will take them on board.

Sandra White: I have a small follow-up point, as someone who was born in Govan, who lived there and who still has relatives there. I know exactly what Dr Paterson means about fatalism. I wonder whether we should put more effort into explaining that being diagnosed with certain types of cancer does not have to be a death sentence. We have screening, which is great, but with the help of Macmillan Cancer Support and others, people can live with cancer. Do you think that we should put more resources into spreading that message, especially in particular areas?

Janice Preston: We have a lot of insight from across the UK and we know that people in Scotland are more financially stressed. We also have some insight from Easterhouse, where we did a health improvement study a few years ago. People said that they did not trust health messages: there is something about health messages being made at national level that does not reflect what people see outside their windows. We need to make that real to the people who live in such areas, and we need to build trust and work with communities.

Alex Cole-Hamilton: On the wider point about attitudes to health messages, there is natural embarrassment about seeking help with cancers that affect the bowels and genitals, especially in deprived communities, but it exists in all communities. We try to break that embarrassment through national messaging campaigns, but we still do not seem to be getting it right. There was a report last week about uptake of cervical cancer screening, which was based on the fact that women are embarrassed about being examined in that way. How can we do better in breaking down that embarrassment?

Professor Anderson: I want to bring the discussion on messaging back to prevention. There is a huge gap in this country in respect of raising awareness about preventative action for cancer, which is not covered by the DCE programme. There is not a person who has been diagnosed with cancer who does not wish that it could have been prevented in the first place. Although Sandra White’s question was about the time after diagnosis, we must think about earlier prevention.

The Convener: Do you want to come back on the previous question, Gregor?

Gregor McNie: Yes, convener. I believe that the question was about challenges to people presenting, where invasive tests would be involved. I think that technology might have a lot of solutions to that. As part of the cervical screening programme, for example, home-testing pilots have been established—I know of one in Dumfries and Galloway—so that people do not have to present at clinics. The fact that the people themselves rather than nurses are doing the tests will break down barriers for some.

The next thing on the horizon is the new faecal immunochemical test—or FIT—for bowel cancer screening. That test, which is already on stream, involves taking one sample rather than three, and evidence is showing that that approach is breaking down a lot of barriers, particularly for men—and especially for men in deprived areas. We therefore impress on the Scottish Government the need to give that test a real push and to ensure that the public are well aware of the change and how much easier it is to do that screening.

Janice Preston: We have a growing amount of evidence that makes it clear that not all the discussions have to take place in healthcare settings. When Macmillan launched our service in the libraries in Renfrewshire a couple of years ago, people came in and saw the kit. When they started to talk and inquire about it, they realised that they had received it in the post a couple of months previously. We need to make those things more visible and we need to have those kinds of conversations. In our work with libraries across Scotland, we are—as we have been told many times—giving people what feels like a safe space. People might feel barriers to going into healthcare environments, so we need to use community spaces more in that way.

The Convener: I call Alison Johnstone.

Alison Johnstone: I have to confess that my question is about prevention, convener.

The Convener: We will come back to you later. Do you want to comment, Dr Campbell?

Dr Campbell: With regard to the previous discussion, embarrassment is a huge issue. Work is going on across Scotland on it—we in Edinburgh are doing some work, as are colleagues in Glasgow and many other places. Qualitative interviews and focus groups involving men and women in various communities are happening in order that we can understand the local issues.

One key point is about the power of narrative and stories. It can be very useful for people to see someone like them at a health forum, a local event or a supermarket, talking about being screened or using the kit. I know that CRUK is trying, through its local primary care engagement programme, to do a lot of that sort of thing.

The Convener: I believe that Miles Briggs has a question about deprived communities.

Miles Briggs: Staying with the point that Janice Preston made, how might we develop the approach that she outlined? Do we need, say, community health hubs to give people a forum at which to discuss the issues and which provides a space that different charities could use?

As for how we take the messages to people, could we make links with bookies, for example, where you might be more likely to have conversations with people? Do panel members know of any examples of work that is going on elsewhere that we could introduce in Scotland?

Janice Preston: There is a lot of evidence to suggest that we are improving the cancer journey in Glasgow—through an approach that we are spreading to Dundee, Fife and other places, we hope in partnership with the Government. We are now engaging with 80 per cent of people in the most-deprived areas, so people from those areas are taking up provision. There is something about using community venues and having that shared community space that makes access easier for people. Of those people, 61 per cent come from deprivation category 1, and we have found that if a needs assessment is carried out of all their needs—financial, practical and emotional, as well as clinical—they feel able to self-manage three months on, and the growth in their confidence is enormous. That is the point in time when not only the people in question but their entire families are receptive: we need to build on that teachable moment. I absolutely believe that using community spaces cross-organisationally and collectively is a huge plus.

Sandra White: I will just pick up on Janice Preston's point. In my Glasgow Kelvin constituency, the Annexe Communities drop-in centre in Partick could be used to capture a lot of men who tend not to go to their doctors. After all, men are used to going to the centre to have a cup of tea, play a game of dominoes or whatever. Should those kinds of facilities be used more for testing? People would not have to go to a health centre; they would be going to a place that they go to once or twice a week anyway.

Janice Preston: Absolutely. Men's sheds, or similar places, are ideal venues. We mostly use volunteers—people in communities, helping other people. The service is managed through the libraries, but it goes wherever people are.

09:45

Dr Morrison: Based on my experience as a screening co-ordinator, I say that one of the challenges is the need for better technology. We all know that screening tests in all their forms are embarrassing and uncomfortable. One of the positive things about the new FIT test is that it is easier and quicker. People face real practical challenges in taking three bowel motion samples and doing a screening test—men and people who are less resourceful find it a challenge to get everything together. Similarly, we can all fully understand how embarrassing and sensitive cervical screening can be. There is also a challenge for the medical profession to develop future screening tests that are more pleasant and easier to do. I would welcome an easier way to do screening tests that do not impose so many barriers.

Professor Anderson: To go back to community approaches, I was one of the research team that designed the weight-loss programme that was carried out through the Scottish Premier League, called football fans in training. Various charities, including Bowel Cancer UK, have been working to try to raise awareness through football clubs. There is a huge opportunity there: a door has been opened for cancer awareness by the football fans in training programme. It seems to be an obvious route to take.

The Convener: I know that programme well from Aberdeen. It happens in other parts of the country, too.

On the impact of the detect cancer early programme, a striking bit of evidence was that there was an increase in consultation without an increase in diagnosis. Ivan McKee has a question on that.

Ivan McKee: Thank you all for coming to talk about such an important issue. My question is on the point that was raised by the convener. If you look at the data from the past couple of years, you see that the numbers for diagnosis at stage 1 have increased very slowly. Very limited progress has been made on that. For example, the data shows an increase in colorectal cancer referrals, but the number of detections has remained flat. Are we targeting the wrong people, or is there an issue about how GPs are dealing with referrals?

Professor Steele: That is a really challenging issue. The problem with bowel cancer is that the symptoms are common ones that many people get every day—rectal bleeding, abdominal pain or a change in bowel habits, for example. There has been a drive—rightly—to increase awareness of those symptoms. The problem is that then many more patients go to see their GPs, who are faced with an almost impossible situation: they have a patient with symptoms that could be due to bowel cancer and they do not want to ignore them. There is a drive to use the FIT at a more sensitive level to help GPs to make a decision about whether an individual should go on to invasive testing. The problem is that if too many patients go for colonoscopies, all it does is clog up the waiting lists so that people who need that investigation are delayed in getting it. We have to be cleverer about having tests to help GPs to make a decision on how they deal with the patients that come to them with symptoms.

Dr Paterson: I was part of the National Institute for Health and Care Excellence guideline group that examined the revision of referral for suspected cancer. That did not cover Scotland—it looked at England and Wales—but I was there through the RCGP. In that review it was clear that even symptoms that one would think are really serious have a fairly low predictability for turning out to be a cancer. For example, diarrhoea on its own has a positive predictive value of 0.94—it is a tiny number. Even big things, such as bleeding, are not that common the first time round.

Martin Marshall describes GPs as “boundary specialists”—they are trying to sit across the boundaries and work out exactly what to do in incredibly complex situations. The complexity comes not just from how complicated the presenting symptoms are, but from the index of suspicion that arises when a patient is somebody who never comes to see the GP. The fact that they have come makes the antenna start to wave.

That can be followed by serial longitudinal encounters and continuity, which in turn—apart from providing the narrative that was talked about earlier, which is so important—engenders a degree of trust, it is hoped, and starts to break down embarrassment. It is probably easier for an old man whom I know to have his bottom examined by me than by someone whom he has never met before. That is the reality.

To have that, though, we need an adequately resourced and staffed general practice workload. I mean to say general practitioners, because when we were at university, we were trained to make diagnoses and plan treatment—the rest of it is a bit of a bolt-on. That is the real deal with doctors.

I think that expecting other people to take on that diagnostic role, without the continuity or the relationship, will present significant challenges and might adversely impact on the detect cancer early programme.

Ivan McKee: I understand that it is complex to determine from the symptoms whether there is cancer, but a lot of that relationship can be modelled. Is there enough data to understand where we need to look and where the highest chance is of finding cancer based on what is being looked at?

It was striking that a lot of the responses said that not much in the way of cost benefit analysis is going on. Do we need to be better at understanding where to put resources to get the maximum effect?

The Convener: Who would like to respond to that?

Dr Paterson: On the point about putting things together and the idea that symptoms A, B, C, D and E could come together, the work by the NICE guideline group suggested that there should be an urgent referral for suspected cancer if the overall positive predictive value was above 2. That would mean that 98 of the people who were referred would turn out not to have cancer. The hit rate is pretty small. That, again, is the reality.

The additional danger is that, if we target resources to ensure that those people are seen timeously, which is incredibly important, it means that the people who have a PPV of 2.5 wait for an inordinate length of time before they are seen. The group that is not quite bad enough but is also not okay can get a really raw deal if we are not careful.

Professor Steele: That is right. A huge amount of work has been done to look at different symptom complexes, but it is not very effective. The most effective tool that we have at the moment, as NICE has picked up, is a sensitive test for blood in stool. If someone does not have blood in stool, the chances of having serious disease are very small. That test is something else in the mix.

The Convener: Are you arguing that the use of simple blood tests—which are used to test for prostate cancer, for example—should be extended or more targeted?

Professor Steele: The test that we are talking about is the same as the test that is used for bowel screenings, which looks for blood in stool, except that it is set at a much more sensitive level, to be able to pick up very small traces. There is no peripheral blood test that would be helpful in that context.

The Convener: You said in response to Ivan McKee's first question that we need to get smarter at identifying who we should target. How can that be done, in the context of what Euan Paterson has described?

Professor Steele: It can be done with a combination of looking at symptom complexes and testing, and at the moment the best test that we have is a test for blood in stool. That combination is probably the way forward.

It is about assisting GPs, not telling them what to do. As we have heard, GPs are professional people. They are doctors and they make sensible decisions.

Gregor McNie: We can also look at how we can gain efficiencies once we have referred patients on. It always helps me to understand the context that the GPs are in when I think that they see only eight to 10 cancer cases a year, on average, out of 6,000 to 8,000 appointments. That is what they are trying to sift through in terms of cancer diagnosis.

It may be possible to make efficiencies when it comes to referring to secondary care. More direct referral pathways could be offered to GPs, for example, which would allow them to refer directly to some diagnostic tests. The current model is that the patient goes to someone in secondary care, and that person makes an assessment, then perhaps has a conversation with the GP and a conversation with the patient. We hear anecdotally—and there is data behind it—about patients who are bounced around the system. There is probably value to be had by building capacity in the system, which would also improve patient experience in that regard.

Dr Morrison: Cost benefit analysis was mentioned. My understanding is that it is quite broad: you have a set of costs and different kinds of benefits and you can put costs against them. That helps to open up the debate about where our resources might best be put for primary prevention, which is to stop people from getting cancer; for, as Gregor McNie said, making the systems more efficient to get people through to an early diagnosis and treat them effectively; and for what we can do to make the experience of cancer less onerous and less difficult.

That cost benefit analysis is a big question. There is a tighter question about cost effectiveness: if we have one effect, which is how to detect cancers as early as possible, what is the cheapest way of doing it? That is what we have been rehearsing so far. That question and the use of the term "cost benefit analysis" is useful, because it starts to raise the question about where, in all the experiences of cancer, we can put our different resources. We need a distribution of resources, because we cannot do everything at every point. We cannot prevent or cure every cancer and we can do something to palliate cancers that we cannot cure.

Dr Campbell: What we need to think about is not a very long-term agenda, but it should certainly not be a quick fix. It is important to remember that awareness campaigns, for example, must be sustained, because the people who will get cancer at some point—us—need to have those messages in mind. Therefore, there is a need for sustained awareness. People take time to absorb the messages and change their behaviour. We trust that, in time, that will feed into the broader cost to benefit ratio.

On health systems, it is important to remember that there is research going on in the UK and internationally on how, while keeping a primary care gatekeeper or boundary role, triage and redesign or tweaking of the health systems can allow for faster referral of the appropriate people. There are pilots going on in England on fast-track systems. There is also a redesign of the Danish primary care for cancer symptoms that considers high suspicion, medium suspicion and low suspicion. A lot of evaluation of that redesign is being done to determine what the optimal pathway is for patients. Scotland is also part of the international cancer benchmarking partnership, which is comparing patient pathways in a number of different jurisdictions to learn what we can about optimal design.

David Stewart: Thank you very much for that contribution. I am interested in cancer survival rates throughout Europe. You touched nicely on international studies. You will know that, last month, *The Lancet* published the Concord 3 study, which compared the cancer survival rates in countries throughout the world. The figures in that were for the UK, not Scotland, and, from memory, we came out extremely well—around fourth place—for all childhood cancers, but not so well for colon cancer, on which we were 17th out of 28. There are obviously big comparisons. Why are the survival rates so different in different European countries?

Professor Steele: I am sure that David Morrison will want to comment on this, but it is really important to realise that such studies do not always compare apples with apples. We have such good cancer registration in this country that we have an accurate knowledge of survival rates, whereas some of the other countries with which we are compared have poor cancer registration, so only a small proportion of the population is being examined. I do not know whether the new Concord study has dealt with that, but it always strikes me as a significant problem. We do ourselves down because of it.

David Stewart: That is a useful point. A quick glance at the study shows that 71 countries were being considered. However, the figure that I quoted was within the 28 European Union countries. We were fourth out of those 28 for childhood cancers, but a lot lower for colon cancer. Why do we have different scores for different types of cancer even within the EU, which has fairly advanced health systems relative to some of the other countries in the 71?

10:00

Professor Steele: Even within the EU—in Germany, for example—cancer registration is only about 7 per cent of everyone with cancer, so these comparisons are dangerous.

There are certainly differences between the UK and the Scandinavian countries, for example, where we are pretty sure that the comparisons are similar. It is probably related to fairly simple things such as levels of deprivation and smoking rates, but I am sure that others will have their opinions.

Dr Morrison: I agree with what Professor Steele is saying. The Eurocare 5 study is the other big international European comparison of cancer survival rates and it has repeatedly shown that UK survival rates for nearly every cancer, apart from skin cancers, are relatively poor. The biggest gap is in lung cancer, where no country's average survival is particularly good, but the gap between the other countries and the UK is particularly large.

I will rehearse what the discussions are. As Bob Steele says, one of the issues is that, at an international level, we do not have the fine detail to show that this is exactly the same kind of patient at exactly the same stage with the general other illnesses or comorbidities that contribute to their ill health. We have to look at a fairly high level and ask whether the result could be an artefact or whether it is just that countries are being selective. That is true of some countries, but the Scandinavian countries return 100 per cent of all their data so it is not the only explanation.

I have done some work with colleagues in Germany and tried to understand who their lung cancer patients are: why, out of all of the people who have lung cancer, those people come to their specialist centres. It is the same story when you look at information from the United States. People tend to report a selective best-case scenario.

We are then left asking questions such as whether we are getting worse kinds of cancers or whether they are more aggressive in some way. The general health of the population answers some of that but we use a thing called relative survival, which compares the population with what we would expect within that population. General health contributes to people's survival and their capacity to take some of the more aggressive types of cancer treatment. Being in good health is a good way to tackle cancer on top of everything else.

David Stewart: Thank you. That was useful.

I have one more question to throw in. I am not making a judgment by making this comment. Professor Michel Coleman, the author of the study, suggested that the reason for the differences is that some European countries spend a higher proportion of their gross domestic product on health, and that the UK has not spent as much as other European countries. I know that there has been a big debate about that, and the *Sunday Times* had an article about how the inflation rate on health is a lot higher than the normal consumer price index, because of technological changes. The author of the study has one view; do our witnesses agree or disagree with it?

Dr Morrison: That is a highly political question and I would be cautious of coming down on one side and saying whether it would explain everything.

However, as we have already said, when looking at the efficiency of a system, we have to accept that, in order to capture patients who might not obviously have cancer—it is one thing to say that someone has symptoms of cancer, but a lot of people are diagnosed by surprise as an incidental finding—we have to allow a certain throughput or number of investigations. Trying to be highly efficient and trying to diagnose people at the earliest stages is a difficult balance. I am not necessarily going to side with Michel Coleman's view on whether that means that we need a change in our total budget, but there is certainly a cost that comes with investigating more people and accepting that a lot of those investigations will have negative results.

Janice Preston: One thing that I like about the detect cancer early programme is how ambitious it is. The last thing that we should do is drop the level of ambition to be the best and concentrate on why we seem to be one of the worst. We have a unique opportunity to shift that.

When it comes to the cost benefit, in particular, if we were to change the statistic that says that 29 per cent of those in more deprived areas are diagnosed late and their lives are then very short, the benefit to the community and Scotland as a whole would be huge.

As members know, Macmillan Cancer Support focuses on people with cancer. That is where we invest and where we focus our time, and we will continue to do so. However, our community engagement is unparalleled by that of any other national agency. People have enormous trust in Macmillan, and there is a real opportunity to get to the heart of those communities and shift the story. It is not about investing in Macmillan or Macmillan investing; it is about the wider collective joining Macmillan and adding to the work that we are doing. We could shift the story with prevention messages, detecting cancer early and screening.

Dr Paterson: I will jump back slightly to the question of whether we are worse than other countries—and why we are worse, if indeed we are—or whether it is just about poor registry and poor comparison. Maybe I am taking a slight leap here, but there is good, solid evidence that the greater the divide between the haves and the have nots, the worse the levels of some fairly impressive health and social metrics, such as life expectancy, maths and literacy, infant mortality, homicides, imprisonment, teenage births, trust, obesity, mental illness—including drug and alcohol addiction—and social mobility. It would not take much to extend that to why we are not doing so well with things such as cancer, because those factors will play out in every single health and social situation that every person in this country suffers from. It bothers me that we still seem so unwilling to acknowledge something that seems so staggeringly obvious. If that issue was addressed in part, the benefits outside of detecting cancer early and preventing it would be enormous.

Brian Whittle: You have led me very nicely into the area that I wanted to address. I have a couple of questions. Will the witnesses speak about poor access to GPs and the influence of 10-minute GP appointments on detection levels?

Dr Paterson: That question is coming my way.

The Convener: It looks like it.

Dr Paterson: The simple answer is that the 10 minutes that we have nowadays is a woefully short time. When I started in general practice in 1985, we had 10 minutes, and that was more or less adequate. Over my time in practice, the complicatedness of health and care, and of treatment and decision making, seemed to grow exponentially to me. We also introduced a whole raft of complexity. In many ways, we introduced very good things, such as involving in a far more natural way the individual whom we were with, rather than having the doctor-knows-best approach. Even as a young GP, that approach did not quite feel right for me, but it was still quite prevalent 35 years ago. However, GPs' time with people has not changed at all, and 10 minutes must be inadequate now.

We are creating a very elderly, very frail and multimorbid population through social care and health interventions, for example, and many people in that population will suffer with dementia. Within the next decade, dementia will become the commonest cause of death. I suspect that the majority of people in this room will peter out in a care home.

David Stewart: That is depressing.

Dr Paterson: As I am one of the older men, I will be one of the first. That is a reassuring fact.

Cost benefit has been talked about. The costs of providing care to the population that we are creating will be astronomical, because those people will require observed care. They will not manage to be looked after in the family home. It is very difficult to look after somebody with end-stage dementia in the family home, so those people are heading for a bed somewhere. Where? That is the committee's next agenda item this morning—that is just a marker.

I have gone on a bit, but 10 minutes for an appointment is not adequate.

Brian Whittle: That led to where I wanted to go. We are asking our GPs to do more and more.

Professor Anderson mentioned the prevention agenda, and smoking, obesity, alcohol and a lack of physical activity have huge parts to play. I want to look at the social prescribing that we ask our GPs to do.

If there is no time to do that social prescribing, the issue becomes one of access to opportunities to be active—especially for people in deprived areas—to get advice and to be included in society. To my mind, if people were more active they would be less likely to smoke and more likely to be in control of their weight and have a better relationship with food and drink. That would provide some redress with regard to the sense of fatalism or lack of hope and achievement, and people would feel included and have better mental health. Where are we with that with regard to cancer prevention? Social prescribing has a big role to play in tackling the high levels of cancer that can be found in deprived areas.

Professor Anderson: What point would you like me to respond to? [*Laughter*.] As a topic, cancer prevention is the elephant in the room: people do not like to talk about it, because it makes them feel guilty, while health professionals say that they are not trained in the area and that they are there to treat. Social prescribing is of great interest, but it is not being as rolled out as widely as it could be.

We lead on the ActWELL study. As part of that, women attending routine breast screening—that is, women who do not have breast cancer but who are at a teachable moment when they are interested in cancer—are asked whether they would like a lifestyle intervention. We deliver that in local leisure centres, but we have found that women do not really like going to leisure centres—they are big, sweaty places that women are not used to. We are offering the opportunity and making the link, but we are also listening to what people are saying.

Physical activity is one element of the lifestyle complex. I do not think that it is the sole route to people thinking about food and drink and obesity, although it is an important part of the jigsaw. Instead, we have to get wiser and smarter about how we introduce prevention. It should be part of the role of all health professionals; moreover, the health-promoting service initiative in secondary care should be flagging it up, but sadly it is not doing so at the moment. Primary care, too, has a role to play, but those people are busy.

We need to look at the totality of opportunities. In the detect cancer early work, we recognise that screening provides opportunities to talk about prevention and, as I said in our submission, we feel that that should be explored. We have evidence that people like such opportunities and take part in them, but they are often missed.

Dr Paterson: I completely agree. However, that is just one example in which the inverse care law is writ large. I was amazed at the amount of time and effort that I sometimes had to put in to encourage people to make a lifestyle change. I can be very persuasive when I put my mind to it, but it was a struggle. I think that it would be relatively easy to get me to shift my mind, but the fact is that the GP workforce per capita is more or less the same across the country, and more time needs to be available in deprived areas to ensure that very complex behavioural change interventions can be made.

Professor Anderson: I am sorry, but I forgot to say about ActWELL that the people who do the interventions are Breast Cancer Now volunteers, who have been trained in an intensive programme. Hundreds of people have come forward to be volunteers, allowing us to develop community capacity with regard to prevention. The ActWELL study is being rolled out now, and our preliminary findings show that it is an opportunity that we ought to be taking.

Alison Johnstone: I really appreciate the general focus this morning on health inequality and its impact on everything that we are doing. I have been on the committee since the beginning of the session, and we have done quite a lot of work on prevention. The message is coming across loud that messages are preventative for only some people—the people whom the messages reach. In some ways, that increases health inequality, and so the question is how we reach the people whom the messages do not reach.

We have also heard from Dr Helene Irvine and Dr Margaret McCartney, who expressed the perhaps quite controversial view that screening might not be the best focus for the money. I do not know whether we want to go into that, but Dr Paterson seems to be suggesting that longer appointments could be preventative. Having visited the Govan social and health integration partnership project, I think that if GPs had that bit more time they could reach people for whom an exercise programme might just be too challenging at the moment.

10:15

Dr Paterson: Longer appointments are useful with regard to signposting people to things. I think that I enjoyed a fairly high level of trust among most of the people I was attempting to serve and that it was helpful for me to make suggestions to them and push, encourage or coerce them to go to an appointment to be checked for something, to attend their screening appointment or to follow up on a live active referral.

Some good work was done five or more years ago in Scandinavia—in Sweden, I think. The study estimated that it took about 10 or 11 consultations between the same two individuals in primary care for a trusting relationship to develop and for people to feel that they could work together. It takes a lot of time, but perhaps that is the sort of time that is needed if we really want to see some transformation.

I would not in any way underestimate the importance of using social prescribing methods such as the links worker programmes, which are great. The issue is not only in general practice, and I would not like social prescribing to be forgotten about.

Alison Johnstone: Does the combination of both strategies represent the most effective primary prevention strategy for Scotland? Is there anything else to point out?

Janice Preston: All the initiatives are good and absolutely need to be supported. However, every submission that you received for today's meeting pointed out that we rely on that health interaction, and the problem is that a lot of people do not get involved in that until it is too late. Working through communities is important—the link officer programmes have been mentioned in that regard. The Scottish Government is committed to spreading one of the link officer programmes with us. Called improving the cancer journey, that programme uses a social prescribing model and reaches 80 per cent of people. The other link officer programme is based in GP surgeries and relies on people going through the door.

We are missing the whole-community effort. We have good communication, but how do we build those messages on to that, how do we start to change the conversations and communities, how do we reduce the stigma, and how do we use our safe spaces where people can talk to organisations that they trust? We need to build on that, not duplicate effort. I think that we need to do more.

Dr Morrison: On primary prevention, so far, we have been talking about how to treat or cure people as effectively as possible once cancer has developed. Let us be positive. We have achieved a lot with smoking, which is the biggest preventable cause of cancer. We still lag behind the rest of the UK in that regard, so further effort is needed—it is an old story, but it is still one that we need to keep pushing.

There is also good news in terms of the minimum unit pricing policy that we are about to implement in Scotland, which we hope will bring down alcohol consumption. However, as I said in my written submission, there is no safe level of alcohol—I am afraid that I cannot tell you a comforting story about that; if you want to minimise your cancer risk, no alcohol is the best policy.

On the issue of overweight and obese people—I am just addressing the three most common issues, but there is of course a longer list—we are not doing well. We are not turning the corner on that issue. Two thirds of our population are overweight or obese. A lot of people do not realise that that is such a major risk factor for some of the most common cancers, such as breast cancer and bowel cancer.

On our attempts to try to stop cancers occurring in the first place, we still have a long way to go with regard to the old enemies and some of the new cancers that we have not tackled so far.

Sandra White: I want to talk about prevention. Janice Preston made a good point. We have been talking about people presenting themselves to the doctor and so on, but I see prevention as ensuring that people are healthy enough not to have to present themselves to the doctor. Budget wise, is enough money spent on prevention, through things such as advertising? Dr Morrison mentioned obesity. Someone in a deprived area who has to feed their family might well go to one of the shops—I will not name them—that sell a lot of food that is not healthy.

What are we doing to educate people? We are doing a lot of work on exercise, particularly in Glasgow, with free entrance to gyms and through football and so on. We need to get the message out to the community. Could we link the Child Poverty (Scotland) Bill to the preventative agenda? Are there some innovative methods that we can use to get the message across to people that their diet is important? Methods such as the Mediterranean diet, which we hear about constantly, are not really that innovative. Minimum pricing of alcohol is a fantastic policy, but we should also consider banning some of the things that go into our food and look at how we label the food.

That was more of a rant than a question—I just wanted to open up the discussion. In order to prevent obesity, we need to educate people to eat better and so on.

Gregor McNie: Sandra White has set the scene. There has been a lot of good discussion about local projects and ways in which we can encourage individuals to think about their lifestyle. Euan Paterson has also talked about what can be done in a GP setting. However, once someone steps outside the practice, they are stepping into a different environment. I remember hearing a Govanhill deep-end GP talk about the fact that their patients had no access to fruit or vegetables within walking distance. That is the context that we are talking about. Academics and wonks talk about the obesogenic environment—they mean places where the unhealthy choice is easier and often perceived to be cheaper.

Cancer UK is tackling that environment to an extent by challenging supermarket high-fat, sugar and salt promotions. The cheapest way to eat is still to eat pasta, rice and whole foods. There is probably some need for education in cooking skills. On the promotion environment, there is plenty of science, such as nudge theory and so on, that shows that people’s behaviours in retail environments change depending on promotions and what is on offer. At the moment, the balance is tipped towards unhealthy foods and we need to tip it towards the healthy ones. That is why environmental interventions such as minimum unit pricing and challenging the promotion of unhealthy foods are vital.

Dr Campbell: I have a point that is related to our earlier discussion—although it also picks up Gregor McNie’s point—about the broader prevention agenda, long-term thinking and how we get everyone to think about the issues. Education is really important. Schools are not represented around the table today, and we should be thinking about fizzy drinks and what is available to kids in school. When I was at school, we had home economics classes, which were about how to cook and eat well, even on a budget.

My colleagues in Stirling and elsewhere have been doing work with the Teenage Cancer Trust on raising cancer awareness among young people without frightening them. The aim is to present a dual message: the cancer symptoms that they ought to think about and the broader healthy lifestyle thinking.

I come from the university sector and, to pick up the discussion on a health promoting health service, one way forward could be to include prevention as part of the broader curricula for students of nursing, medicine and allied health professions, as well as including it in the sports science agenda.

Emma Harper: David Morrison mentioned lung cancer. I am interested in that, as I am the convener of the cross-party group on lung health and we are looking at a respiratory quality improvement plan for Scotland. It looks like we are going to get Dr Tom Fardon to look at that, given that such plans are working in Wales and Northern Ireland. Is that something that can add to tackling lung cancer, even though it is a quality improvement plan that will focus on lung health in general?

Dr Morrison: I do not know the details of that, so I cannot say. What is good for your general lung health will be good for lung cancer—not smoking and not being exposed to environmental or occupational risk factors for lung diseases will greatly reduce your chance of getting lung cancer. Even if you do smoke, the interaction with other environmental or occupational exposures can make things worse. Any strategy to improve lung health will be useful for lung cancer.

We have been talking about other issues, such as obesity, and it is worth saying that what is good for cancer is usually good for heart disease, stroke, dementia and many other chronic illnesses. Therefore, we are not in a silo when it comes to cancer. A lot of what we are looking for to improve the general health of the population will be good for all of us.

The answers are complex, of course. On obesity, the foresight report was a superb report that involved some broad thinking, but if one message can be taken from it, it is that it is not a case of tackling any one issue. Education is not the only answer, nor are health interventions. It is an immensely complex subject. In a sense, tobacco is one of the easiest issues to tackle, because there is no good in tobacco. However, when it comes to our diets, people have to eat, and we must understand people before we can think of an approach that is fair.

Dr Paterson: My point is linked to that. In the 30 years for which I worked as a GP, I honestly think that there was only one person whom I encountered who smoked and who had a level of learning disability that meant that they did not understand the issue. In that entire time, I did not see one other person who smoked who did not know that smoking caused cancer and maybe some of the other stuff as well. Providing that information is not enough. The message is out there.

I will go round the table quickly. This is a group of highly privileged individuals. Put your hands up if your body mass index is between 20 and 25. Now do so if your fat index is less than 20 per cent. Now do it if you have five portions of fruit and veg a day. Now do so if you have no alcohol. Oh, my goodness! That is not good news. Now put your hands up if you do not smoke, you do not do drugs and you exercise for at least 30 minutes a day. Can anyone here say that that is the case? I see that Brian Whittle and Anne Anderson have raised their hands—leave now! That is two out of 30-odd highly privileged people, yet we are trying to suggest that this is an education message that we need to get across to the general community. We ought to be cognisant of that.

On obesity, it might just be the case that I am sometimes overinfluenced, but I thought that the series of programmes entitled “The Men Who Made Us Fat”, which was shown about five years ago, was really powerful. Arguably, obesity is a result of the underlying social malaise of aggressive marketing and consumerism. That is what is making people fat.

Professor Anderson: We have a lot to learn from tobacco control when it comes to other lifestyle factors. It has taken a long time—two or three decades—to get to where we are on pricing and availability of tobacco. We need to look at how that happened. It did not just happen overnight. The legislation that is in place would not have been introduced if it had not been popular enough to get the thumbs-up from the electorate.

Rather than education, I will call the first stage of that process awareness raising. Awareness had to be raised of the link between tobacco use and risk to health. CRUK is doing stellar work in raising awareness of the link between obesity and cancer, but for such a long time in this country we have had bland messages about activity being good for us. Physical activity can help to prevent cancer—we need to get that message out and be clear about it. Physical activity helps with other things, too, but let us get the cancer message out loud and clear.

That is what the tobacco control people did—they raised the bar on awareness and then they got people on board. Where are our role models now? Where are the health professionals saying to people that we need to do something about cancer and physical activity? With tobacco, we used advocacy by really important people in our communities. We needed to work on that before we could get people to agree that we ought to do something about the marketing, the pricing and the availability of tobacco.

The issue is not just about children. Tobacco control has always involved tackling young people smoking. Christine Campbell talked about children and students, but cancer prevention is possible for adults. We know that, even after the age of 50, we can help to reduce the risk of breast cancer among post-menopausal women.

Let us not call it education. We are talking about awareness raising, advocacy, having role models and getting people on board. Let us not focus only on kids. We need to look at the whole population. At any age, lifestyle changes can help to reduce cancer—and, by the way, diabetes and heart disease.

Jenny Gilruth: I want to drill down on Sandra White's point about education. Does the strategy need to be more explicit? Professor Anderson has just made the powerful point that physical activity can help to prevent cancer. I know that the issue is not all about children, but Christine Campbell said that none of us around the table is involved with schools, and I was a teacher in a previous life. You talked about schools banning fizzy drinks. In Fife, *The Courier* is campaigning to ban energy drinks in schools, which is a good example of how schools can take action to try to inform behaviours. The issue is not just about schoolchildren or younger people but, presumably, if we can have an impact on people's behaviours at an earlier stage, that can have an impact on their chances of contracting cancer later in life.

10:30

Do you agree that there needs to be more of a connection between health and education, because the committee keeps hearing that there is a disconnect between the two? In our session with Dr Burns, he talked about that disconnect with regard to adverse childhood experiences. The two systems are not talking to each other or sharing information adequately. Do the health and education systems need to sit down and audit the health and wellbeing curriculum, which is one eighth of the school curriculum? Do we need to sit down and look at the detail?

Professor Anderson: I confess to being president elect of the UK Society for Behavioural Medicine, so I will use my theoretical basis in answering.

Clearly, working with children and parents is needed. Cancer is a disease that has a life-course impact, so the early years are important. With regard to children, the education on food in particular is now very good in Scotland. There is a difference between what someone hears and the knowledge and education that they have, and what someone does. One of my party pieces when talking to an audience is to ask "Who knows the five-a-day message?" Everyone puts their hand up because they have learned the message. However, when I ask "How many people eat their five a day?", it is about 3 per cent. Education and health are so important as a basis, but let us not lose the bigger picture, which includes parents and every aspect of a life course.

Janice Preston: That is entirely true. I am a huge believer in the teachable moment. That does not involve only the person who has cancer but their family as well. In schools, there is something to be said about not wrapping things up in cotton wool but using the experiences that there will be in schools every day to talk about those things and join up health and school. We absolutely need to ground learning in the reality of a situation—someone told me the other day that their kid was getting resilience training for the second day but that they did not quite understand it.

We have a programme in Lanarkshire called "Give us a break!", which is geared to 10 to 14-year-olds who are going through a difficult time—it is not bereavement, just change. At that point in time, they are open to uncovering their own strengths, using them and building their resilience. When we teach that in the abstract, they can learn the messages but they do not act on them. We should be bold and use the opportunities in school to talk about cancer.

Ash Denham: I will change the topic slightly because I wanted to pick up the idea in Cancer Research UK's written submission of GPs referring directly for tests. At the moment, if somebody suspects that they might not be well, they go to a GP. If the GP agrees, they are referred to a secondary care specialist, who then orders the tests. If the GP knows what tests to order, they could refer for them straight away, which could save money and free up some out-patient time as well. Is that something that we could look at in Scotland?

Gregor McNie: That should be looked at. The Scottish Government is looking at one strand of that on direct access to computerised tomography scans for some vague suspicions. Anecdotally, we hear more and more that patients are often bounced around a system only to end up getting the test that the GP would have asked for in the first place. If we are redesigning systems, we must ensure that it is those patients who are referred directly, and not a huge number of patients who do not need tests. There is strong evidence from some pilot areas that direct access is being used quite well and not being overused, and that the normal fears that we might get about secondary care and the system being overwhelmed are not being borne out. There is a lot of opportunity in that area.

Dr Paterson: General practice has a reasonable amount of access to a reasonable amount of tests, which probably cover a lot of the common tumours. Direct access for CT scanning, which is available in some but not all boards, is probably more for people for whom the likelihood is that the boat has been missed. Those people present with the triad of weight loss, loss of appetite and being tired all the time, but nothing much else. Clearly, there is something serious going on at a biopsychosocial level—it could be almost anything—but a quick CT scan might well get to the bottom of it, rather than that person having to be bounced round the system. However, we will probably not be able to make a huge difference to the life expectancy of those people.

Brian Whittle: Euan Paterson and Professor Anderson have both touched on this but, as we all know, smoking gives you cancer. Despite the great work that has been done in Scotland to reduce the number of people who smoke, we find when we dig underneath the data that the percentage of people who smoke is only 9 per cent in the 20 per cent least-deprived areas smoke but 34 per cent in the 20 per cent most-deprived areas, where people can probably least afford to do it. Obviously something else is going on; indeed, witnesses have mentioned fatalism. I guess that we know the answer to this question, but are we putting enough resource into this area to carry on the great work that is being done here? How do we tackle that major inequality?

Gregor McNie: I think that you are right to suggest that health messaging is probably not the best way of challenging tobacco use in some of these constituencies. A lot of the data will probably bear out the impression that those to whom the health messages have penetrated will have given up already, and we face a harder mission in some deprived areas, where different motivators are probably required for people to quit. Those motivators might include nicotine's control over people's lives, and, in that respect, one might focus on the financial aspect and the idea of being able to buy more independence and freedom from nicotine dependency.

However, this is also about breaking what in many cases is a social glue. As you have pointed out, smoking is a very normal behaviour in many of these postcodes; in some places, the percentage of those smoking is touching 40 per cent. Cancer Research UK is investing a lot in research into the potential of e-cigarettes, and as long as such devices remain in the hands of smokers, we see a lot of potential in them to move people from tobacco. So far, the data shows that they are being used by smokers instead of being taken up by non-smokers. We need to do all that we can in what is an extremely challenging area, and that is one aspect that we would point to for a potential win.

Professor Anderson: With regard to health inequalities, I want to move beyond the issue of tobacco and highlight obesity as a very good example. In our submission, we highlight two studies in which we have been involved that bring prevention and screening programmes together. Our BeWEL study involved those who had tested positive for bowel cancer and been invited for a colonoscopy but who did not have cancer, although they were at higher risk of getting it, as they had had a lesion or a polyp that was removed. We offered them the opportunity to go on a weight loss and physical activity programme. That paper, which was published in the *BMJ*, was very successful. We also recently published a paper that showed that there was no difference in response by social demographic group. As we all know, it is not necessarily the case that the whole population goes through screening—people from poorer areas are less likely to, for example—but we sometimes forget that a lot of people from poorer areas do come through it, and that is an example of those people responding equally well to an opportunity. It is a similar story with the pilot study for the ActWELL programme, which I have already mentioned.

Eighty per cent of women are coming through the breast cancer screening programme; not all of them come from deprived areas, but a lot of them do. It provides an opportunity to offer something, and as we have seen, the uptake has been high.

There is no one way of addressing health inequalities, but we should be looking at things that could make a contribution, and we have demonstrated that offering lifestyle programmes to those coming through screening, who are at a teachable moment, seems to work equally well with people from deprived areas.

Janice Preston: That is absolutely right. What we need to do is make the most of that point of engagement. This is not about putting in lots of extra resources but about working together and making the most of every engagement.

Dr Paterson: Perhaps I am being overly pessimistic, but my slight worry is that, given that we are talking about the people who have attended for screening, we are already tipping the balance against people from deprived areas because fewer of them go. Although it is a small difference, that will inevitably widen the gap in health inequalities.

We are talking about great points of intervention. If people go for screening and find that, crumbs, they have had a lucky escape, no wonder they begin to get a wee bit more motivated. The problem is the people who have not had that yet. It is still not easy, but we can encourage people to think about smoking, for instance, after they have had an infarct, and they say, “Yeah, maybe you were right. Let’s stop now.” However, until that point, it is different. We have to do more for the people whom we are not reaching at all.

Professor Anderson: Sure, but do you ignore the opportunity? They might never come through another health service. Do we say that, because we cannot get them all, we should not do something?

Dr Paterson: It is a matter of the cost benefit ratio. Absolutely.

Emma Harper: Health inequalities cover rural and urban areas. I am a South Scotland MSP; that region is pretty much rural. Are there specific challenges or things that we could do differently? Our local NFU Scotland group has engaged a lady from the national health service to go to the auction marts and do health checks and blood pressure checks on farmers. That is something unique that is happening in my rural area. What can we do in addition to that?

Professor Steele: It is really important that deprivation in rural areas is different from deprivation in cities. We examined uptake of bowel screening and breast screening in relation to deprivation. We found in cities a huge difference between deprived communities and non-deprived communities in uptake of bowel screening. However, in rural areas there was no difference at all.

What we measure in rural areas using the Scottish index of multiple deprivation is quite different from what we measure in cities, so we need to take a different approach to deprivation in rural areas. What the approach will look like is something for us to work on—one size does not fit all.

The Convener: Would that be a variant of the kind of targeting about which other witnesses have talked?

Professor Steele: Yes. That is exactly right.

Janice Preston: We have a mobile bus, use of which has grown. We target remoter areas with it. There is also an opportunity to attach other messages. We find that uptake in those areas is high in relation to their population, so that is good use of our time.

No matter where people come from, we need to address their needs holistically. If they are worrying about where their next meal will come from, they will not engage with messages about prevention or getting better. In Glasgow—we are doing work in Fife and Dundee, too—we have found that with the 80 per cent whom we engage with, if we sort the other things out, three months later they are receptive to the conversation because they are in a better place. In that respect, it does not matter where people live. We can do that through current resources, not new ones. In Scotland alone, 17,000 people were helped with benefit advice last year, which amounted to £45 million.

Dr Morrison: To respond to the question about rurality, we still have a bit to learn about the variations in early diagnosis and access to care. One of my current academic pieces of work is to examine access to radiotherapy services throughout the country in order to see whether there is a barrier to getting to such services because they cannot easily be moved and made local. There are mobile vans for breast screening. In NHS Greater Glasgow and Clyde, there is an initiative to make those services more accessible and to use them more helpfully in order to reduce the travel barriers that are faced by people who do not have access to a car.

There is better understanding of the barriers to be gained. Is there a barrier to getting to the GP, a screening service or hospital? We do not yet have that fully laid out; the evidence is a bit thin, so we need to do more work. However, there are also some practical things that we can do and, in some cases, are doing—for example, reorganising the mobile mammography vans.

10:45

Miles Briggs: I want to touch on the future of the detect cancer early programme. It has focused on the three main cancers—lung cancer, colorectal cancer and breast cancer—which account for about 40 per cent of all cancer cases. To what extent, does the panel feel, have other cancers been neglected? This week, for example, we found out that prostate cancer is now killing more people than breast cancer. How would the panel like to see the detect cancer early programme developing, particularly in relation to some of the rarer cancers, such as brain cancer?

Professor Steele: With regard to different cancers, you have to be careful with what can be done. Prostate cancer is a good example. There has been a lot of interest in screening for prostate cancer, but we know that it does more harm than good. It is a very important principle that we should not introduce a screening programme that will cause more harm than benefit. It is really difficult to get at prostate cancer, because even symptoms are not predictive of it. Therefore, until we know what would be effective intervention, it might not be valuable to put an awful lot of effort into prostate cancer. Further, some of the rarer cancers are extremely resistant to early diagnosis.

The detect cancer early programme has been a fantastic opportunity, and a lot of the work that has been done through it has been amazing. However, it is not focused on prevention. I wonder whether we should be moving towards looking at early detection and prevention together, because we might get a bigger bang for our buck.

The Convener: When the Scottish Government established the detect cancer early programme, it set a target of a 25 per cent increase in detection or examination at the first stage of the targeted cancers that Miles Briggs mentioned. However, the figures fall far short of that target. Can you explain that?

Professor Steele: I think that it is because the target was hugely ambitious—but why not?

The Convener: Is the conclusion therefore that a less ambitious target should be set?

Professor Steele: That is certainly not the conclusion. We should keep pushing.

Dr Morrison: On what we should do next, I absolutely accept what Bob Steele has said. A rational approach would say that it is difficult to find good symptoms. People do the obvious things; if a person obviously has symptoms of cancer, the GP will refer them.

One of the surprises that has come out of the detect cancer early programme has been the amount by which early detection of lung cancer has increased. We might not have predicted such a large increase in early detection of the disease because lung cancer has obvious symptoms; for example, a chronic cough, because we are talking about people who are smokers anyway and who might have other lung diseases that go with that. I have to say that, from other audit information on cancer services, the evidence is that more people are getting curative surgery, and that, in recent years, survival is starting to increase as a result.

It is possible to be pleasantly surprised. If I had to be pessimistic, I would have said that it would have been really difficult to shift the rates on lung cancer. However, there has been a welcome increase in the rate of early detection, which just shows that we cannot necessarily guess what will succeed.

Gregor McNie: The success in relation to lung cancer that David Morrison just mentioned is beyond what many people would have imagined. The challenge now is to build on that. More people are surviving because of that success—that is the human story behind the figures.

The DCE programme will be needed more as our population ages. We have talked about the early detection challenge, which very much relates to people with cancer. Efforts around that have to be maintained.

We have talked previously about public awareness and the need for people to be willing to present with symptoms. That needs continued investment. There also needs to be a continued feeding to the public of the message that they should report to a GP if there is a change from what is normal for them.

On the prevention agenda that involves the four in 10 cancers that could be prevented if people led healthier lives, and the benefits with regard to other diseases, I contend that the £40 million that the detecting cancer early programme has behind it would not even touch the sides of a proper prevention effort. We need to look to the total £13 billion health budget and really challenge how much is going into prevention: we need to put some big investment into it.

Dr Paterson: On what was just said about lung cancer, NICE's work showed that symptoms are not particularly good as positive predictive values. However, a pretty good test can be offered that is relatively well taken up and not particularly embarrassing to take: the patient can be sent for a chest X-ray. It is not the be-all and end-all, but it is a great place to start.

If a patient has vague symptoms and a normal chest X-ray, the role of the general practitioner is often to undiagnose rather than to diagnose. In that situation, a GP can to a degree be confident that the person is okay. They might need to be watched for a while, but they do not need to clog up the expensive acute care system.

Ditto with introducing—[*Interruption*.]

Thank you: I could not think of the name. Ditto with introducing the FIT for bowel cancer as a point-of-contact test. We used to do point-of-contact testing for bowel cancer—not with the FIT, to be fair—but the test was withdrawn. Point-of-contact testing would make a huge difference. Those tests have big benefits.

The Convener: The final question is from Emma Harper.

Emma Harper: I believe that Gregor McNie brought up near the start of the meeting the trial of self-testing for human papillomavirus that is happening in Dumfries and Galloway. That could lead to something really amazing because of the time that it will save for people who will be able, instead of attending appointments, to take a wee kit home. That could be beneficial all round—5,000 women in Dumfries and Galloway are defaulting on the smear test right now.

The Convener: Does Bob Steele want to respond?

Professor Steele: It is not particularly important, but I will just say that the previous test, which was withdrawn, was not sufficiently sensitive, but the new test is much more effective and helpful for GPs.

The Convener: If I were to summarise in a sentence the message that we might take from this evidence session, it might be that we should continue to be ambitious on detection, but do a good deal more on prevention. That none of our witnesses does not support that view allows us to reach a consensual conclusion.

I thank you all very much for your input. We will take a short break.

10:52

Meeting suspended.

10:58

On resuming—

Care Homes (Sustainability)

The Convener: Under agenda item 2, we will take evidence from two panels on care home sustainability. I welcome to the committee Fraser McKinlay, the controller of audit and director of performance audit and best value for Audit Scotland, and Claire Sweeney, associate director of Audit Scotland.

Fraser McKinlay will open the session with a short statement.

Fraser McKinlay (Audit Scotland): Thank you, convener. It will be a very brief opening statement. Thank you very much for inviting us today. We were fortunate enough to listen to the fascinating previous evidence session, so we are delighted to pick up on any issues that the committee has following that discussion.

Although it would be fair to say that we have not done a lot of work specifically on the sustainability of the care home sector, we have, as you know, on behalf of the Auditor General for Scotland and the Accounts Commission, done a lot of work over the years on the sustainability of the health and care system overall. We are very pleased to answer questions from the committee on those issues today.

I will highlight two reports that we have published in the past couple of years to give a flavour of the work that we have done. In September 2016, we published “Social Work in Scotland”, which set out how effectively councils, specifically, were planning to address the financial and demographic pressures that face social work services. We did that work because, at that time, as integration authorities were coming into being and integration joint boards were being set up, we felt that it was important to remember that local authorities still had specific responsibility for social work services.

In that report, we reported that the current approaches to delivering social work services were not sustainable in the long term. We estimated that, if councils and IJBs continued to provide services in the same way, social work spending would need to increase by between £510 million and £667 million by 2020. That is an increase of somewhere between 16 and 21 per cent.

We recognised that social work services faced significant challenges because of a combination of financial pressures, demographic change, and the need to implement a wide range of new legislation and policy. We therefore highlighted that there is a real need to engage the public in a debate about how we deal with the challenge because, as we heard earlier in the meeting, some of us are likely to need some of these services at some point in the future.

11:00

In March 2016, we published a report called “Changing Models of Health and Social Care”, which looked at the whole system of health and social care and drew out some of the more innovative and changing models and different ways in which health and care services were being provided. In particular, we looked for evidence of services being shifted to provide care in people’s homes or in homely settings.

In that report, we found that in parts of Scotland new approaches to health and care were being developed, many of which were aimed specifically at preventative measures. We heard about some of those this morning. We recognised that the transformational change that was required to meet the growing demand for services was not happening fast enough and that the new models of care were, generally speaking, small scale and not widespread.

One of that report’s conclusions was that the Scottish Government could do more to help to make that transformational change happen and remove some of the barriers that boards and councils face in trying to make that work. The report also showed that the growing number of people who have complex health and social care needs, particularly frail older people, together with continuing tight finances, mean that current models of care are unsustainable.

We are doing more work on health and social care services. We plan to produce our second report on the integration of health and social care later this year. We will be delighted to speak to the committee about that when we publish the report, but for now we will be delighted to answer any questions that members have.

The Convener: Thank you; that was helpful. Can you start from where your opening remarks concluded, with the Scottish Government’s response to the report “Changing Models of Health and Social Care” and whether that response meets your recommendations? How far do you believe that to be the case? Are there issues that need to be reinforced? Does the response provide enough clarity to public bodies in carrying out their duties?

Fraser McKinlay: I will kick off and ask Claire Sweeney to come in, if that is all right.

As I prepared for today’s meeting, I reminded myself that the report was published almost two years ago. It is amazing how time flies. Although a lot of good stuff is happening, the Government has been active on many fronts and the delivery plan sets out a direction of travel that feels like the right one, my sense is that some of what we found two years ago still holds true. That means a pattern of lots of very good stuff happening locally, but a continuing question about the extent to which that is genuinely being co-ordinated and driven to ensure that it is being delivered with pace and at scale.

I did not count exactly but, in the earlier evidence session, I think that I heard reference to eight, nine or 10 different initiatives, all of which I am sure are doing very good things. However, it is striking that so many different initiatives in roughly the same area of service delivery are being delivered across the country. I am not advocating that one size fits all and that everything should be rolled out centrally; that is not what our report was about. However, there is still a question about the way in which we are learning lessons and ensuring that the things that seem to work are delivered more widely.

Claire Sweeney (Audit Scotland): One of the major issues that we have highlighted around the delivery plan over the past couple of years is the great consensus around the overall policy vision in Scotland, which is a good thing. However, we do not see the connection between the overall vision and how it will be implemented or how realisable it is.

Last year, in our most recent NHS overview report, we recommended that something was needed that would show the workings between here and now and the overall vision. Work is under way to develop a financial framework that will essentially start to show the workings of how we will get from here and now to achieve the vision of more people being cared for in a homely setting, and the right care in the right place at the right time. We think that that is important not just for accountability—although accountability really is important—but for the system to understand the steps and stages that need to be worked through to start to realise that change.

We are acutely aware that there is a lot of pressure around some of the acute need in the system. We look a lot at accident and emergency need, delayed discharges, the pressure on GP services and the like, and that can take up a lot of attention and resource. The framework, which will start to show the stages that people need to work through, should start to move us a little bit away from focusing on just the crisis that some of the system faces—I am sure that it can feel like that on the front line.

The Convener: Do you have a sense of whether there is a pace of change where change is happening? It is clear, as Fraser McKinlay said, that there are very good initiatives and developments, but are things happening quickly enough?

Claire Sweeney: In some areas, we absolutely see people grasping the approach, running with it and starting to make real inroads into local services, but in a lot of places we also see people still getting tied up in debates and discussions about whose resource it is, where it would be best spent, and how the governance arrangements will work. Areas in which we have seen people putting in time and attention to get the building blocks in place so that they can start to really focus on improving outcomes have been key for us. That is what all the change around integration was meant to achieve. We see too many parts of Scotland still being tied up in mechanics rather than focusing on what the approach is about to deliver for people locally.

Fraser McKinlay: The report that we will publish later this year, which builds on the committee's work on integration last year, will put us in a better place to answer that specific question. In a sense, that is what we are trying to get at. The report is the second of three that we have committed to, and it will really begin to get a sense of where we are and whether we are as well advanced as would be expected.

Ivan McKee: Thank you for coming to talk to us. I was very interested in what you said about the financial framework that is being set up and specific local areas in which you see progress being made. I would like to drill down into that a wee bit further.

Are we starting to see measurable results in areas in which implementation is most advanced, in terms of both improved outcomes and reaching the big prize of getting more effective financial performance in the secondary sector?

Claire Sweeney: We will be able to give a very clear story about that when we publish our second report in the series on work around integration.

We have kept a very close eye over many years on the shift to caring for people more in the community. If truth be told, the pace is not quick enough. We have highlighted that in a number of reports.

The early signs of integration impact that I have seen have been twofold. Where integration has worked, there has been demonstrable and measurable change but on a smallish scale in reducing delayed discharges and better responding to people's needs and what really matters to them locally, for example. That is one way in which we are starting to see signs of change with integration.

The second way is potentially a bit more hidden and less visible to people. There are changes in how health and social care work together. Integration is starting to surface some legacy issues that relate to how the health system and local authorities in particular worked together in the past. It is starting to shake that up and to address issues that have held things back for a long time. The jury is out on the extent to which that will lead to a big systemic change but, in some areas, people are starting to have difficult conversations that it could be argued have not been had in the past. That has to be a good thing.

I am very conscious that education and housing services were mentioned in the previous session. There is the question of the extent to which they are starting to become involved in health and social care integration issues. Those are some of the things that we will be looking at and testing more fully in our second piece of work. Some signs are emerging.

Fraser McKinlay: Where we can see real successes—an obvious example is the figure for delayed discharge in some places—we should try to unpick the extent to which that is a result of the approach that we have taken to the integration of health and social care and the extent to which it is a result of having really good people working together locally. We must ask to what extent the change of system and structure is driving that change and whether some of those things would have happened anyway. There is a cause-and-effect relationship that we will try to tease out.

Ivan McKee: Are you confident that there is a good process that will take best practice from where we are learning things and apply it across the piece?

Claire Sweeney: As we said, there is scope to do better around that. There is a need to learn from what is working well and to think about what is transferable. We accept that it is not a case of saying that it is a one-size-fits-all approach and that if it works in Fife it can work in Glasgow, but we think that more care and attention could be paid to looking at what makes it a success and what can be transferred. There is more work to be done on that.

Sandra White: Audit Scotland's second recommendation was about investment in the 2020 vision and the workforce and delivery plans and, at the beginning of our discussion, Fraser McKinlay gave a figure for the investment that is needed. With the transfer of funding from health to social care and the funding for delayed discharge, the primary care fund, the integrated care fund and funding for technology-enabled care, if my arithmetic is correct, £765 million has been transferred. I hear what you say about the difficulties of health, social care and local authorities working together and I am sure that we are all aware of that—unfortunately. Given that all that money has been transferred across to those areas in the budget, do you think that the process for setting the budgets of health boards, local authorities and integration joint boards is sufficiently in place? Given that £765 million is involved, is that being monitored sufficiently in order to deliver the 2020 plan?

Fraser McKinlay: That is something that the financial framework work is designed to help with. The committee's report also said that the local budget setting process is more difficult than it needs to be. We know about the timing issues between health boards and councils. That has been a difficult process. That goes back to Claire Sweeney's point about people being focused on some governance and budget issues up to this point. As important as those are, they seem to have taken precedence over asking the question about what that money can deliver.

It is easy for me to say this, but mindset is part of the issue. Much of the local discussion and debate, particularly between NHS boards and councils and integration joint boards, is about how they are managing the 5, 10 or 15 per cent cut in their budget. There are different approaches to that across the country. We are seeing far less discussion about how they will spend the £600 million or £700 million to deliver the best outcomes for their community. It is easy for me to say that from an audit perspective, but we need to see that kind of shift now that things are up and running and the governance systems are in place.

Sandra White: Audit Scotland will look at that and you mentioned that there will be a report. Should the Health and Sport Committee continue to focus on that aspect of the budget, given that £765 million is a lot of money? We want to know where it is going and whether it is being spent in the right way.

Fraser McKinlay: We are all for more parliamentary scrutiny of budgets—if you want to contribute to that further, it would be very welcome. We will continue to bang the drum on clarity and transparency. As well as the NHS overview report, Claire Sweeney mentioned that every year, the Accounts Commission produces local government overviews. Trying to figure out how the money works between local government, health and everything else is now quite complicated, because there are increasing numbers of pots of money that are designed for specific purposes. In some cases, they are put in a budget line in one place for use in a different sector. We will continue to try to bring some transparency to that, and if this or another parliamentary committee can keep a watching brief on that, that will be very welcome.

11:15

Claire Sweeney: It also comes back to the point that we have been making for a number of years now about the need for long-term planning. We can find it quite difficult—sometimes for good reason—to identify the money that is being spent on more preventative interventions. You have already heard a lot about that this morning, but part of the challenge is that, with that kind of investment, which in some cases can be quite small scale, the payoff might not happen for a number of years. That can be difficult in a partnership context, particularly if people are planning their budgets year on year and might therefore not be thinking about the impact 10 years down the line. The pressure on other parts of the system can also lead to difficulties. As Fraser McKinlay has said, we need that shift in focus locally so that we can start to be a bit more ambitious and think differently, but I would say that, given the pressures on the system, that is incredibly hard to do.

Brian Whittle: The previous panel helpfully pointed out that most of us will end up requiring some kind of intervention from the social care market—some of us sooner rather than later—but I want to look at the care of the elderly in care homes and the fact that the effect of the very welcome introduction of the living wage is not necessarily being mitigated. After all, the costs, the income and the staffing levels in the service are mostly imposed, and people in the system have very little flex in how they run it, with the big costs to be found in staffing. Is there any evidence that a potentially unsustainable strain is being put on the system?

Claire Sweeney: Yes, and you heard a lot about that in the earlier evidence session and have seen it in the submissions. It mirrors some of the messages that we have set out in previous reports, particularly the report on social work services in Scotland that Fraser McKinlay mentioned, in which we explicitly make it clear that the current provision of services in Scotland is not sustainable. That report looks at social care in the round, but it also has things to say about residential care homes in particular. The challenges that are highlighted in the report and which remain valid are the pressures with regard to the funding model, the ability to secure workforce and the value that is placed on that workforce. There is a challenge and a push to ensure that people see the sector as one that they want to work in and one that children want to be trained and go through higher education with the aim of being employed in. That is difficult. Moreover, we must not forget that it is not just the social work or social care side of things that is important; the sector employs a lot of nursing staff, too. As a result, there are challenges in securing a workforce that is fit to deal with people who often need an awful lot of health and social care support, and the challenges that were highlighted in the report in question remain.

Brian Whittle: Correct me if I am wrong, but not that many decades ago, care homes were seen almost as granny farms. Nowadays, people are going into care homes much later in life when, as you have pointed out, a lot more specialist nursing care is required. Are we adapting quickly enough to that changing model?

Claire Sweeney: There is no doubt that the model is different now. You heard in the previous session about the way in which GPs' workload and their interaction with patients have changed over the past five or 10 years. The system is very different now, which is why we felt it important to have something that showed how the overall vision of caring for people in the right place at the right time would be achieved with the resources that are available in a system that has changed beyond all recognition over the past 10 years.

The needs of people in care homes are very different from what they were before; for example, a few years ago, we might have talked quite a lot about the ability to stop people going into residential care homes. That was seen as the default when those people could instead have been cared for at home, although there had to be an acceptance that some of the packages that needed to be in place to do that were quite significant.

There have also been programmes to recognise the support that is needed for unpaid carers. For those who want to keep their relatives at home, the support that is needed to help them with their caring duties has increased a lot over the past few years. However, we would still question the extent to which everyone has recognised the need to use resources differently in that context.

Running a care home now is a very different ask from what it was even five years ago. Whether the funding models have changed to reflect that is a legitimate question to ask. Some of those concerns came through in the evidence session, and we have such concerns, too.

Alex Cole-Hamilton: Good morning. Thank you for your interesting presentation.

One of the obvious problems that we face in meeting our future care home needs as a result of the changing demographic is the lack of capacity that exists in the sector. In Edinburgh, we have 600 fewer residential care home beds than we require at the moment, and we are a country mile behind where we will need to be in 20 years' time.

One of the barriers is the tension that exists with planning. Big-build residential care homes often bring in objections, particularly when developers do not consider the needs of overstretched local health services and the demands that will be placed on them, not to mention local residents' concerns about a change in the character of the area. Is there anything that we need to do through planning law with regard to where we site residential care homes to make life easier for communities and planners, or have we got the balance right?

Fraser McKinlay: That is an excellent question. Unfortunately, I am not sure that I have the answer to it. The Planning (Scotland) Bill is going through Parliament at the moment, and the Local Government and Communities Committee has asked for views. I will go away and have a look at that. The extent to which planning is a barrier is clearly an issue that we might want to look at in a joined-up world.

An additional question to ask is the one about what kind of service provision and therefore what kind of—to use the auditor term—assets we need to deliver. What kind of buildings do we need? Do we need big care homes, sheltered housing or something else? I was struck by what an earlier witness said about the greater need for what I think he called "observed care", given the increase in the incidence of dementia.

This is very much a moving feast, and we need to keep checking our assumptions. If the principle of the policy is that we should shift the balance of care away from institutions to care at home or care in a homely setting, it could be assumed that we might need fewer care home beds, but it does not feel as if that is where we are now, and if people are right about what is happening with conditions such as dementia, I am not sure that that necessarily follows into the future. That brings us back to the challenge that we face on long-term planning in terms of finances, workforce and buildings. What will we need in 10 years' time? If planning is one of the things that make answering that question more difficult, we ought to look at it as part of the whole-system review.

Claire Sweeney: It is also worth bearing in mind the need for local areas to help to develop a market. A few years ago, in a report on the commissioning of health and social care services, we commented on the degree to which local areas are facilitating and developing a market. We know that many services are provided by the private sector and the voluntary sector, and we are very interested in the degree to which NHS boards and local authorities are working constructively with those sectors to make sure that the services that are in place locally are fit for purpose.

We absolutely recognise that in some parts of Scotland—in the central belt, in particular—a major challenge is how expensive land is, and that has a huge impact on the capacity of the care home sector. We are not talking only about residential care homes. A range of factors impact on the health of the services that are available locally.

David Stewart: Good morning and welcome. What is your view on the improvement hub—the so-called ihub—that was set up nearly two years ago by Healthcare Improvement Scotland? Last night, I watched its online presentation—perhaps I need to get out a bit more often—which provides an excellent analysis of the work that it has done. What is your assessment of the effectiveness of the ihub's leadership and its speed and manoeuvrability in effecting the changes that are needed?

Claire Sweeney: We have commented in previous reports about the importance of having an improvement focus and about giving areas the space to learn and develop the improvement approaches that fit them well locally. That is essential. We are interested in the extent to which NHS boards—predominantly, but not alone—and the IJBs working with local authorities can invest in that kind of central support. It is essential that they have that. When that is developed well, we have seen that it is not necessarily just a central team that makes it work. There are tools and techniques, and the learning that needs to happen, so boards need support to get that embedded locally, and it is important that that happens at a critical mass in the local area.

We know that there is a focus on improvement nationally and we think that it needs to develop even further. We have not looked in great detail at the resource ask for that, but we will certainly bear it in mind in our second review of integration authorities. It is an important part of what can help to make this work.

David Stewart: In your general assessment, did you take account of the effectiveness of the ihub. Is two years long enough for you to assess how effective it is?

Fraser McKinlay: The short answer is that we have not really looked at the effectiveness of the ihub specifically. The extent to which two years is long enough is a bit of a judgment call. It is one of those things that we would rather have than not. Anything that helps to share good practice and provides a place to which people can go to learn has to be a good thing, and we can pick that up as part of our wider work.

The wider point is that it strikes me that we are still guilty of looking at health problems from a health perspective. Our system is designed that way, and some of the conversation earlier this morning came from a health perspective. I was struck by how little councils were mentioned. I know that there was mention of working in leisure centres and other places, but if the general consensus is that inequality and deprivation are central to this, improvement resource needs to be about a joined-up response to that rather than, or possibly as well as, specifically health-related intervention. Although we have nailed the analysis of the issue, and the committee heard from Sir Harry Burns not long ago that he has been saying this for a long time, it still feels as though our systems of accountability and improvement are struggling to catch up with that. That has to be part of the shift over the next while.

David Stewart: You are saying that we have to be careful not to be in a health silo and that we are really talking about poverty and inequality. They are the big issues.

Fraser McKinlay: I am by no means an expert in this—you had the experts in earlier—but my sense is that it is not either/or. Of course there will be things that can be done. The delivery of the health intervention could be better and lessons could be learned.

We also need to be better at joining up our approaches and learning the lessons of community engagement. We heard a lot of great stuff from Macmillan Cancer Support today and I was fascinated by the example of an NHS board in the south of Scotland working with NFU Scotland locally. That is the kind of innovative work that we need to see happening everywhere.

David Stewart: One example is the health statistics that came out today showing that the bowel screening programme figures for disadvantaged areas are quite disappointing. That mirrors what we were discussing earlier about health problems in disadvantaged areas.

Miles Briggs: Alex Cole-Hamilton raised a point about future provision, and it goes back to local authorities. To what extent is there a disconnect between what we know we will need and what we are planning towards? Jones Lang LaSalle did a report on this recently that says that, in 2018, Scotland will be 3,000 care home beds short but, to meet future demand, we will need about 10,800 on top of that by 2028. In terms of your work, are we getting anywhere near meeting what people say we will need? Why is that not being reached? Is it up to the Scottish Government or to local authorities to realise that in future, and where is the disconnect?

11:30

Claire Sweeney: With the introduction of IJBs, work is being done to look more closely at local need and think about longer-term projections. We intend to look at all that as part of this second piece of work.

Again, to return to the two reports that we are talking about today, particularly the “Social Work in Scotland” report, we have said that that has not been in place in the past. We recognise that that can be challenging, because we are talking about a different level of demand. As we have said, the make-up of the people in care homes and their needs is different. The challenges involved in securing a workforce are different, and events such as Brexit potentially impact, too. There is a need to look closely at future demand and, to return to our earlier point, there is a need for longer-term planning.

The financial framework that we have talked about should help with some of that by connecting the policy vision with delivery on the ground and providing a sense of the stages that all the parties involved need to go through in order to achieve that. I guess that the simple answer is that we are not quite there yet and that there is more to do.

Fraser McKinlay: Arguably, the creation of integration authorities is designed to do exactly that. Therefore, it is important that, as we have said, IJBs in particular are able to get beyond governance issues and setting themselves up as new organisations and into having exactly that discussion about local needs and service delivery and therefore what service model is required. There is, of course, a bit of a crystal-ball gazing in all that, so scenario planning is important. Ensuring that the focus is on an assessment of people being able to access the care that they need in the most appropriate setting is key. It is always difficult to make a judgment on that, and the people who are based locally are best placed to make those judgments.

Miles Briggs: In various pieces of work we have heard about what is destabilising current provision. Scottish Care has referred to a number of aspects to that, including the living wage not necessarily being properly funded and cities being more expensive. In Aberdeen and Edinburgh—the cities that Alex Cole-Hamilton and I represent—payment of the living wage will not necessarily attract people into the care sector. Do you have any comments on that?

Claire Sweeney: In a previous report, called “Commissioning social care”, we talked a lot about the challenge of making the work attractive, its profile in Scotland and the projection that we will need far greater numbers of people to work in care services than are available at the moment. Therefore, affordability and the attractiveness of care as a profession are issues. We know that there has been work done to try to change that, but the underlying issue is, of course, resources—how much is paid for services and how funding works around them. The challenges will vary across Scotland, but there are common pressures.

Fraser McKinlay: Another strand of our work that members will be aware of is our recent work on the workforce. Last year, we published a report on the acute part of the system, and we are working on a sister piece on primary and community-based care, which will build on last year’s work by the Government and the Convention of Scottish Local Authorities on the beginnings of a workforce strategy for the sector. That is important for reasons that have been outlined.

I was struck by some of the responses that the committee received before Christmas on its care home inquiry. At one level, it can absolutely be argued that paying the living wage is a good thing—full stop. Beyond that however, I was interested that some responses said that the living wage does not seem to be working in terms of easing the recruitment difficulties in some areas. Therefore, in simple terms, the cost base has increased without providing any real benefit—beyond the facts that providing the living wage is a good thing to do, and that workers feel more valued and all the other things that come with that. However, on whether it will ease the pressures that some services are facing, we will need to wait and see.

Emma Harper: Our briefing paper mentions the recommendations of the “Changing models of health and social care” report. One of the recommendations is that we should ensure that new models of care—here and abroad—are shared. I am aware of two projects in Dumfries and Galloway that have been promoted by the integration joint board and which seem to be functioning well. The community health sync project—known as CoH-sync—has seen community groups being invited to tender for delivery in health and wellbeing centres in the region. The second project is called mPower, and is funded through European money worth €8.7 million, and looks at over-65s with long-term conditions.

Initiatives must be piloted to figure out whether they work, and they must then be audited and shared. That takes time. My point is that the process to evidence what works takes a long time. How do we change things? What would you recommend in order to move things along?

Claire Sweeney: We have spoken quite a lot about that in some of our previous work. We recognise that we cannot have a one-size-fits-all approach: what works in one area will not work in other areas. People need to be involved in how the services are changing, so it is important to involve communities in finding out what works best for them.

We have talked a lot about self-directed support, for example, in which people have a much more even and shared focus with healthcare and social work professionals in determining what is right for them. That will differ very much from person to person, let alone from IJB area to IJB area, and a whole lot of issues mean that the care that a person gets in one area might be very different from the care that they might get in another area.

Of course, that makes provision not very easy to audit—not that that is the purpose of the services—but we need to take account of the fact that people in different areas want different things. That is fine and absolutely right, but we would shine a light on the things that work really well, or on the success factors or principles that could be applied in other areas, and make it clear that they need to be shared and that the whole of Scotland needs to be able to learn from and move on them.

It is absolutely right for improvement to be focused on local support, so that people can work out what needs to change and can get the right solution for that area with the staff who are involved and the people who receive the care. That is all correct, but there must also be improved sharing of good practice and learning across the whole system. There is still scope to do that.

At the start of this evidence session, we mentioned some of the things that might be getting in the way, one of which is the focus on having discussions to agree budgets, and the focus on governance and structures, when leaders in the system should be just as—if not more—focused on the positive impacts that they are achieving through change. There certainly needs to be more focus on learning and improvement.

We have also seen, over the years, lack of evaluation. It is really important that projects that are piloted are properly evaluated and the lessons shared. If that does not happen when people set up a new project, they will really struggle to prove that it is making a difference, and to argue for resources to be put into it.

Ash Denham: I just want to pick up where Emma Harper left off and ask about changing models of care and the models that we might move to in the future. In your opening remarks, you said that new models are being put in place, but they are quite small scale at the moment, and are limited to certain areas. Can you give us examples? Might such models be scalable across Scotland? Indeed, would that be desirable?

Fraser McKinlay: As part of our work on changing models of health and social care, we produced a supplement listing a range of individual case studies. We looked at 12 different areas, including Forfar, as well as more international parts—for example, Canterbury is often cited. The point that we are making in the report, and which we continue to make, is that good things are happening in every part of the country: it is not as if there are black spots where there is a lack of innovation. Maybe that is okay; maybe we need to let a thousand flowers bloom, because it is the local dimension that will make the difference.

However, we would observe that that does not seem to be the case at the moment; it does not feel as though what we are doing will have impact at the scale that will be required to meet the challenges in the system as we understand them and about which we have heard today—the demographic changes, the financial situation and everything else.

What was interesting about the process was that we had a look at some things, thought that they looked quite interesting and good and then had a big debate about whether they were good and the extent to which they could be rolled out. We specifically did not say that it is possible to apply something that is happening in Forfar in Glasgow; we suggested that whatever had made the approach successful in Forfar could be identified, then people could think about how those characteristics could be applied in Glasgow. I am not suggesting that that never happens, but it seems that it is not happening enough at scale to meet the challenges that we know the system is facing.

Jenny Gilruth: Culturally, there seems to be an imbalance with regard to integration between social work, health boards and integration authorities, and “Social work in Scotland” makes it clear that integration has created complex governance arrangements. Are cultural issues impeding progress?

Fraser McKinlay: The short answer is that we will let you know in November or December, but I will try to be more helpful than that.

In our first report on integration, we recognised the complexity of the landscape. It certainly feels complex to those who work in it, and my sense is that the people who receive services are pretty unaware of how it all works. However, there being a degree of complexity does not mean that the system cannot work. There are the integration joint boards, and people are genuinely committed to making the process work.

We have seen cultural differences between councils and health boards. Councillors and NHS board members have had to work through the process of coming together on IJBs. There are also a number of different cultures on the ground. Again, there are many places where people in social work and health boards have been used to working together for a long time, so this sort of thing is not brand new.

However, the challenge is in how to make the step change. After all, IJBs are accountable for about £8 billion of public spend, so we should be starting to see the ways in which that money is being spent differently. How is the integration of health and social care making a genuine difference to how that significant public resource is being used? That is the big question that we will be trying to test throughout this year.

Claire Sweeney: We have kept quite a close eye on the progress of integration since our report was published in 2015. I would say that two issues have emerged. The first is that a set of technical issues needs to be resolved—there is no doubt that some technical things still need to be worked through.

However, I also say that that issue is much smaller than the issue of how the cultures can come together, and the need for leaders in the system to accept that there are a few technical issues to work through, but to be committed to improving outcomes for local people and to using their resources collectively to find the best way to improve services for folk in their area. That is absolutely possible, and indeed, it is what we expect leaders to be focusing on. From the audit perspective, that means that we expect governance arrangements to be set out very clearly so that we—and local people—can understand them. The most important thing, though, is achievement of the outcomes.

Jenny Gilruth: On that point about local people, are overly complex governance arrangements detrimental to greater transparency? Do they put people off because no one understands how the systems work and how they talk to each other, with organisations as a whole therefore becoming far less accountable than they might previously have been?

Claire Sweeney: The arrangements absolutely need to be understandable to local people, not just to auditors, and it is important that the people who manage and run a system understand it, too. We know that that is not the case in some places, so there is a need to be clear about what people are accountable for and who is responsible for delivering the services that people receive. Over and above that, however, there needs to be a focus on improving outcomes. If the whole debate is taken up with governance and funding challenges, that opportunity will be missed.

Fraser McKinlay: On the extent to which ordinary folk understand the governance arrangements, I have to give a kind of yes-and-no answer. In principle, it is of course important that people understand how it all works, but it is probably more important for them to be genuinely engaged and involved in a discussion locally about how health and care services are delivered to them. I am not sure that people going to a GP or trying to get a care package in place are necessarily all that concerned about high-level governance structures. We here will always be concerned about such structures, because they are really important for accountability but—I think that the committee has already highlighted this in its work—integration joint boards and their partners need to become much better at engaging communities in meaningful discussions about design of local services. At the moment, that is patchy, at best.

The Convener: I thank our witnesses for their very helpful evidence.

11:44

Meeting suspended.

11:47

On resuming—

The Convener: Our next evidence-taking session is again on care home sustainability. I welcome to the committee the Cabinet Secretary for Health and Sport, Shona Robison, and Geoff Huggins, who is director of health and social care integration. I believe that the cabinet secretary wishes to make an opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thank you very much, convener.

I welcome the committee’s interest in care home sustainability and am happy to have the opportunity to respond to some of your questions. I emphasise that, in seeking to promote sustainability, we need to see residential care in the context of the wider health and care system, whether it be care at home or in hospital.

Our vision is to enable people to live independently at home or in a homely setting for as long as possible. A sustainable residential care sector will play a key role in helping us to achieve that vision in partnership with the wider health and care system. There is, and will continue to be, an important place for residential care and care homes in Scotland. However, they will have a different emphasis in the future. Whether it be delivering a higher proportion of intermediate care or providing specialist care to people with dementia or other neurological conditions, the role of a care home is already evolving to meet people’s needs better.

As part of your earlier evidence, stakeholders highlighted some of the challenges that face the sector. They include recruitment and retention of staff, including nursing staff, lack of care home availability in some areas, and instability in the market. Addressing those challenges has required a change in the way in which we approach social care to ensure sustainability.

Following the same models of care and support simply on a bigger scale or paying more for less will not allow us to create something that is sustainable for the future. Nor will it ensure that we can deliver high-quality, flexible services that move away from time and task and have people's choice, control and independence at their heart. Much of that is about redesigning services in a whole-system way and using existing resources more effectively to improve quality. That is why we have integrated health and social care, which has opened up opportunities to develop different models of care that reflect the changing needs of localities.

As the committee has been aware through the process, a number of integration authorities are beginning to make that shift and develop plans to support an efficient, effective, diverse and sustainable market for high-quality care. Because of that, the role of care homes is evolving to better meet people's needs.

In some places, care homes are being used to provide intermediate care for patients who require it on discharge from hospital or to prevent hospital admission. Fife integration authority is one example. It has commissioned intermediate care beds where short-term rehabilitation is provided with a view to returning people to their homes when they are ready.

Significant progress is being made on work to address the workforce challenges, such as sustaining a registered nursing workforce within care homes. In several areas, integration authorities are taking a cluster approach by working flexibly with care homes to ensure that registered nursing input is available to residents. In some localities—for example, East Lothian—NHS staff are regularly used to staff care homes.

Such cluster approaches are also seen in the training and upskilling of care home staff. NHS Dumfries and Galloway is working with Scottish Care on piloting work to support our care homes in the area through an enhanced education and support role, particularly with some of the specialist nurse and advanced nurse practitioner work. In palliative care, Highland Hospice is using a tool and approach for mentoring to support community palliative care across the region in a range of settings, including care homes. Currently, staff in 20 care homes across the NHS Highland area are benefiting from that approach.

The national care home contract has been, and is, a good foundation for care home sustainability over the past 10 years. Through it, there have been year-on-year uplifts that have not been mirrored in the rest of the UK or in other sectors. Over the past three years, funding through the national care home contract has increased by 13.2 per cent from £609.31 to £667.09 per place per week. However, we recognise that there is more to do to ensure long-term sustainability as well as enable local commissioners to redesign and commission services based on local population needs. That is why the national care home contract reform process is currently under way.

Part of that reform involves working with providers to co-produce a shared, transparent understanding of what it takes to provide a care home place through the development of a cost-of-care calculator. Alongside that, work is being done to enable variation in the contract to respond to different models of care. In its care home market study, the Competition and Markets Authority recently praised our approach to setting a national rate and our work with providers to reform the approach. We are building a programme of reform for adult social care that allows us to consider what residential care should look like in future.

Our approach to ensuring sustainability demands that we move beyond the short-term fix to think about longer-term sustainability. For that to happen, all parties need to work together. We are committed to doing that through integration, through working with partners to improve our national care home contract, through our reform of adult social care and through the actions in the national workforce plan, the second part of which was published in December.

I welcome the opportunity to discuss the matter with the committee in more detail.

The Convener: Thank you very much, cabinet secretary. As you rightly say, the issue stands in the wider context of the integration of health and social care. We heard evidence this morning from Audit Scotland on some of the aspects of integration that have a bearing on care home sustainability. One thing that came through strongly in that evidence was that, although there is good practice in particular parts of the country as you described, there is a need to share learning much better and to ensure that we not simply have good local initiatives, but join them up.

What is your take on that? How far does the health and social care delivery plan address that issue?

Shona Robison: It is critical. I am a firm believer that what works and best practice should be spread. The caveat to that is that what might work in a remote and rural area might have to be different from what works in an urban setting, because of the availability of the workforce. There are also particular market conditions in different areas. There are challenges in Edinburgh and the

Lothians that are not necessarily the same in Glasgow, for example.

There is absolutely a need to share best practice. Geoff Huggins can speak more about the improvement work that is on-going to help to do that. Nobody should be immune from asking for support on improvement. No one has all the answers but, without doubt, there is good practice that it would be good to share more widely.

Geoff Huggins (Scottish Government): The important thing to recognise is that, across the country, we are seeing how systems of care are evolving. When we look at an area such as the city of Edinburgh and think of all the different components that go into providing older people's services, we can draw a diagram that has about 47 different boxes on it, including those marked "Hospital", "Care at home", "Respite" and "Support for carers", all of which are systems of care. We often focus on one of the components rather than looking at the whole story.

We are having an interesting conversation about the evolution and development of residential care into step-up or step-down care, such as palliative or end-of-life care. In rural areas, services for people who, historically, would have received continuing care in NHS facilities are beginning to be provided in community hospitals. In other areas, such services are beginning to be provided in hubs. There are some general principles, but how the system is put together will probably be quite different from area to area.

In the first few years of integration, one of the most interesting aspects has been how housing, which is not a fully integrated service, has been among the most devolved areas. Supported housing solutions have been provided in a number of areas. That can be done in some property markets but not in others. There is a need for not just adaptability, but learning. We tend to talk about the process as a sort of conscious localism. It is necessary to know the evidence base and to know what everybody else is doing in order to find the best solution for an area, and learning is a part of that.

Miles Briggs: Good morning, panel. The cabinet secretary is probably aware that it has been announced this morning that Renaissance Care is to close its home in Musselburgh. The rationale for that was partly to do with factors that are destabilising the sector. I printed off the statement of the company's chairman, Robert Kilgour, on the issue. He mentions the apprenticeship levy and what has not been put in place in Scotland. He says:

> "We currently get absolutely nothing back from the Scottish Government for this extra 'Jobs Tax' and they are making it very difficult for the social care sector to claim any credit back from these new extra payments to spend on apprenticeship or training schemes as was intended and as is happening in England."

Do you have any comment to make about that?

Shona Robison: As I set out in my opening remarks, we have taken the approach of trying to support the sector. As you will be aware, we have provided significant resources to enable the living wage to be paid to all parts of the sector, including the independent sector. We felt that that was important in helping it to recruit and retain staff. In addition, as I said, we have significantly increased the funding that is provided through the national care home contract.

I am aware that the care home in question had particular difficulties, not least to do with a lack of en suite facilities, which meant that it was struggling to meet some of the standards that were required. I think that it was a complex picture. Investment was required, and the owners would have had to decide whether, on balance, they wanted to go ahead with that.

The UK Government has decided to take forward the apprenticeship levy. We have worked with employers to make sure that resources are passed on when it comes to what we do here in Scotland, so I do not recognise the scenario that has been painted regarding the apprenticeship levy. Many issues impact on the care home sector, but that is not one that has been highlighted. An issue that has been highlighted to me, not least by Scottish Care, is the impact of the loss of nursing staff as a result of Brexit and the inability to recruit nurses into the sector. Previously, a large percentage of those nurses came through EU channels but, in effect, the door has now closed on the relevant recruitment agencies in Europe. Scottish Care told me that directly.

Of all the issues impacting on the care home sector, the apprenticeship levy has not been highlighted to me as being significant. However, we have made sure to translate resources to support employers, as you would expect, and I am happy to write to the committee with further detail, if members would find that helpful.

12:00

Geoff Huggins: Perhaps I can make a couple of further points. First, as the cabinet secretary has pointed out, the apprenticeship levy is a UK measure. With regard to the conversations about the national care home contract and the creation of the cost calculator, the costs of the living wage and the apprenticeship levy have been built in and they are understood as costs in the process. Indeed, the apprenticeship levy was considered as an item during last year's negotiations.

Of course, the living wage and the apprenticeship levy apply to all care homes, not just the home in Musselburgh, and we therefore need to take account of a wider range of factors that are not purely to do with the environment in which care homes are operating. Clearly other providers and other homes have been able to operate effectively within that framework. It is quite easy to identify Government policy as the reason for the closure, but there might be other reasons that you will want to consider.

Miles Briggs: With regard to nursing, Scottish Care has pointed out the interesting fact that 6 per cent of the home care workforce are EU nationals, but a concern that has been expressed about future training is that the drive to reach the Government's target for training child carers might lead to the loss of adult carers. Do you have any comment on that? Are you feeding into the system to ensure that the college sector, in particular, can train the people that we need?

Shona Robison: Scottish Care has identified that nearly 8 per cent of nurses in care homes are EU nationals, so recruiting nurses into the care home sector will, without a doubt, be a significant challenge. That is why we are looking at other models. As I made clear in my opening remarks, some of the solutions lie in having a workforce that is, potentially, employed by the NHS and provides locality-based solutions to care homes and nursing homes. Some of that is already happening in some areas, and we are testing the approach further in Dumfries and Galloway using not just nurses but allied health professionals and others. I think that a longer-term solution can be found along that direction of travel. Of course, we are in the meantime trying to promote the benefits of a nursing career in a care home environment, but we have to look at the introduction of locality-based teams.

Expanding childcare provision and, in turn, the childcare workforce is obviously a good thing. The challenge that we face is that the same people might be attracted to both of these areas; that is why part 2 of the workforce plan, which was published at the end of last year, makes clear the need to promote care as a career and sets out the campaign that we will undertake this year as an element of that work. We are also looking at very clear opportunities for career progression to, say, a regulated profession such as nursing, so that those who enter the profession as care workers can see a clear career pathway.

All those things are about making care a more attractive career choice, not just for young people but for people in other careers or other walks of life. The workforce plan sets out a lot about our intentions with regard to minimising the impact of people making other choices.

Geoff Huggins: We are conscious of the challenge, and we are doing cross-Government work with officials in other departments and other parts of the Scottish Government to understand the dynamics. As the cabinet secretary said, part 2 of the workforce plan starts to use and develop integrated workforce data and better local market analysis. As we go across the country visiting integration authorities, we hear very different stories about availability; again, that raises the likelihood of quite different models of care developing according to the different labour forces that might be available. That is the reality of the situation.

Sandra White: Good afternoon, cabinet secretary. I often wonder whether we have got the terms right here. I am not going to make any suggestions in that respect, but phrases such as "care home" and "residential care" just do not seem right to me. Perhaps the terms are why such places sometimes get such bad press. In some cases, staff are not being paid the living wage. On the point that was made by Miles Briggs and the cabinet secretary, I think that the jobs should be looked at as careers; however, the workforce is made up predominantly of low-paid women. A care home—if that is what we are going to call them—or provider that cannot afford to pay the living wage under the care home contract should not be in the business. I am pleased to see that that will be pushed and that progression into other careers will be promoted.

That point is really important, given the changing nature of care and the great changes in residents' needs, which mean greater nursing care. After all, we are carrying out this investigation because of the Bield situation. I must declare an interest, in that a relative of mine stayed in a Bield home and received excellent care. I cannot fault the company for that care. Bield's approach is to have small units in communities, which has worked beautifully. What is the Government doing to alleviate the situation in the areas where Bield has closed care homes, and has cited not having enough money as a reason? What is the Government putting in place in the communities where Bield homes are closing?

Shona Robison: Our priority has been to ensure continuity of care for Bield residents and to ensure that the quality of care is not compromised. Bield has made it very clear to me that it has decided to go back to its core housing with care business, which it sees as the future direction of travel. For a number of years, it has had difficulties sustaining its diversification into the care home sector. The decision was difficult to make

The important thing has been to make the transition and continuity of care the priority. Officials including Geoff Huggins have been very closely involved in that, and I have had regular meetings with Bield and the affected health and care partnerships to ensure continuity of care and that plans are put in place for residents. Good progress has been made; new providers will take over some of the care establishments in question. As for the others, a lot of work has been put in to ensuring a smooth transition. After all, it is important that we minimise the impact of the change on vulnerable elderly people.

Geoff Huggins can perhaps talk in detail about the progress that has been made, but I think that Bield is where it wants to be with regard to the March and July positions, and that it has made the progress that it needed to make.

The Convener: If you do not mind, we will take some more questions first and then hear some of the detail.

Alison Johnstone: In your opening remarks you talked about a vision of people living independently at home for as long as possible, and Mr Huggins has referred to the need to look at the whole story. As we are all aware, the private rented sector has increased by a third over the past two decades, which means that more people will be ageing in private rented accommodation. When we discuss the issue, we often talk about adaptations to local authority or social sector housing. Is the Government discussing with landlords access for carers and adaptations that might be needed, outwith the social housing model? It is important that we involve landlords in the discussion if we want to lessen the future burdens on our care homes.

Shona Robison: I agree. It should not matter what the tenure is; it is the care needs of the person who is living in the property that matter. It should not matter whether the person is renting or is an owner-occupier, or whether their landlord is a social landlord or a private landlord. What matters is what they need in order to remain at home safely.

When it comes to integration, housing has perhaps come to the table at a later stage in the process, but it is certainly at the table now. There is more work to be done on direct engagement with landlords, but as far as decisions about putting in aids and adaptations are concerned, the tenure of the property should not matter. The issue should be what the person needs.

Geoff Huggins: It is probably fair to say that that is an issue that is less reflected in housing contribution statements, where the focus has, in general, been on the registered social landlord sector, and on council-owned and owner-occupied properties. Adaptation is particularly challenging in the context of the private rented sector because of landlords' desire to be able to rent out residences again. Conversations about adaptation would involve conversations about tenancy.

Over the past 12 months, the discussion about housing has developed quite quickly. Increasingly, people are viewing housing with support as the replacement for what residential care currently does. The approach to aids and adaptations that has been taken is interesting. Historically, the approach would have been to go through a process similar to a health and safety audit and to then do everything to the house, but when conversations have been had with individuals about what they feel they need, they have tended to ask for a lot less. As a consequence, they tend to believe that they have more capacity and capability. Approaching the issue in a different way—thinking about the potential for rehabilitation, physiotherapy and maintaining mobility as an alternative to adaptation—is also part of the rethinking from the perspective of the individual.

Your question is entirely on point: there is more work to be done in that area.

Alex Cole-Hamilton: Geoff Huggins talked about fighting the symptoms of increasing demand rather than taking a bigger-picture approach, and he mentioned Edinburgh. In our discussion with the previous panel, I raised the fact that although Edinburgh has some 600 fewer residential care beds than it needs at the moment, there is a tension with planning. Could you give us an idea of what discussions you are having with Kevin Stewart and other ministers about a whole-systems response to our growing care needs?

Shona Robison: There undoubtedly needs to be a bespoke solution for Edinburgh, and for the Lothians more generally. The local market is extremely challenging, and we are already paying well over the national care home rate in order to secure places, the availability of which is limited. The delayed discharge situation in NHS Lothian accounts for a large percentage of the overall picture on delayed discharge, and the problem is growing.

A number of things are being looked at, but a whole-system solution is required. Consideration needs to be given to providing more intermediate care. Many people can get home, but need support on their way home. Changes are being made to care at home. More locality-based work is being done in an effort to secure a more sustainable workforce that will enable us to keep people in their own homes. On top of that are the on-going needs of people who are no longer able to remain at home.

Innovative work is going on—for example, on a business case around the concept of training care homes, which was mentioned in the workforce plan. That would be done in partnership with the universities. The model has worked very well in Norway. Student nurses and student care workers would, in the care home, come through a very high-quality training environment, like a teaching hospital.

12:15

That is not going to happen next week, but it could provide quite an interesting new model of high-quality but affordable care that would also have a training and innovative research component. Work on that idea is on-going, to see how it might progress. Short-term work will have to be done, so we are working very closely with the partnerships. Geoff Huggins spends a lot of his time working with the Lothian partnerships to help them to make short-term progress while other models of care are being developed. He will come in on that subject, as he is closer to it.

Geoff Huggins: I want to pick up on a couple of items. I am not entirely sure where the 600 fewer beds figure comes from. When we benchmark, we say that Edinburgh probably has slightly fewer residential care home places than elsewhere, but not significantly fewer. We see that as a system-of-care issue, rather than an individual component.

I have reflected on how other similar situations in Edinburgh have been resolved. As some committee members might also have done, I came to university here a number of years ago and was in private rented accommodation. If I were to come to university here now, I would be in one of 20 or 30 purpose-built student accommodation buildings. They have resolved one component of the accommodation and land problem, so there is the potential to resolve other such problems. However, that will require a system solution. We spend quite a lot of our time talking about the city of Edinburgh.

Alex Cole-Hamilton: I can tell you where the figure of 600 came from. It was from a rebuttal to an oral deputation that I made to City of Edinburgh Council's planning committee, in objection to a proposed care home in my constituency whose location would impact on local health services and so on. That figure was used as the overriding argument by councillors to reject my objection, as it were, so it sticks with me very viscerally.

I have a very specific question on that. That proposal was for a 64-bed care home in Cramond, just off Whitehouse Road. One of the reasons for my going in to bat for the community in opposition to it—not that I have an ideological objection to the development of new care homes in my constituency—was the impact that it would have on Cramond medical centre, which would have no capacity to deal with, potentially, a hundred new patients with high-end needs. Is there specific guidance to new care home developers about patients bringing their doctors with them, if they are reasonably close, or about how local health services can respond to the imposition—as some of them feel it is—of a new care home in their area?

Geoff Huggins: There are a couple of things to say on that. As part of our work on dementia, in relation to the quality of medical care in care homes, we saw that people did take their doctors with them as they moved. That brought with it particular challenges about access and engagement. Therefore our general assessment is that it makes sense for a general practice to be connected to a care home. However, those practices would then need to take account of what their likely requirements would be. The cabinet secretary spoke earlier about the nursing component. In the future, we will be looking to have allied health professionals, physiotherapy, social care, general practice geriatricians and probably some geriatrician specialists in the psychogeriatric space. Part of the purpose of integration is to enable us to build a mix of services for a locality rather than to think about how many of this or that we have.

Was the home that you were objecting to a private one, with privately purchased places?

Alex Cole-Hamilton: Yes.

Geoff Huggins: That is another component of the Edinburgh story—the increasing number of homes that are intended for only privately funded occupancy.

Ivan McKee: I want clarification on the earlier discussion. My understanding is that the UK apprenticeship levy is a reserved and UK-levied tax, from which the Scottish Government does not get any additional funding to fund modern or foundation apprenticeships. Is that your understanding?

Shona Robison: There have been negotiations on what should come to us, but they have, I understand, been quite difficult. Geoff Huggins's point was that there should be no detriment to the employer because of its inclusion in the national care home contract discussion.

Geoff Huggins: It is difficult to be an expert on everything all the time. We have had the conversation before: is the benefit of the levy from Scotland meant to be applied in Scotland, whether through reserved or devolved powers? We would need to make sure of that and write to the committee.

Ivan McKee: All that it would do is replace funding that was there through the Barnett formula anyway, so it is not additional.

Shona Robison: Exactly. The funding is not new money.

Ivan McKee: That is clear. Thank you for clarifying that point.

It is good to see that the numbers for the outcome of delayed discharge for December last year show a 10 per cent reduction, which is movement in the right direction. My question is about flexibility around the care home contracts that you mentioned. Roughly, the cost of a person's being in an acute bed for a day is the same as the cost of their being in a care home for a week. The disparity is huge, so the more people who can be moved through the process, the better.

How much of the blockage is down to the amount of money that is paid to care home providers? There could be situations on the margin where a service costs a bit more, but a person's being stuck in an acute bed costs seven or eight times the cost of a care home place, because of the blockage and lack of flexibility in the contract. Is there work to be done to allow more flexibility to take action on delayed discharges?

Shona Robison: You are right that the picture on discharged discharges is that there are continual reductions. They are 10 per cent less than last year, and in 34 of the past 35 months the number of delayed-discharge bed days has been below the previous year's equivalent month. That is good but—as I alluded to—a small number of pockets of partnerships account for an increasing number of the delays that remain. That is the situation in the city of Edinburgh and the Lothians, and a bespoke solution is needed to resolve it.

The negotiation on this year's national care home contract rate will reach a conclusion, with work being done alongside it on the cost-of-care calculator. That is about the cost of care including recognition that there will be variation based on locality. Costs in Edinburgh are different from costs elsewhere, so enough flexibility has to be built in.

Complex care need is growing because people are older and their needs are more complex when they go to a residential care home. Those greater needs must be reflected more in the cost-of-care calculation. All those factors are wrapped up in this difficult and complex piece of work.

We are also looking at whether the nursing component should be included in the rate or provided in a different way—for example, by locality-based teams that are employed by the NHS. That is part of the on-going discussion. We have to think more innovatively. That adds complexity to the questions about what the national care home rate pays for and what is provided directly through a staffing component that may be NHS employed. The care home sector would meet that cost or have it deducted from the rate.

That is quite complex, but it is a critical way of resolving in the medium to long term the annual debate about the rate. We need to move away from that and to develop a framework solution that takes into account palliative care needs, complex care needs and local variation in the market.

Geoff Huggins: There are two interesting aspects to that. First, if there is an inappropriate admission to a care home—that is, an admission that could have been avoided—it will probably cost upwards of £60,000, given that the person will probably be in the care home for an extended period. That is the financial cost rather than the human cost. Once someone is referred to a care home, they will probably stay there, so the cost of an inappropriate referral can be significant and will have an impact on the overall system dynamics.

Secondly, one of the early pieces of work on integration was the step-down approach in Glasgow, which used residential care as a process to enable people's needs to be assessed in a non-hospital setting before they moved on. Significantly fewer people are now going into residential care, having been through step-down care. It has the benefit both of better flow and an increased likelihood of people returning home with the necessary capacity and support, which is an important human benefit.

The simple translation from weekly costs to the individual is very important and we must always have it at the front of our minds, although we also need to think about the bigger picture.

Brian Whittle: Cabinet secretary, as you have suggested, and as we heard from the previous witnesses, the evolution of the services in care homes is very quick because care needs are growing ever more complex and the age at which people are entering care homes is rising. However, care homes have limited flex around their income and staffing costs. In my region, we have lost a couple of care homes apparently because the introduction of the living wage—which is welcome—was not fully mitigated against and, given the percentage of costs represented by staffing, put a strain on them. Do you recognise that strain and the fact that it is unsustainable if it continues? That speaks to Ivan McKee's point about the increased cost to the NHS of someone staying in the acute care system because a care home bed is no longer there. Can you comment on that?

Shona Robison: Let me address first the issue of the living wage. The Government's decision to provide public money to the private sector to help it to pay its staff the living wage has been quite controversial. It might just be me, but there is something counterintuitive about the private sector complaining about that. It is the right thing to do, because it is important to sustain the workforce and I do not think that care homes would have been able to deliver the living wage without that public subsidy. We are very clear that that money needs to find its way to the staff on the front line. The health and social care partnerships are also very clear—and it is part of their negotiation—that that money must go where it was intended to go.

In 2016-17, we allocated £250 million for social care. In the current financial year, almost £500 million of front-line NHS spend has been invested in social care and integration, a component of which is support for the living wage. In 2018-19, we are going to give an additional £66 million for social care, part of which will be to maintain the payment of the living wage and ensure that it continues to benefit the 40,000 people who previously did not get it. Despite what we have said about the need to recognise the complexity of care home costs, the national care home contract has increased by more than 13 per cent over the past three years. That is a significant increase that has not been seen elsewhere.

I am not saying that I do not recognise the challenges, but there needs to be a recognition of what the Government has done to step into that space. That has not happened anywhere else in these islands, although there are the same pressures throughout the UK. For example, we pay a higher contribution to the national care home contract here than is paid elsewhere in the UK, even before the increase for next year is negotiated, and we also pay a contribution to the living wage. I stress that some difficult business decisions are being made in the sector. As Geoff Huggins alluded earlier, it is sometimes easy to blame the Government for some of the challenges, but that is not always a fair assessment of the situation.

12:30

Geoff Huggins: It is important to remember that the national care home contract took account of the living wage changes. In the first year in which we undertook the contract, because of the representations that we received about small and rural care homes and from the owners of single care homes, we added to the agreement that particular challenges to providers arising from the new structure and the changes in what was required would be open to local negotiation. We directly referenced that issue and understood it.

Brian Whittle: Just to clarify, cabinet secretary, I was not blaming anyone; I was merely passing on the view of care homes that, although you might have put money aside to pay the living wage, it is not necessarily making its way to where it should be—or, indeed, it is militating against care homes. There is a recognition, not just in my area but in many areas, that it is becoming difficult to maintain the care home system.

Shona Robison: The solution involves the cost-of-care calculator bringing transparency to all aspects—not just what is paid through the national care home contract but what is now seen as a reasonable profit for the independent sector to make. There is huge variation in that profit. I accept that, over the past few years, the margins have been very tight for some providers, but other providers have made quite a healthy profit. We need to bring transparency to all of that, not only so that the public contribution that we make leads to improvement in the quality of care and staff being paid the living wage, but so that there is a reasonable profit for the provider, although not all providers receive such a return. The cost-of-care calculator is important in bringing transparency to all of that.

Ash Denham: Let us return to the idea of sustainability in the medium to long term. We clearly need to identify innovative models of care, and you mentioned an example in Norway that sounds interesting. Is the Government looking at ideas, pilots or projects in other countries that Scotland could learn from?

Shona Robison: We have been very open to looking at best practice elsewhere. For example, we have been trialling the Buurtzorg model here with the aim of empowering front-line staff to work in more of a care-at-home environment in which they manage a case load and can make changes and adjustments to care that enable more rapid changes when someone needs more or less care. The idea is that front-line staff will make more decisions around care rather than pass them back to, for example, three sets of managers, which can take some time.

As you have probably guessed—I have mentioned it three or four times—I am very taken by the idea of looking more at what skills the staff in the care home sector need to support people in the increasingly complex care home environment than at who employs those staff. The reality is that, even if the benefits and attractiveness of a nursing career in the care home sector are promoted, there are going to be challenges.

The NHS is a very attractive proposition for nurses because of the diversity of career opportunities that it offers. The idea of locality-based teams—not just of nurses but of other skill sets—providing those skills to the care homes and nursing homes in an area seems to be a very strong way forward. That is already happening in some areas, but I would like us to look at whether it is a viable proposition.

We are increasing the number of training posts for nurses, so we are increasing the workforce overall. There are always demands on the nursing workforce—we must recognise that—but we could make a career in the care home sector an attractive proposition for nurses and other allied health professionals, which would increase quality, bring sustainability and, potentially, help the care home sector to avoid having to pay agency nurse rates. In one case, the rate was £1,200 a night, which is not sustainable. We recognise that.

David Stewart: I have a general question about the improvement hub, which the cabinet secretary will know was set up almost two years ago by Healthcare Improvement Scotland. I mentioned earlier that I watched the online presentation last night, and I thought that it was first class. It focused on such things as sepsis and the new FIT procedures for bowel screening. Is that the right vehicle through which to manage change in the sector, or is it just one factor in the equation of change within the care sector?

Shona Robison: It is probably one factor, although Mr Stewart is right in saying that it does some really good work. We want local partnerships to analyse their problems, so that they know what their local needs are and where they have challenges, strengths and weaknesses, and we want them to ask for support.

The partnerships that ask for support most often are the ones that are doing the best. We have seen most of the challenges where there has been a reluctance to ask for support. Asking for support should never be seen as a weakness; it should be seen as a strength. It means that the partnership has identified where the challenges are and wants support in overcoming them. Some of our strongest-performing partnerships have asked for and have received quite significant support.

Geoff Huggins: It is a good question. The pilot frailty work that the ihub has done in Fife has also been really effective. We see it as one of the reasons for the improvement in a number of the indicators there, but it stands alongside the data work and the objective of creating capability for change in local partnerships.

In response to the previous question, I will add something about two or three things that we are doing that are making greater use of technology, looking across housing, care home and community hospital solutions and exploring mixed-use environments. We have become aware of a case in England in which an Italian restaurant was developed as part of a mixed-use environment and the overall funding model. Apparently, it made £8,000 during its opening weekend. We do not have to do things as they have always been done but can find different ways to do them. The other work concerns the location of care. Do we take it to the outskirts of the town or put it where people are able to tap into other facilities? There is a lot going on. The sector will learn, but the approach will also be bespoke.

Emma Harper: I have a quick question. We now use the language of “models of care”, which trips off the tongue quite easily. It is our common language, but I wonder whether there are people who still do not understand what is meant by changes of care in relation to respite in the home versus respite in another place. It is about not just bricks and mortar or dementia care in another place but wider connectivity to the community and everything. I wonder whether a role or remit is required for more public engagement and awareness raising regarding the language that we use to describe better care models.

Shona Robison: Someone—it might have been Sandra White—mentioned the importance of the language that is used, and I think there is something in that. Rather than compartmentalise things and say, “This is this,” or, “That is that,” the concern should be the care needs of the person. Whether and where they receive respite should be tailored to their needs. We started off by saying that we cannot look at one part of the system in isolation but must look at the whole system. There is definitely something in that, and perhaps there is a need to change or adapt some of the language.

Geoff Huggins: There is a more general issue as well. We talk about going to the hospital or seeing the doctor, but there are other options such as the pharmacy. On the social care side, I find it interesting how surprised and how pleased people often are by the care that they receive. It is a surprise to them because it had not been their understanding of what social care is.

I spoke to a colleague whose mother had returned from hospital. She lived in a terraced house and had expected to need adaptations, but instead she received rehab. The consequence was that, six to seven weeks later, she was able to go up and down stairs and had the capacity to use the whole house. That was a mind-blowing outcome for her, although what she received was normal. However, that is not the dialogue that we have. About 10 years ago, one of my colleagues suggested that we should make a documentary soap to explain what happens, but I do not think that the broadcasters would take it on. It is hard to get the information across.

Emma Harper: Thanks.

The Convener: Thank you very much, colleagues. It has been a very full session, and I thank the cabinet secretary and Mr Huggins for their attendance.

12:41

Meeting continued in private until 12:56.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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