HEALTH AND COMMUNITY CARE COMMITTEE

Monday 10 June 2002
(*Afternoon*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE

16th Meeting 2002, Session 1

CONVENER
*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS
*Bill Butler (Glasgow Anniesland) (Lab)
*Dorothy-Grace Elder (Glasgow) (Ind)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Nicola Sturgeon (Glasgow) (SNP)

COMMITTEE SUBSTITUTES
Brian Adam (North-East Scotland) (SNP)
Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD)
Ben Wallace (North-East Scotland) (Con)

*attended

WITNESSES
Dr Adam Bryson (Beatson Oncology Centre)
Dr Harry Burns (West of Scotland Regional Cancer Advisory Group)
Malcolm Chisholm (Minister for Health and Community Care)
Dr Charles Clark (West of Scotland Regional Cancer Advisory Group)
Dr Carol Davidson (Ayrshire and Arran Cancer Planning Group)
Stephen Greep (Ayrshire and Arran Cancer Planning Group)
Dr Anna Gregor (Scottish Cancer Group)
Professor Paul Harrison (Beatson Institute for Cancer Research)
Dr Huntly McCallum (Ayrshire and Arran Cancer Planning Group)
Helen McDermott (Beatson Oncology Centre)
Roseanne McDonald (Ayrshire and Arran Cancer Planning Group)
Liz Porterfield (Scottish Cancer Group)
Professor Roy Rampling (Beatson Oncology Centre)
Margaret Spalding (Beatson Oncology Centre)
Ms Ede Stewart (Beatson Oncology Centre)
Elizabeth Stow (Beatson Oncology Centre)
Mr Brian Sugden (Beatson Oncology Centre)

CLERK TO THE COMMITTEE
Jennifer Smart

SENIOR ASSISTANT CLERK
Peter McGrath

ASSISTANT CLERK
Michelle McLean

LOCATION
Glasgow City Chambers

Scottish Parliament

Health and Community Care Committee

Monday 10 June 2002

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:08*]

Subordinate Legislation

Community Care (Assessment of Needs) (Scotland) Regulations 2002 (draft)

Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002 (draft)

The Convener (Mrs Margaret Smith): Welcome to this afternoon's meeting of the Health and Community Care Committee in Glasgow. I welcome the Minister for Health and Community Care and our witnesses.

Item 1 concerns subordinate legislation. We must consider two affirmative instruments and two negative instruments. The first affirmative instrument is the draft Community Care (Assessment of Needs) (Scotland) Regulations 2002, the motion on which the minister will move. The Subordinate Legislation Committee has nothing to report on the instrument and no members' comments have been received. Do members wish to debate the instrument?

Members: No.

The Convener: No debate will take place and no points of clarification have been raised. I ask the minister not only to make any points on the instrument in question, but to give us an update on where we are on the personal care agenda and to let us know whether we are on track for 1 July.

The Minister for Health and Community Care (Malcolm Chisholm): There are two instruments on personal care. The draft Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002 exempts the first £145 of personal care and the first £65 of nursing care. There have been concerns about what will happen to people who are in care homes at present. Under the draft Community Care (Assessment of Needs) (Scotland) Regulations 2002, people who are in a care home at present will automatically get the money. The assessment applies only to new entrants to care homes. That is the effect of the two affirmative instruments.

A lot of work has been done on implementation during the past few weeks. I thank the implementation steering group for that, in particular, Alexis Jay, who spearheaded the work. From the reports that I have received, all local authorities are on track to deliver free personal care and free nursing care from 1 July. There is an issue about councils making payments in arrears to care homes, so care homes might not receive payments until two or three weeks into July. Obviously, those payments will be backdated. Everything should start on 1 July. There might be some hiccups here and there, but I am not aware of problems at the moment and we do not envisage any difficulties with the starting date.

The Convener: I am sure that we are all pleased to hear that. I ask the minister to move the motion on the draft Community Care (Assessment of Needs) (Scotland) Regulations 2002.

Motion moved,

That the Health and Community Care Committee, in consideration of the draft Community Care (Assessment of Needs) (Scotland) Regulations 2002, recommends that the Regulations be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

The Convener: On the draft Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002, the Subordinate Legislation Committee has nothing to report and no members' comments have been received.

Motion moved,

That the Health and Community Care Committee, in consideration of the draft Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002, recommends that the Regulations be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

Community Care and Health (Scotland) Act 2002 (Consequential Amendment) Order 2002 (SSI 2002/233)

The Convener: We move to the negative instruments. No members' comments have been received on the Community Care and Health (Scotland) Act 2002 (Consequential Amendment) Order 2002. The Subordinate Legislation Committee will relay its comments to the Executive. No motion to annul the order has been lodged and the recommendation is that the committee should make no recommendation in relation to the order. Is it agreed to make no recommendation?

Members *indicated agreement*.

Meat (Hazard Analysis and Critical Control Point) (Scotland) Regulations 2002 (SSI 2002/234)

The Convener: No members' comments have been received on the Meat (Hazard Analysis and Critical Control Point) (Scotland) Regulations 2002 and the Subordinate Legislation Committee has no comments. No motion to annul the regulations has been lodged and the recommendation is that the committee should make no recommendation in relation to the regulations. Is it agreed to make no recommendation?

Members *indicated agreement*.

Cancer Services

The Convener: Agenda item 2 is on cancer services in Scotland. This morning, the Health and Community Care Committee had an interesting visit to the Beatson oncology centre departments in the Western infirmary in Glasgow and at the new site at Gartnavel royal hospital. I thank the staff and the members of the patients action group whom we met during our visit for their input into what was an interesting and stimulating meeting.

We have the questions with which we were armed in advance and a new barrage of questions for our first witness, who is the Minister for Health and Community Care. The focus of much of our questioning will be the Beatson centre, which is often in the news and is of key interest to the people of Glasgow and the west of Scotland. We also have questions about the progress of the cancer plan and cancer services in Scotland. Given that we have a lot of witnesses, we will begin with questions. If, by the end of questioning, the minister feels that we have not covered all the issues that he wants to cover, he can add something then.

Janis Hughes (Glasgow Rutherglen) (Lab): As the convener said, we had an interesting visit this morning and members who have visited the Beatson centre in the past saw changes today. Will the minister highlight specifically what is being done to take into account the expert advisory group's recommendations?

Malcolm Chisholm: Many of the expert advisory group's recommendations have already been acted on. For example, the group's report contains recommendations on staffing. Although it is by no means the only example, the increase in the number of nurses is the best known one—the cancer strategy group recommended 34 extra nurses in the second round of investment. Other staffing recommendations have been, or are being, acted on. We have been successful in recruiting nurses but, as is known, there has been more difficulty with other staff groups. The organisation of services has been another prominent theme, and action has been taken on the development of multidisciplinary teams and tumour-specific teams.

Anna Gregor will speak later so I feel a bit strange speaking about certain issues when she obviously knows a lot more about them than I do. However, I will say that most of the recommendations are being acted on. The report was prepared for Greater Glasgow Health Board so there is no obligation to act on every point. For example, recommendations on clinical physics—specifically, those on the precise number of staff—have not been accepted.

14:15

The Convener: My question probably overlaps with Janis Hughes's question to a degree. What progress has been made on achieving the objectives of the Beatson oncology centre's action plan? What areas of the action plan still require work?

Malcolm Chisholm: A lot of progress has been made. The plan had various sections. It began with the interim arrangements, which have been put into practice—including the reorganisation of the clinics. Most of the sections of the action plan have been acted on.

A big study is being done by a consultancy firm, FRMC Decision Support Ltd. It is considering the longer-term organisation of services in the west of Scotland. Further reorganisation of peripheral clinics is part of that. The subject is also highlighted in the action plan. Those studies have yet to be finalised; the conclusions will arrive in the next few months.

The Convener: Peripheral clinics are of concern across the west of Scotland. I acknowledge what you say about the continuing work. We must consider people's ability to access services close to their homes and the clinical evidence on access to specialists. What is your view on that?

Malcolm Chisholm: The expert advisory group report contained clear recommendations on the best ways of reorganising clinics. Two issues could be confused. The interim arrangements were discussed during our debate on the Beatson centre in December and some members expressed concerns. However, the arrangements were required to address the work loads of consultants. Members will all know from their visit that the work load of clinical oncologists is still an issue. As well as the interim arrangements, there is a more fundamental look at the organisation of services. Again, Anna Gregor is far more qualified than I am to speak about that. The expert group report will be a clinical judgment of what is desirable rather than of what may be necessary because of temporary staffing difficulties.

The Convener: The comments in the expert group's report suggested that the present arrangements had developed over many years in an ad hoc way. Would Dr Gregor like to comment on that?

Dr Anna Gregor (Scottish Cancer Group): Thank you for the opportunity. I am conscious of the fact that Dr Adam Bryson will give evidence after the minister and that that may be a more appropriate point at which to discuss the factors and practicalities. In general terms, Scottish cancer services have a wonderful opportunity—especially in the west of Scotland—to consider patient need from a fundamentally different point of view. The balance between the standard of services that can be delivered as near to a patient's home as possible and the regional and specialist services to which a patient has to travel is one that everybody struggles with. The ability of the west of Scotland service to look at that afresh, which has come out of the need to review the position of the Beatson as the west of Scotland cancer centre, should be welcomed.

Shona Robison (North-East Scotland) (SNP): I want to move on to consider the planning and management of services at the Beatson and the arrangements to monitor them. Are there any moves to shift the Beatson back under the control of the North Glasgow University Hospitals NHS Trust? The patient representatives that we spoke to this morning made their views on that very clear: they have no confidence in the ability of the North Glasgow University Hospitals NHS Trust to manage the Beatson satisfactorily.

Malcolm Chisholm: I, too, have spoken to the patient representatives. I know that that is their view. There will be a ministerial decision in due course, but I am happy to listen to the views of Greater Glasgow NHS Board and anyone else with an interest in the matter. I do not have to make a decision at the moment—there is a lot of work to be done before such a decision needs to be made.

The expert advisory group assumed that the Beatson would be part of the North Glasgow University Hospitals NHS Trust, although on an entirely different basis. It assumed that the Beatson would be a separately managed unit, which is quite different from the arrangements that pertained before 5 December 2001. If the committee were to ask for all the group's recommendations to be implemented, that would include the management of the Beatson within the North Glasgow University Hospitals NHS Trust. It is my decision and I will listen carefully to the many different views. It is not an immediate decision because there is a great deal of work to do in the meantime.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Given that Adam Bryson's contract has been extended only until September 2002, the decision will have to be made quite soon or there will be a vacancy. We heard from patient representatives that that could complicate the situation further. The Beatson provides a west of Scotland service. Could it not be managed as a special health board?

Malcolm Chisholm: There are various options for the Beatson's relationship to the Greater Glasgow NHS Board, including the status quo. The question about the medical director is a slightly different matter. The expert advisory group has recommended that there should be a medical

director and most of us agree that a medical director should head up the Beatson, irrespective of its future relationship with other bodies.

Greater Glasgow NHS Board will advertise the post of medical director very soon—in the next few days. That is an important appointment. Adam Bryson is staying for an extra three months and we hope that there will not be too much of a hiatus. If such a hiatus does arise, we will discuss with Dr Bryson and others how to deal with it.

Shona Robison: On that point, the appointment process can take time and three months is not long to get someone of the calibre that we will be looking for. Are you saying that there is flexibility in the arrangements with Dr Bryson, so that his contract could be extended?

Malcolm Chisholm: Dr Bryson has been seconded. I think that the committee will speak to him later this afternoon. Far be it from me to say what Dr Bryson wishes to do.

Shona Robison: I am asking whether the opportunity to extend the contract exists.

Malcolm Chisholm: He has been seconded for six months initially and there has already been some flexibility in that. It is desirable and important that we advertise for a medical director without delay. That is what will happen.

Nicola Sturgeon (Glasgow) (SNP): The patient representatives to whom we spoke this morning expressed the more general view that the geographical area covered by the west of Scotland cancer centre should be reviewed with a view to possible rezoning. They also suggested that Forth valley should be included in the Edinburgh area instead of the west of Scotland area. What are your views on that proposal? Has it been considered?

Malcolm Chisholm: Again, the expert advisory group recommended that the option should be considered if a certain ratio of consultants to patients, particularly new patients, has not been reached by later this year. That must be the principal decision. If at a certain point it appears that the work load for consultants at the Beatson is unacceptable, it would be correct to consider whether there needs to be some rezoning.

Given all the renewed activity, it is premature to take any such decision now. The new consultant posts are being advertised; and in the most recent investment round, we announced that there would be two medical oncologist posts in addition to the new clinical oncologist posts. Although it is never an easy job to recruit oncologists, I am told that it is possibly easier to recruit medical rather than clinical ones. If that happened, it would be entirely helpful. Moreover, I am told—and you can ask Dr Bryson about this—that there have been several expressions of interest in response to the latest advertisement for clinical oncologists. A lot of activity is going on: one if not two locums are also on the way. As a result, the number of consultants will increase over the next few months and two new people are starting imminently. The situation is not static. Although rezoning is not absolutely ruled out if it is necessary, we hope to recruit the extra consultants to ensure that it will not be required.

The Convener: We have heard that the first of the new consultants started today.

Malcolm Chisholm: Yes. When I said that they were starting imminently, I had this week in mind. I was just not sure of the day.

Nicola Sturgeon: I have two further points. I think that the expert advisory group said that if 20 clinical oncologists were not in place by September, patients might require to be moved elsewhere. Within what time scale would you begin to consider such an option? Given the time involved in interviewing and appointing people and given that we are only three months away from the deadline, do you know what the situation is likely to be in September?

Malcolm Chisholm: The committee probably has many questions for Adam Bryson. I have discussed the issue with him, and he certainly feels that 20 oncologists will likely be in place by September. Obviously that is not absolutely certain: let us say that that is the expectation. We hope to go beyond that point quite soon. As I have said, the extra medical oncologists will have a knock-on effect on the clinical oncologists' work load.

The situation is moving, but if there were a continuing difficulty, it would be only right in principle—and in accord with our general approach on waiting times—to give people the option to move to an area where there is less pressure on the health system.

Dr Gregor: We should remember that there is an optimal size for a regional cancer centre. The general consensus is that single establishment cancer centres that serve 2 million people and over become too large and difficult to manage effectively. Instead of reacting to a resource issue by moving patients—with all the disruption and difficulties that that can cause—it might be helpful to consider the matter from a strategic planning viewpoint. We would need to consider how we could redistribute cancer services where networks give us the opportunity to examine the consistency and quality of care across Scotland as a whole. We would also need to consider how we plug the regional cancer centres into those networks in a more effective and efficient way.

Nicola Sturgeon: That brings me on to my last

question. The expert group flagged up the possibility—it did not go into detail—of a second cancer centre for the west of Scotland. I understand that that is now a much longer-term consideration, but is such a possibility being considered in the planning process?

14:30

Malcolm Chisholm: That is certainly not in the plan at the moment. A lot of work is going on in planning for the new Beatson cancer centre at Gartnavel. Many groups and staff members are involved in that process. An assessment needs to be made of how big that centre should be. The arguments for a second cancer centre were very much to do with possible unmet need for radiotherapy. Again, Anna Gregor will be far better qualified to talk about that than I am, but it does not appear obvious that if such unmet need existed, a second centre would necessarily be required. The impact of such demand might be more on the size of the original centre than on the need for a second centre. That is perhaps the recommendation of the expert advisory group that has received the least unanimous support. However, I am sure that there are issues about the precise size of the centre, as Anna Gregor can explain.

Dr Gregor: We have 5 million people in Scotland and, as things stand, we have five cancer centres. We would need to be absolutely confident that building another cancer centre somewhere else would resolve some of the difficulties that we have resourcing those centres with the necessary technical support and manpower.

Bill Butler (Glasgow Anniesland) (Lab): Given the fluidity of the situation, is the minister confident that treatment and care have been maintained at an acceptable level within the Beatson oncology centre?

Malcolm Chisholm: The standard of care has always been high. That is what I said when I first visited the centre on 1 December, when we were at the height of the crisis. I do not think that anyone questions the standard of care, and I welcome the opportunity to pay tribute once again to all members of the staff team at the Beatson for all the work that they have done during these difficult times.

I have no reason to think that there is an issue with the standard of care, but there have been unacceptable features such as the length of waits, which is what is most often highlighted. That issue affects not only the Beatson but has been flagged up in the various reports of the Clinical Standards Board for Scotland. It is critical that we take action on waiting times at the Beatson and elsewhere. That is one of the key reasons why we need the extra capacity, which means extra staff, more linear accelerators and more scanners—although most of those are located not in the Beatson but elsewhere in Glasgow.

There are general issues with the length of waits, but I do not think that there has been an impact on the quality of care that people have received from the superb staff at the Beatson.

Mary Scanlon (Highlands and Islands) (Con): My question relates to the cancer plan, which is not yet one year old. Managed clinical networks are a major plank of the cancer plan. How is accountability shared across the different bodies and organisations that are involved in delivering the cancer plan?

Malcolm Chisholm: The situation is different from that in some other areas. The Scottish Cancer Group, which is chaired by Anna Gregor, is the key group. The regional cancer advisory groups are in the driving seat at regional level. They consider both the organisation of services and investment priorities. The decisions on cancer investment that were announced two weeks ago were very much the recommendations of the regional cancer advisory groups. Within those regional cancer advisory groups there work tumour-specific teams, which are where the managed clinical networks come from. Anna Gregor can talk about the clinical details of that.

Mary Scanlon's question is mainly about accountability. In principle, the department still has a central role to play in performance management and in other areas. We are also seeking a great deal of transparency. We know about the Clinical Standards Board for Scotland reports and I am advised that the regional cancer advisory groups, which were to report every six months on progress within their region and on what is happening to the new investment, are publishing their reports today. There is a degree of transparency in this area of work. The accountability arrangements for cancer are not fundamentally different from the arrangements that are in place for other illnesses or other parts of the health service.

Mary Scanlon: I will be more specific. This morning, we heard from a member of the patients group that, in the west of Scotland, 25 per cent of women who have ovarian cancer die needlessly.

I refer you to chapter 4 of the cancer plan, which states:

"By April 2002, a major service redesign initiative aimed at improving the patient journey from referral to treatment will be in place."

Someone might say, "I saw my GP for months and finally saw a different GP who sent me for tests, but I should have been sent earlier." The Clinical Standards Board for Scotland's report on

ovarian cancer says that formal arrangements between general practitioners and gynaecologists in the multidisciplinary teams have been agreed in seven hospitals. Twenty-five per cent of hospitals have that formal, multidisciplinary way of working in order to identify ovarian cancer, which is difficult to detect.

Malcolm Chisholm: It would be more appropriate for Anna Gregor to answer some of the detail of your question. However, during the debate in Aberdeen, I announced the guidance and protocols for referrals, which will be relevant to some of the points that you raise about GP referrals.

Mary Scanlon: Are you satisfied that GPs have the training and support to pick up potential cancers early on, so that they can refer patients to the Beatson?

Malcolm Chisholm: I have to be careful, as I am stepping into clinical territory—it would be far more appropriate for Anna Gregor to deal with that point. In general terms, I am saying that there has been action on the referral guidance. I am not sure which managed clinical network you are referring to, but a lot of work is being done on the development of managed clinical networks for many different tumours in different parts of Scotland. Anna Gregor may wish to pick up on that point.

Dr Gregor: In the west of Scotland, the gynaecological managed clinical network, which is led by Dr Davis, is an example to us all of how to provide gynaecological oncological services to the local population. Referral guidance is the first step in supporting the development of local arrangements, so that each part of the primary care service knows where to refer patients with high-risk symptoms. That is part of the work load of all the networks and is being developed as we speak.

Mary Scanlon: Do you think that the systems, procedures and staff are in place and that the figure of 25 per cent of women with ovarian cancer dying needlessly is a thing of the past?

Dr Gregor: I am afraid that I do not know where that figure comes from, so I cannot comment on the situation in detail. Undoubtedly, there is a need for improved diagnostic services for all patients with cancer. In fact, ovarian cancer is known as the silent killer probably because it is so difficult to detect in its early stages. It would be foolish of me to pretend that no patients experience delay in accessing services. However, that delay being labelled as unnecessary is an issue that should be dealt with in more detail.

Mr John McAllion (Dundee East) (Lab): My first question relates to an answer that the minister gave to Bill Butler, in which he said that the waiting times for access to scanners are unacceptable. This morning, we heard that waiting times for outpatients in particular are totally unacceptable. Some consultants are reclassifying out-patients as in-patients and giving them a bed for two days in order to get them on to a much shorter waiting list. It was suggested to us that many scanners elsewhere in Scotland are underused. Is anyone in the health department trying to assess underutilisation of scanners throughout the country in order to establish whether they could be redesignated to provide further assistance?

Malcolm Chisholm: That is precisely the kind of area that we are interested in. I attended the big health service conference in Dunblane this morning and I will return there after this meeting. One of the things that we were demonstrating there was the prototype of the waiting times database, the point of which is to allow identification of where there are shorter waiting times and to allow people to go there. In principle, if there is a shorter waiting time for scans elsewhere, that capacity should be used.

As well as scans, I am concerned about radiotherapy, which was also flagged up in the Clinical Standards Board for Scotland's reports. I do not know what the committee picked up on that issue from the Beatson centre this morning, but I was pleased that, following the Clinical Standards Board's visit to the Beatson, the waiting times for radiotherapy have come down considerably. Although they are not yet satisfactory, there has been a significant improvement in radiotherapy waiting times at the Beatson over the past few months.

I am concerned about scanning. That is why, in addition to the separate programme for investment in scanners, some of the investment decisions that the regional cancer advisory groups took two weeks ago were for extra scanning capacity. Another magnetic resonance imaging scanner will come on stream at Gartnavel general hospital this year and the south-east group prioritised a new scanner at Dr Anna Gregor's hospital in Edinburgh, the Western general. Although there are unacceptable waits, new scanners are coming on stream. If people can be referred elsewhere, that is highly desirable.

Mr McAllion: You mentioned that the Scottish Cancer Group is a key group and that the regional cancer advisory groups are the driving forces. We have also heard about the treatment centres. Many different organisations and bodies are involved in delivery and planning of cancer services. Will you describe how the money in the cancer budget and control over that budget are distributed among the different bodies?

Malcolm Chisholm: The fact that the Scottish Cancer Group and the regional cancer advisory

groups are in the driving seat has been widely welcomed. That structure represents an interesting model. The question of what I am, as opposed to someone else is, responsible for and what I should be making decisions about comes up all the time. Money decisions on the total health spend and on how much goes to cancer are Government decisions. Questions such as those that relate to the organisation of the Beatson centre and where it fits structurally within the health system are also Government decisions. It has been widely welcomed that Anna Gregor and her colleagues will make the decisions about investment priorities, because it is self-evident that they know far more about such matters than does anyone else at the table.

On reorganisation of services—another key issue—the front-line staff are leading change. The cancer strategy shows that policy in action. Government has a responsibility to put up the money and it is interesting to think about the fact that it has done that differently in relation to cancer. Many of the Health and Community Care Committee's discussions and the discussions on health in general focus on the balance between what the centre should decide and what NHS boards should decide.

It is interesting that we have taken the decision to ring fence the money for cancer. Every time I come to the Health and Community Care Committee, many of our discussions break down into consideration of where the line is drawn between what the Government decides and what local agencies decide. The fact that the cancer money is ring fenced has been widely welcomed and it means that quite a lot of money is coming on stream. The decisions about the figure of £10 million were announced in November, the £2 million for the Beatson centre was announced in February and the additional £13 million was announced two weeks ago in Aberdeen. That amounts to £25 million, which has been coming on stream since November and which will continue to come on stream throughout the year as staff are employed and as equipment is commissioned.

The Executive has decided the total amount. The regional cancer advisory groups have decided what the money will be spent on. Although the expenditure flows through the boards, one could argue that they have almost been bypassed in this instance, because we have made the decisions about the amounts of money, and the regional cancer advisory groups have made the decisions about how the money will be spent. Nonetheless, the money still flows through the boards into the appropriate service. The money is ring fenced.

Mr McAllion: The Scottish Cancer Group does not take part in those decisions.

Malcolm Chisholm: The Scottish Cancer Group has a relationship with the process. All bids from regional cancer advisory groups go through the Scottish Cancer Group. Anna Gregor would be able to describe that process better than I, if members would like to pursue the matter. The investment priorities for each of the three regions were decided by the regional groups and that was all referred to the Scottish Cancer Group.

Dr Gregor: The one thing that I would add is that the central spend of the Scottish Cancer Group is less than 1 per cent of the £25 million additional money.

Mr McAllion: Are the regional advisory groups the key people?

Dr Gregor: Absolutely. That is where the service needs to change. The additional money is useful leverage as well as a facilitator for building capacity.

Dorothy-Grace Elder (Glasgow) (Ind): Before I pose my question, I point out that the scanners of which the patients said there is a shortage, which was confirmed by the clinicians, are not only MRI and computed tomography scanners, but ultrasound scanners. Concern has been expressed about that.

14:45

For some time, several clinicians at the Beatson have been as concerned as the 28 UK oncologists about the shortage of funding for, and restriction of the use of, new drugs. At the moment, that concern relates to colorectal cancer. In view of the bad outcomes of colorectal cancer in Scotland, should not the health board lift those restrictions from the Beatson, despite the verdict of the National Institute for Clinical Excellence, which was merely rubber-stamped by the Health Technology Board for Scotland?

Malcolm Chisholm: There has been a series of cancer drugs and some of NICE's decisions, followed by those of HTBS, have been welcomed by you and many others. Herceptin was one of the most recent examples.

I think that Dorothy-Grace Elder refers to a new judgment by NICE on some colorectal cancer drugs.

Dorothy-Grace Elder: Yes.

Malcolm Chisholm: I was not aware that HTBS had decreed on that yet.

Dorothy-Grace Elder: It has, yet again, rubber-stamped a NICE decision.

Malcolm Chisholm: There is obviously some controversy surrounding that; Professor Jim Cassidy recently expressed some views about that. NICE and HTBS are well qualified to consider the effectiveness of new drugs, so it is difficult for

me to give a snap judgment on a particular drug with which I am not familiar.

All I can say in general is that there must be some assessment of drugs' efficacy. We cannot take the view that every new drug or technology is automatically desirable. We must judge whether those drugs will be clinically beneficial. I am obviously straying out of my territory.

Dorothy-Grace Elder: The clinicians have stated that they wish to use those drugs.

Dr Gregor: Drugs are only one part of the overall cost of cancer care, or overall care. The evidence-based recommendations from HTBS and the Scottish medicines consortium are advisory. I am well aware that health boards are taking those recommendations into account. However, it is up to the networks, together with the health boards and their regional groups, to include in their strategic plans implementation of those recommendations.

Dorothy-Grace Elder: The recommendations were not evidence based because HTBS admits that NICE did not submit evidence. It commented only on what it knew, but it did not receive evidence as it was being produced.

Dr Gregor: That is a matter of practical working. The UK currently has three evidence-based review bodies. It would be inefficient to review evidence three times. Evidence is evidence is evidence, whether it is reviewed this side of Hadrian's wall or down south.

The Convener: I thank the minister. We will return to you later on in the proceedings.

We will hear now from the witnesses from the Beatson oncology centre. Good afternoon and thank you for coming along this afternoon. While your name plates are being popped on to the tables in front of you, I ask you to introduce yourselves and give us an idea of what you do at the Beatson oncology centre.

Dr Adam Bryson (Beatson Oncology Centre): I am Adam Bryson. I have been interim director of the Beatson oncology centre—as was referred to earlier this afternoon—from last December and will, prospectively, remain in that position until about September this year.

Professor Roy Rampling (Beatson Oncology Centre): I am Professor Roy Rampling. I have been at the Beatson for 14 years. I am employed by the University of Glasgow, and have an honorary contract at the Beatson. I have a particular interest in brain tumours and head and neck cancer.

Helen McDermott (Beatson Oncology Centre): I am Helen McDermott. I am the partnership representative from the Manufacturing Science Finance union—the MSF. I also work in the clinical physics department at the Beatson. I am mostly involved with brachytherapy, especially new brachytherapy.

Ms Ede Stewart (Beatson Oncology Centre): My name is Ede Stewart. I am the urology nurse specialist at the Beatson oncology centre. I have been in post for 11 months.

Margaret Spalding (Beatson Oncology Centre): I am Margaret Spalding. I am a senior 1 therapy radiographer at the Beatson oncology centre. I also work at Glasgow Caledonian University as a part-time lecturer in radiotherapy. I have worked at the Beatson oncology centre for 20 years.

Elizabeth Stow (Beatson Oncology Centre): I am Elizabeth Stow and I am a regional officer with the Society of Radiographers.

The Convener: Thank you. We will go through our questions, and if anyone wishes to address any major points that we have not covered, they may do so. I hope, however, that committee members will by the end of the meeting have asked Dr Bryson about everything he has ever known about cancer. I thank Dr Bryson again for his time and I thank the staff at the centre. We appreciate greatly your input.

Bill Butler: This question is the same as one that I asked the Minister for Health and Community Care. Given the widely publicised pressures on the Beatson oncology centre, do you feel that the treatment and care there have been maintained at an adequate or appropriate level during this challenging period?

We heard this morning that the action group that has been formed is worried about there being a "leadership vacuum", as it was put, after September this year. Will you also comment on that?

Dr Bryson: I have been impressed since I came to the Beatson last December with the level of commitment on the part of all groups of staff, from consultants to nurses via therapy radiographers and so on. Because of the staffing situation, the greatest pressure has been in clinical oncology consultancy. I have been impressed that the consultants have gone way beyond the extra mile to maintain the quality of service to patients.

I am conscious of the fact that airline pilots do not have the privilege of flying their planes 16 hours a day—a restriction that seems not to apply at the moment to clinical oncologists at the Beatson oncology centre. There is no doubt that consultants are under an awful lot of pressure, but consultants are human. There is always a risk that that pressure, despite the checks and balances in the system, will lead to errors.

I will ask others to comment on that in a moment, but I will first reply to your remarks about there being a potential leadership vacuum from last September. Subject to the acquiescence of my colleagues at my job in Edinburgh, I am prepared to be flexible about when I leave the Beatson. My ideal would be that the medical director post would be filled and there would be a period of overlap, so that there is no question of there being the kind of hiatus or vacuum that was referred to. I ask Professor Rampling to comment on the quality of care.

Professor Rampling: It is difficult. If we say, "Yes, the quality has been maintained.", the committee would ask what was the problem. If we say that quality has not been maintained, that is a big issue. There must be a comparator. We must judge whether the care is adequate compared to other units that deliver similar care. The answer is that overall quality has been maintained.

One does have to take short cuts, though. If we are seeing more patients per day, the amount of time that we can allocate to each new patient is reduced. Maintaining adequate care comes at a price, the kind of price that Adam Bryson has talked about. I see my colleagues every day and the pressures are enormous. Those pressures will lead to breakdown if they are not addressed. There is no question about that. We live in constant fear that the way in which we are working might lead to error. It is not a sustainable situation, but overall, the quality of care has been adequate.

Bill Butler: Are the pressures being addressed?

Professor Rampling: A lot of effort is being put into all areas and some of that effort is successful. Addressing infrastructure and the new nursing allocation will certainly be a great help. We have put great efforts into retaining our radiographers. Radiographer numbers are a problem nationally. Our physics staff is excellent and our waiting times have come down; we now have one of the best waiting times in the UK. Many infrastructure issues have been addressed.

The big problem is with senior clinical oncology staff. That is not a matter that can be addressed just like that. Last year, there were 50 vacancies in England and Wales for clinical oncologists. Those posts were not filled; there were no adequate staff. It is very difficult to attract people to a department in which there are known problems. I believe that the message that we must get out—it is a correct message—is that the problems are being addressed and that the Beatson centre will be a good place to work. However, the problems will not be solved overnight. It will take a long time and we must convince people who have huge choices—a qualified clinical oncologist can work almost anywhere in the country—that Glasgow is the best place to come to work and that it will offer them a very good future.

Dr Bryson: I will comment briefly on consultant resources. At our lowest point, we had 15 and a half whole-time equivalent consultant clinical oncologists carrying a work load that had been quantified as requiring 23 consultants. Of those 15 and a half, one was on medium-term sick leave from which—thank goodness—he has returned. We are now back up from 14 and a half to 15 and a half. An additional consultant is starting today and a new consultant will start on 1 July. A locum will start a week today, so that post will be filled until the end of September. I am negotiating with another potential locum, who might come from another part of the world for perhaps as long as a year, although that is merely a possibility. There is the possibility that we might be able to recruit two clinical oncologists as a result of an advertisement that was lodged in the medical press about three weeks ago.

Nicola Sturgeon: The expert group made a number of recommendations about staffing levels in different areas, not only in clinical oncology. I know that funding for posts has been made available and that many posts have been filled, for example there are 34 or 35 new nurses.

Dr Bryson: We have covered clinical oncology, which is surely the most difficult nut to crack. On medical oncology, we now have a funded establishment of 6.4 staff, which is an increase of two over our previous funded establishment. Those posts have been advertised. We have received three expressions of interest, which are not yet at the stage of formal applications, but we are confident that we will fill those two vacancies during the summer.

15:00

Continuing through the categories on the staffing levels table in our submission, I would prefer to leave aside haemato-oncology, because it is not part of the Beatson oncology centre. The information on haemato-oncology is provided only for completeness. On palliative medicine, we currently have in post 0.6 whole-time equivalent staff, but we have offered appointments to three individuals who—assuming that they take up the offer of appointment—will bring that figure up to 2.8 whole-time equivalent staff. Two of those individuals will job-share, although they will work more than half time each, and the third—assuming that she joins us—will work full time.

Therefore, we have the real prospect of moving to an excellent position in palliative medicine. The important point is that the presence of additional palliative care support will alleviate to some extent the pressure on the clinical oncologists. However, one must be cautious about the extent to which that can be expected to apply.

On radiotherapy physics, we employ scientists and medical technical officers. We do not accept the recommendations of the expert advisory group, which suggested that we were substantially under par in both those areas. We believe that the advisory group has misinterpreted the national guidance. Our interpretation is that in funding terms and, to some extent, in filled-post terms, we are within a post or so of an appropriate level of staffing.

Others here can speak more eloquently than I about therapy radiographers. We must, however, bear it in mind that there is a moving target because we are bringing on two additional machines at Gartnavel in the course of this year. At the end of the year, we will be operating two machines more than we do currently. We have currently sufficient therapy radiographer staff to meet the demands of the machines that we operate, but we cannot be complacent. We envisage difficulties towards the end of this year in recruiting more therapy radiographers to fill the additional posts that will be required fully to operate the machines. Again, I emphasise that we are fully funded for the salary implications of the posts that we need to fill.

The mould room—if we continue down the table—is not an issue and we have recruited the additional 34 nurses for whom funding was allocated. There is a discrepancy on the table between the number of staff in post and the number of funded posts. That is inevitable in any organisation in which people leave and join and there is a hiatus, which is described in shorthand terms as a vacancy factor.

We are recruiting one additional occupational therapist, one additional speech and language therapist and one additional physiotherapist. Those posts are not located within the Beatson oncology centre, but are provided to us by the complement of professions that are allied to medicine within the North Glasgow University Hospitals NHS Trust. Again, the recommendation of the expert advisory group was that we should seek to reverse that.

The final group that I will highlight is pharmacy, in which we have funding for seven additional pharmacy posts and several additional technical support posts. A composite west of Scotland advertisement is scheduled to appear this week. We must wait to see what emerges from that, but we are currently substantially below complement. We have funding for the additional posts, but we must see how successful we are in recruiting to those posts.

We are therefore, with the unique exception of clinical oncologists, either at a level at which we are staffed to our establishment figures or we are at a level where the discrepancy is attributable to natural normal turnover. We will also rapidly expand the therapy radiography programme over the next few months. Perhaps therapy radiography colleagues want to comment on that.

Margaret Spalding: The main fear in relation to therapy radiography is about what we will do as more machines are installed in the Beatson oncology centre. The graduates for this year have been absorbed into the existing numbers of staff. What will we do in December when we need to staff two more machines? There is not much of a pool of people, which will soon become a problem if we increase the service to use the capacity of the new linear accelerators. We do not have the staff fully to use that service. There will probably be nine graduates next year, but that is a year away and we will be in trouble by then.

Janis Hughes: Staff and patient morale were highlighted during the crisis. The environment in which patients were being treated was not always pleasant, despite staff's hard work in trying to maintain the service. Have there been improvements in staff and patient morale?

Helen McDermott: Dr Bryson has achieved a lot in the way of increasing morale. He has an open door and everyone can go to him with problems. He has also done much to improve the environment through small things such as photocopiers and furniture. I can say honestly that staff morale has improved.

Janis Hughes: Is morale better because staff see, and are happy with, the way in which management is trying to attract new people to fill vacancies, which makes staff hopeful that some of the problems will be alleviated in future?

Helen McDermott: I have never had a problem with the Beatson management, either before or after Dr Bryson came. The management has always been committed to consultation and partnership, but it has not always had sufficient resources.

Janis Hughes: Are you happy that sufficient resources are in place?

Helen McDermott: They are coming.

Janis Hughes: So the things that you need are being provided.

Helen McDermott: Yes.

Nicola Sturgeon: I apologise in advance if my question is slightly unfair and cannot be answered categorically. Are the witnesses reasonably confident that, for the foreseeable future, we have seen the last of the resignations among clinical oncologists, which is perhaps where the pressures are greatest?

Dr Bryson: On the contrary, it is only a matter of time before there is another resignation. That is in

the nature of any organisation, especially one that employs highly committed consultants who have their career paths to consider. It is important that we try to ensure that consultants have in the Beatson the opportunities for progression to which they aspire; however, sooner or later a consultant will wish to develop his or her career in a way that cannot be achieved in the Beatson. For example, he or she might want to move to an academic post that does not exist in the Beatson.

Nicola Sturgeon: I appreciate that staff do not stay put for ever and a day. My question was about the kind of resignations that took place last year, which were a result of people toiling under pressure. Are you reasonably confident that the situation is stable?

Dr Bryson: I have said that the absolute number of consultants on the ground is growing. We have two additional clinical oncologists and we will soon have two additional consultants plus a locum in palliative care. That is bound to reduce pressure. I must ensure that the pressure that remains is distributed equitably among consultants so that some consultants do not feel that they are disadvantaged relative to others. In such circumstances, one or more consultants would, with some justification, feel that they did not want to or could not stay.

Shona Robison: The patient representatives will be heartened by the fact that you said earlier that you would be prepared to be flexible in relation to the handover period. They were concerned about that.

I asked the Minister for Health and Community Care a question about whether the Beatson would be managed by the North Glasgow University Hospitals NHS Trust. I do not know how far you can go in answering this question, but what benefits do you see in having the Beatson managed by a special board rather than the North Glasgow University Hospitals NHS Trust, in which the patient representatives do not have confidence?

Dr Bryson: If you ask any group of clinicians in the NHS how much autonomy they would like, the answer will be that it would like full autonomy, please. The staff in the Beatson are no exception. That is so because there is a strong feeling that, in order to control one's destiny, one has to control the resource and not be accountable to too many layers of invisible managers. North Glasgow University Hospitals NHS Trust is large and the Beatson makes up only a modest part of it, with an operating budget of around £15 million out of a total of around £400 million. Although the Beatson is important in a west of Scotland context and in the context of cancer treatment, it is a small part of the North Glasgow University Hospitals NHS Trust.

I have always felt that there were other ways of achieving the same objectives than that kind of isolationism, particularly given the fact that the Beatson oncology centre depends on the North Glasgow University Hospitals NHS Trust for a range of clinical and non-clinical services, such as catering services, laboratory services and imaging. What is important is a mechanism to ring fence funding that is specifically for cancer and cancer centres, which Dr Gregor and the minister talked about.

I believe that we are in the process of setting up an arrangement whereby the planning and commissioning of regional cancer services in the west of Scotland will be done on a regional basis, rather than with the collaboration of the five west of Scotland health boards, and the top-sliced funds that would be created will be used and monitored. If that arrangement is set up, many of the benefits of the universal declaration of independence approach that some advocate would be achieved. However, I must say that I understand the view that, because of the history, many of the staff and patients have that the last thing that they want is to return to the fold of the North Glasgow University Hospitals NHS Trust.

Professor Rampling: There is a strong feeling that our representation was not adequate in the period leading up to Christmas, when we had the resignations. For example, we were joined with the cardiac division and our clinical director was not an oncologist. We felt that our unique problems were not adequately represented or addressed. There is a fear that we might go back into that situation after having enjoyed a much better period in which we have a direct line for our problems and can address them quickly. The fact that we have a much quicker reaction time is why, naturally, we would like to preserve that arrangement.

I am not entirely sure how that arrangement can be preserved. I take Adam Bryson's point that not every separate unit could have separate representation. However, returning to the old management structure would not be an appealing proposition for us.

Margaret Jamieson: I am quite heartened that you say that. As someone who represents an area outwith the Greater Glasgow NHS Board area, I can say that sometimes we feel that we were forgotten about and did not get our say in the development of services. It is interesting that both of you see the service as serving a wider area than Glasgow.

I want to deal with the ways in which the Beatson action plan relates to the work of the expert advisory group. Where are you in relation to the drawing up of the strategic plan? What will that mean for the service?

Dr Bryson: I will pick up your first point. I have made plain my view—I believe that it is clearly held in the Beatson oncology centre—that the centre is the west of Scotland's cancer centre. We have made a feature of that logo in our advertising for staff. The centre happens to be located in north Glasgow. That is an accident of geography. We must ensure that the five health boards in the west of Scotland have a shared sense of ownership of the Beatson oncology centre. Ownership is accompanied by rights and obligations.

Margaret Jamieson: I think that the obligations will be met.

15:15

Dr Bryson: Absolutely. That is good to hear. We consider the centre a west of Scotland entity. One key group of recommendations in the expert advisory group's report said that we should examine critically how services were being delivered throughout the west of Scotland, with a view to reconstructing the way in which those services are delivered.

As has been said, the suggestion has been made that the services as they are configured have grown up in a haphazard fashion. I know for a fact that that is the case. We have the opportunity, which we are taking, to review all those arrangements as they apply to the entire population that is served, with a view to creating a new set of more sensible arrangements for the delivery of specialist oncology services throughout the west of Scotland.

We in the Beatson oncology centre recommended to the fledgling west of Scotland regional cancer advisory group that it should sponsor a piece of work on the principles on which such a revision of clinical services throughout the west of Scotland should be based. That work is coming to an end. That group's last meeting is tomorrow and the write-up of that work will be completed by the end of this month. From that should come a set of recommendations that will go initially to the west of Scotland regional cancer advisory group and from there to the west of Scotland NHS boards.

Recommendations will outline the principles that should underpin the reconfiguration of services throughout Scotland. They include matters such as local access, where that can be achieved without comprising the quality of care, equity of access and the quality of care.

Mary Scanlon: What progress has been made on the development of cancer-specific managed clinical networks?

Dr Bryson: A substantial amount of progress has been made, but it is patchy. For example, more progress has been made on gynaecological cancer than on many other networks, as has been said. It is a fair general statement that most networks are just coming into being and getting their act together now. They are in the process of appointing their lead clinicians. One or two of those lead clinicians are consultants in the Beatson oncology centre, but most are other cancer stakeholders, such as consultant gynaecologists and consultant surgical oncologists whose base is outwith the cancer centre.

Mary Scanlon: It is interesting that you say that, because in its report on ovarian cancer, the Clinical Standards Board for Scotland is not too happy about the progress that has been made, particularly with general practitioners. One of the board's standards is that

"patients are considered for chemotherapy by a multidisciplinary team"

and less than half—about a third—of hospitals complied with that standard.

Have you taken on board chapter 7 of the cancer plan, which is about the role of primary care in cancer management—which is likely to expand in the next decade—better information and communication technology and better working with other clinical professionals, such as physiotherapists, dieticians and occupational therapists, and GPs?

Dr Bryson: The Clinical Standards Board's report is valuable, but it is somewhat historical now. It looked at a snapshot of services throughout Scotland around a year ago, but things have changed a lot in the past year. In the west of Scotland in particular, arrangements for ovarian and other gynaecological cancers have moved on substantially from those that were identified over a year ago.

It is clear to the Beatson that, if managed clinical networks are to mean anything, they must mean that there is involvement by the disciplines and all the stakeholders who care for patients with cancer, including those in primary care and those from the disciplines to which you referred.

Mary Scanlon: What changes have occurred in the role and influence of patients as a result of the implementation of the cancer plan?

Dr Bryson: On managed clinical networks specifically, patient representation on those is a formal requirement. As those networks come into existence, they identify patient representatives to participate in their work. More generally in the Beatson oncology centre, we greatly value the views of individual patients and views that are presented in a more organised fashion. Perhaps there has been evidence of that this morning.

Mary Scanlon: Are you satisfied that

appropriate and adequate partnerships are formed with GPs?

Dr Bryson: Can I answer that question?

Mary Scanlon: It is taking you a while to think about it.

Dr Bryson: To pick up on a point that Professor Rampling made, to answer yes would smack of complacency. There is much more to do, but I emphasise that part of the difficulty is the pressure of work on staff at the Beatson. When one is fighting for one's life, one tends not to think too much about the opera. At the moment, survival is our primary objective. We must work with colleagues in other disciplines and other parts of the NHS, but because of the pressures that we are under it is sometimes difficult for us to be as involved in collaboration with others as ideally we might like to be.

Professor Rampling: Perhaps at a later developmental stage, with the central network organised and running, the GPs will be brought into that structure. I think that the gynaecological MCN is working quite well and is probably at a stage at which that is about to happen. The colorectal and head and neck MCNs are just beginning to get their acts together and to run along the same lines, but the gynaecological MCN has formed the prototype.

Mary Scanlon: There is a threat in the expert advisory group report that if the recruitment of at least 20 consultant oncologists is not achieved by September, the number of new patients that are accepted will be reduced and arrangements for excess patients to be treated elsewhere will be needed. That report was published in February 2002. Given the recruitment patterns that you mentioned, can we assume that that threat no longer exists to patients in the west of Scotland?

Dr Bryson: It would be premature to dismiss it. By September, I would like to think that we will be close enough to 20 consultants for us not just to say, "Well, okay, there are 19.5 or 19.8, but the number is below 20, so we must automatically look for solutions outwith the west of Scotland." We need to be sensible and grown up about the matter and assess a rapidly changing and developing situation as we approach September. The bald criterion that was used took no account of developments in, for example, clinical oncology, medical oncology or palliative care support.

Given that consultants will bear the brunt of the problem, I think that, as we approach September and find out what the likely staffing level will be, it will be important to ask the consultant body, "The situation is better than it was six months ago, but is it sufficiently better for us to dismiss the recommendation or at least to put it in abeyance?" We should not say right here and now that we can ignore the recommendation.

Mary Scanlon: So it is still a possibility that the number of new patients might be reduced and that excess numbers of patients might be treated elsewhere, even though we know that centres elsewhere have reached their capacity.

Dr Bryson: Yes, that is a fair point. The recommendation is contained in the expert advisory group report. Sitting here today, I am in no position to dismiss it. However, I hope that the threat will recede between now and September.

The Convener: We will move on to a new section of questions.

Dorothy-Grace Elder: I want to ask anyone who wishes to reply about the overall progress that has been made in reducing waiting times.

Professor Rampling: Waiting times for what?

Dorothy-Grace Elder: For first seen right through to outcome.

Professor Rampling: We have always said that we do not have waiting times for first referral. Once referred, any patient will be seen within the week at the next available clinic. We had reached that position at the time the consultants left and have maintained it ever since. As a result, it is not an issue. We have always tried to do that.

The waiting time for receiving radiotherapy has improved dramatically. As I said, we can get a patient on to radical radiotherapy treatment within three weeks if they do not need a computed tomography scan. However, because we are image-limited, the waiting time is longer if we need particular imaging.

Dorothy-Grace Elder: How much longer?

Professor Rampling: If a patient needs a CT scan, it can add another two weeks or so to the waiting time.

Dorothy-Grace Elder: So you agree with your colleagues that there is a serious problem with the shortage of space on CT and other scanners.

Professor Rampling: There has been a shift of emphasis from treatment delivery to imaging as the limiting step. It is a very important matter.

Dorothy-Grace Elder: How would you propose to cure that situation?

Professor Rampling: We need more scanners in Glasgow. I cannot comment on how efficiently scanners are used outwith the city; however, I know that the CT and magnetic resonance imaging scanners are used to capacity in the North Glasgow University Hospitals NHS Trust and the South Glasgow University Hospitals NHS Trust. We need additional scanning.

Although I believe that we are getting another MRI scanner at Gartnavel hospital, we have a problem south of the river and it would help if more imaging resources were allocated there. Because technical problems arise if a scan is required as an integral part of the planning process, we need a network or system which allows a scan to be carried out and contains the personnel to carry out such scanning. Those are the two solutions to the problem: we need at least a modest increase in scanning capability and the ability to produce planning scans.

Dorothy-Grace Elder: Could that ease the situation in a relatively short number of weeks or months?

Professor Rampling: It would take months, not weeks.

Dorothy-Grace Elder: I want to move on to the prescription situation. Have clinicians, nurses and professionals protested to some of you about the lack of health board funding for approved new drugs? For example, there has been controversy over the Beatson being among a number of institutes that have been denied funds to prescribe colorectal drugs that are used in the rest of Europe. Is that a real problem?

Professor Rampling: As that is not my area of expertise, it would be wrong of me to get into detailed technical argument about it. There is a big problem with the pressure to use very expensive drugs where our other sections of infrastructure are underfunded. If it came down to a question of where funds should be allocated, one would have to look carefully at ensuring the delivery of adequate, conventional, standard care. There is no doubt that such care improves outcome and survival rates. If that were optimised, it would probably make more of a difference in overall care than the marginal difference provided by new and very expensive drugs.

I cannot comment on the colorectal drugs because I do not know the body of evidence. However, I know that the NICE recommendations on the use of those drugs were fairly proscriptive. I am familiar with a similar situation with brain tumours, where recommendations were made that were reasonably sensible at the time but should now perhaps be revisited in the light of new evidence. The problem is that patients do not always get a full and clear view of that evidence when they make statements to the press and to their MPs. The evidence is not always as clear-cut.

Margaret Jamieson: I want to consider the services that are being planned for the Beatson when it finally moves to the Gartnavel site. What organisation is going on to ensure that patient groups and staff, in particular those below consultant level, are involved in that process?

15:30

Dr Bryson: The day after the announcement of the Treasury funding for phase 2 of the Beatson, we set in process the establishment of a project board to take a high-level overview of the arrangements for the new cancer centre. We also established about seven sub-board working groups, each of which in turn has several working groups that are considering particular aspects of the work of the new cancer centre. Our aspiration is that every member of staff as well as the patient groups will have an opportunity to participate in the planning of the new cancer centre. That does not mean that people will get everything that they might wish, as that would simply not be achievable.

The other positive thing to be said is that, as staff in the Beatson know, we have just recruited as our design advisers a company that is based in the UK but has strong transatlantic links. The company's American partners were responsible for designing the world's premier cancer centre, which is in Houston, Texas. We certainly intend to capitalise on that source of expertise as well as on the not-inconsiderable expertise that exists within the Beatson itself.

Margaret Jamieson: When the design of the service is being considered, surely the total patient journey must be taken into account. Will not each group of staff that is employed in the Beatson be able to bring something to the table on that issue? When the Beatson moves from its current site out to Gartnavel, I hope that the service will not simply be delivered in the same way but that the opportunity will be taken to give an extended role to the staff groups in particular. I also hope that those who already have the skills will be in a position to make use of them.

Dr Bryson: I absolutely agree. We must not simply assume that what happens in the Beatson just now should happen at Gartnavel. There is an opportunity to question everything that we do. Included within that is the possibility that some of what is done within the cancer centre could be relocated so that it is somewhat closer to where patients live.

Margaret Jamieson: What consultation do you have with universities regarding staff groups for which national shortages have been identified, such as in the professions allied to medicine? What are you doing in terms of work force planning to ensure that the disciplines that will be needed in the next five to 10 years will be delivered?

Dr Bryson: There are two things to be said. I will say something, then perhaps I will turn to someone from the Society of Radiographers.

We make representations about the discipline shortages about which we have heard so much today. Professor Rampling is involved in the medical side of that. At the end of the day, the decisions are made by others, but one hopes that, after hearing from people at the sharp end, they will make the right decisions about expanding training programmes for oncologists, radiographers, physicists, physics technicians and so on. Perhaps Helen McDermott will say something on the physics front.

Helen McDermott: The situation with physicists and technicians is not bad, but it is hard to get well-qualified technicians. The course that Glasgow Caledonian University ran has just finished; it is not training physics technicians any more, but Paisley University might start running the course instead. It is not a question of getting staff; it is a question of getting good staff who are able to contribute and do not need a lot of training.

Elizabeth Stow: The shortage of therapy radiographers is not just a Scottish problem. There is a UK shortage of therapy radiographers and the situation is critical south of the border. One of the problems that we are experiencing is that trusts in England are poaching many of the few therapy radiographers who graduate in Scotland by offering golden hellos. They are approaching our undergraduates, offering to pay off their student loans and to give them free accommodation and fast-track careers. We cannot blame new graduates for wanting to move somewhere more attractive than here, given a lot of the bad press that the Beatson has had.

There will be 10 graduates from Glasgow Caledonian University this year. Not all of them will stay in Scotland, because not all of them are Scottish or British students. One of the problems is that Scottish universities do not particularly care where their students come from. They just want to fill the places. Their priorities are different from the health service's priorities, but it would appear that the health department does not speak to the education department about work force planning for allied health professions.

The situation is different for medical staff and nursing staff for whom there is an element of strategic planning that does not exist for allied health professions. That is a serious issue for the Beatson, given the number of therapy radiographers that it requires. There are 130-odd therapy radiographers in Scotland. Almost 80 of them are in the Beatson, so it requires the lion's share of therapy radiographers in Scotland.

When you examine the initiatives and the strategies that are coming out of the health department and the strategic work force planning report, you should look carefully for the paragraph that deals with allied health professions. You will find that you are directed to the allied health professions strategy. When that is launched in a week or two, you will find that you are directed to the strategic work force planning report. No strategic work force planning is in operation for the allied health professions, especially therapy radiographers. It is left to individual centres to pressurise individual universities. That is not to say that the Beatson has not been in touch with Glasgow Caledonian University and it is not to say that Anna Gregor and her colleagues have not initiated work, but until now it has been woeful.

Margaret Jamieson: I apologise for using the old terminology, but I have been away from where you are for three years. I want to ask you about continuing professional development for allied health professionals. What is your organisation doing to encourage young people who are considering their options for university to come into your field?

Elizabeth Stow: The therapy radiographers take CPD seriously and they understand that they must take it seriously. Of course there is pressure on time and staffing. We can encourage radiographers to continue to update their skills, but unless there is adequate funding, there will always be a pressure on CPD. My organisation still encourages young people to enter the profession because we feel that we must. However, it is difficult. The profession is mainly female. Generally, the girls who come to do therapy radiography are very bright, as highers in maths and physics are required. It is not only clinical oncologists who have huge choices: there are huge choices for potential radiographers as well.

There is a public perception—again, the publicity has not helped—that no one would want to be a therapy radiographer now, given the bad publicity that the Beatson centre has received. We have to try to overcome that and encourage bright girls to enter the profession. We run a radiography awareness week every year and we have made a video, in collaboration with Channel 4, to encourage girls to enter radiography. We also encourage departments to link up with local secondary schools and invite potential students to visit them. However, because of the pressures on the Beatson centre, the staff do not have much time to show potential students around.

The Convener: A short supplementary question from Nicola Sturgeon and a final couple of questions from John McAllion will wrap up this section.

Nicola Sturgeon: I imagine that, because radiography is a predominantly female profession, many radiographers will take career breaks. Are any courses available to assist people who, having taken a career break, want to re-enter the profession?

Elizabeth Stow: Not in Scotland, as far as I know.

Margaret Spalding: There is a return-to-radiography programme down south and some of the universities are active in encouraging people to take that up. So far, there is nothing like that in Scotland.

Nicola Sturgeon: Would such a programme help?

Margaret Spalding: Yes, to some extent. However, the number of radiographers up here is very low. Down south, it is a completely different ball game because of the number of people involved. Up here, we have about 130 radiographers and it would probably not be viable for universities to set up courses. That would probably be too costly.

Dr Bryson: Ad hoc arrangements have been put in place for individuals who are seeking to return to the Beatson centre. However, those arrangements have been less structured than would have been ideal.

Margaret Spalding: They are department based.

Elizabeth Stow: My organisation should not be a voice in the wilderness in trying to encourage people into therapy radiography. If we received some support through a publicity drive, that would be hugely helpful.

The Convener: You have had a little bit of publicity today.

Mr McAllion: You said that your revenue budget is just over £15 million and the minister described all kinds of additional tranches of ring-fenced money that are being allocated to cancer services. Do you have enough resources to enable you to implement the cancer plan in the west of Scotland?

Dr Bryson: Yes.

Mr McAllion: So there is no problem with resources.

Dr Bryson: Not now. When we received the £2 million of additional funding and, subsequently, a further £300,000 to establish two additional medical oncology consultant posts and an additional consultant post in palliative care, together with their secretarial support, we secured the revenue funding that was required to run the service that we need to run. However, the work load in cancer services is increasing every year by approximately 5 per cent, if we count the heads coming through the door, and by between 10 and 15 per cent if we take into account the complexity of care that is now on offer. The fact that we have sufficient resources now—assuming that we can fill the vacant posts—will not prevent us from knocking on the Executive's door next year and in subsequent years, looking for more. That is what we will have to do if we are not to fall into the trap that the Beatson centre has fallen into over the past two or three years.

Mr McAllion: We talked to patient representatives this morning who were passionate about the unacceptable waiting times that people have to endure before they get access to a scanner and about the tremendous pressure on consultants. We were in a ward where the overcrowding was almost Victorian. I know that seven years down the line there will be a new Scottish cancer centre, but in the interim it appears that such unacceptable conditions will continue. Surely that is a resource matter. Something must be done now about the overcrowding in the wards and the lack of scanners.

Dr Bryson: I agree. We are doing as much as we can to alleviate the pressure on the wards, in the pharmacy—another heavily congested area—and in the out-patient department. We are in the process of implementing plans to reduce pressure in those areas. Perhaps I misinterpreted your question—I took it to refer to the additional funding, which was for salaries.

Mr McAllion: I was asking about the total.

15:45

Dr Bryson: On a staffing level, once we fill the posts for which we have funding, we will not have a staffing problem. Clearly there are other issues and space is one of the key areas for consideration. Space was not an element of the initial action plan, but when I came into the Beatson in December it became as plain as a pikestaff that the question of space needed to be addressed. We have already moved a medical records store out of the F block of the Beatson, which the committee visited this morning, into another part of the Western infirmary. We are moving day-case and out-patient chemotherapy from the Western infirmary to a 24-bed ward in Gartnavel that we have managed to acquire. Those are important steps, but they will not be enough.

Of the 55 to 60 additional staff that the £2.3 million that has been allocated will buy, many will work in wards and will not require office accommodation. However, 25 to 30 members of staff will require space in their own right. That is probably our biggest challenge in the short to medium term. In four to six years' time, it will not be a problem, because we will have access to a new cancer centre. I am determined that the steps that we are taking now will ensure that the new cancer centre has adequate accommodation to meet our space needs in 2006. However, for the

immediate future, we will continue to have to use the difficult ward and pharmacy environments, with whatever improvements we can introduce in the meantime.

Mr McAllion: I think that it was Professor Rampling who said that he wanted more imaging and scanners south of the river. If you could have three service developments for cancer services in the west of Scotland right now, what would they be?

Dr Bryson: Scanning would be one. There is a light at the end of that tunnel, because there will be a new MRI scanner at Gartnavel within three months. There will be a new CT scanner at the Glasgow royal infirmary, which will relieve pressure on the Western infirmary CT scanner. There is an investment programme within the North Glasgow University Hospitals NHS Trust for ultrasound imaging, too. That is one development.

At the top of my list—it is not a development—would be the opportunity to fill the vacant consultant posts. The third and most difficult development to achieve in the short term would be to identify additional satisfactory and suitable accommodation so that the additional staff whom we recruit are not working in the congested environment in which we are working at the moment.

The Convener: Thank you. We could carry on asking you questions, but we must bring this section of the meeting to a close. Thank you for your contribution to the committee's work and for showing us around the cramped wards. We saw not only the bad side of what is going on at the Beatson, but the good possibilities that the new Gartnavel site offers. Please pass on our best wishes to the rest of the staff and thank them for all their hard work.

Dr Bryson: I took the precaution of inviting a cancer nurse specialist to come to the committee. She has not had the opportunity to say anything yet, but I know that the committee was interested in finding out what a cancer nurse specialist is, so perhaps you will give us the opportunity to enlighten you.

The Convener: Of course. You thought that you had escaped.

Ms Stewart: As I have said, I have been in my post at the Beatson for 11 months and see my role as one of patient support and information sharing. We have managed to develop quite a few services in that short time. For example, the fact that our radiotherapy treatment reviews are now being carried out by a multidisciplinary team instead of wholly by medical staff has made a difference. Obviously, all nurses, especially clinical nurses, are trying to find out whether their own nurse-led clinics can support medical staff, which has also helped.

A major part of our role is patient information, either verbally through telephone support or through written communication. We are also looking at communication through managed clinical networks, with all the peripheral areas that they involve. Although the job is multifaceted, it is very exciting.

The Convener: Do you see the specialist nurse as the potential lynchpin of communication? Do such nurses act as a point of on-going contact for patients?

Ms Stewart: Absolutely. Because of the multifaceted nature of the patient's journey—from GP referral and the peripheral hospital appointment through to the intense period of treatment at the Beatson and follow-up care—the clinical nurse specialist has a pivotal role in providing back-up support, communication and information.

Dorothy-Grace Elder: Do you help cancer patients to come to terms with the pain that they might suffer?

Ms Stewart: I certainly deal with patients' pain control. However, if the situation cannot be dealt with simply, we refer the patient to our palliative care staff, who are experts in the field. Two palliative care nurses have also come on board, which will certainly expand that service.

Dorothy-Grace Elder: That is very much to be welcomed by the family as well as by the sufferer.

Ms Stewart: Yes.

Mary Scanlon: The expert advisory group report from February says:

"It is recommended that the BOC's role in the provision of educational programmes for nurses … be clarified and defined, and that an education strategy be developed and resourced to support this."

Are you satisfied that such a strategy is now in place and that an education programme for nurses has been "clarified and defined"?

Ms Stewart: I might be misinterpreting your question. I know that specialist nurses are running an education programme for other staff. Are you asking about education programmes for specialist nurses?

Mary Scanlon: One of the expert advisory group's recommendations was that an education programme should be "clarified and defined". I was wondering whether you were satisfied that any such programme was clearly defined.

Ms Stewart: An extensive education programme will be run by all the clinical nurse specialists in all cancer site-specific areas in the latter part of this year.

The Convener: I think that we have covered just about everything. I thank the witnesses for their attendance and their evidence. After a break for coffee, we will hear from witnesses from the Beatson Institute for Cancer Research.

15:54

Meeting suspended.

16:02

On resuming—

The Convener: Our next witness is Professor Harrison of the Beatson Institute for Cancer Research. Thank you for joining us this afternoon. We will ask you questions and, if you feel at the end of the questions that you would like to cover something else, feel free to catch my eye and intimate that to me.

Bill Butler: Have the difficulties that the Beatson has faced during this pressured period had any impact on the institute? If so, will you describe that impact?

Professor Paul Harrison (Beatson Institute for Cancer Research): In one sense, the Beatson means different things to different people. The Beatson laboratories are funded mainly by Cancer Research UK and are distinct from the Beatson oncology centre. The Beatson laboratories comprise the Beatson institute, where I work, and the University of Glasgow's departments of medical oncology and radiation oncology, which involve academic research staff and clinicians who work in the Beatson oncology centre. That is quite confusing.

Bill Butler: Have there been tensions and pressures in the component parts?

Professor Harrison: The bad publicity has an effect on everybody. The issue of attracting excellent clinical oncologists has been mentioned; that issue arose when a replacement for Professor Stan Kaye had to be found after he went to London.

Having a good research base and the possibility of funding options to do what we call translational work—finding how information from pure research into cancer can be translated into new diagnostics or new treatments—are important for many oncologists when considering their careers. The west of Scotland is an ideal place for such studies because of its large patient population. However, the publicity surrounding the Beatson oncology centre and the issues that arose because of that have detracted from those studies.

Bill Butler: What difficulties have you had with translational work?

Professor Harrison: Cancer Research UK has given a lot of support to basic research in the Beatson laboratories, but we need extra funding to translate that into positive initiatives for new therapies or new diagnostics. I know that you have been focusing on the urgent problems of the here and now, but it is short-sighted for the Government not to have a long-term strategy for cancer infrastructure. Such a strategy should acknowledge that using information on cancer for new therapies and new diagnostics is the way of improving clinical services in future.

Bill Butler: Have the pressures of the recent period made planning more difficult? Have those pressures led to the current situation?

Professor Harrison: For translational work, one has to have excellent scientists working in conjunction with excellent oncologists. It is a two-way process. For a good translational project to be clinically useful, interaction between the clinical oncologists, the medical oncologists and the scientists is necessary at all stages—from the original idea, to the preliminary work to test whether the idea may be useful, to getting it into the clinic for diagnostic testing.

Bill Butler: Has that necessary interaction been diminished because of the pressures on the clinical side?

Professor Harrison: It has been temporarily, at least, but what I heard earlier is very encouraging and will have a positive impact on the research community.

The Convener: Have there been positive changes in cancer research in Scotland since the implementation of the cancer plan?

Professor Harrison: As I understand it, most of the plan is directed at clinically oriented subjects, which is a disappointment to some of us. As I said, major funding is coming to our laboratories from Cancer Research UK. A new building is going up and Cancer Research UK and the University of Glasgow are putting in the best part of £10 million to more or less double the size of the Beatson institute for such research. That is very positive, although it has nothing to do with the cancer plan.

We would like the Government to come in with funding for initiatives that accelerate and enhance the possibilities of translating work into beneficial new diagnostics or treatments or even of understanding public health issues. For example, the evidence on smoking and the risk of cancer is unequivocal, but the relationship between socioeconomic status and the risk of cancer or the chances of surviving cancer is not well understood and requires more research. Again, collaboration between clinicians, oncologists, epidemiologists and scientists is required to understand that relationship.

Mary Scanlon: How are cancer trials being integrated into the work of cancer services in Scotland?

Professor Harrison: That is not really in my area, but a lot of work is being done in Scotland—in the Beatson oncology centre and at a clinical trials unit. There is a special funding body in the Cancer Research UK campaign portfolio for bringing new drugs to clinical trials. Glasgow is one of the major contributors to those trials. I think that I am right in saying that Glasgow contributes proportionately more people to the trials than do other centres in the UK. It is a major player in such work.

Mary Scanlon: Are you involved in the clinical trials?

Professor Harrison: I am not personally involved in them but people in the department of medical oncology in the Beatson laboratories are. Unfortunately, some of those people are attending important scientific meetings this week and are unable to attend this meeting.

Janis Hughes: I understood your answer to a previous question to mean that you thought that the cancer plan gave more emphasis to clinical care than to some other areas, such as prevention, detection and research. Is that your opinion? If so, what balance do you think the cancer plan should strike?

Professor Harrison: The need for strong basic research work was highlighted in the cancer plan as being important but much of the funding has gone into more clinically based projects. The Executive should take on board the fact that strong basic research work is valuable if we are to improve cancer services.

It is becoming increasingly clear that cancers are quite heterogeneous. If we can find a diagnostic method of distinguishing the various sub-types, which might have differing prognoses and require differing treatment regimes as they might respond differently to various drugs, we can improve cancer services. That is the sort of area in which funding, apart from funding from charities, could be applied.

Janis Hughes: Are you saying that funding with regard to clinical care is top-heavy because that is where improvements can be seen most easily?

Professor Harrison: Yes, and that is inevitable in a way. However, it would be wise not to take a short-sighted view. As part of the cancer plan, there should be a long-term strategy for delivering new services and new diagnostic methods and targeting the drugs and the treatments to individual tumour types as they become better understood. That might develop better outcomes for patients in the long term. Such long-term strategic planning should be taken seriously at this stage. However, I accept that there are other urgent issues that have to be dealt with as well.

Dorothy-Grace Elder: This morning, we were told that the Beatson has 70 open clinical trials, which makes it perhaps the biggest clinical trials unit in the UK. Have you seen any improvements at the institute since action was taken at the Beatson?

Professor Harrison: I can say only what I have said before. Everybody gets tarred with the same brush and the concerns about the Beatson oncology centre rub off on us. There was a backlash, but now the situation is improving again.

It is important to stress the positive developments on the research side. A new building is going up, the Beatson institute has a new director and there is an almost twofold increase in research capacity. Such developments are part and parcel of delivering long-term improvements in cancer treatment and should be seen collectively. The research work is a positive thing for Glasgow but does not get the positive press that it deserves.

Dorothy-Grace Elder: Would it be appropriate—as others have told us it would—to have special incentives to recruit people from some specialities to work at the Beatson?

Professor Harrison: Yes. It is well known that it is difficult to attract young post-doctoral scientists who can do cancer research.

Dorothy-Grace Elder: We have heard of golden hellos being offered to radiographers in other parts of Britain. In principle, would you approve of that, in view of the circumstances?

Professor Harrison: Apart from that, I would like extra resources to be made available for research projects that test whether basic findings may be of practical significance. That is a priority.

The Convener: So, if you could choose which development to fund to improve cancer research, that is what you would ask for.

Professor Harrison: That would complement the tremendous amount of investment from the charitable side—in our case from Cancer Research UK. About £8 million of research money is spent in the Beatson laboratories, about £6 million of which comes from Cancer Research UK. Extra funding from the Government to complement other funding for research in that specific area—which, arguably, has most relevance from a Government perspective—would be very useful.

Dorothy-Grace Elder: You talked about a backlash. Can you instance any losses that you have had?

Professor Harrison: The whole business did

not help at all in terms of medical oncology appointments and academic appointments.

The Convener: The bad publicity has not been good for you, but you have not lost any staff or failed to recruit people because of it.

16:15

Professor Harrison: Well, Professor Kaye left and went to London. Only he can say exactly what the reasons for that were.

The Convener: I am conscious of the time. We will have to pull a few things together. I thank Professor Harrison for his evidence.

Our next witnesses are from Ayrshire and Arran cancer planning group. I advise our witnesses from the west of Scotland regional cancer advisory group and the Scottish Cancer Group that I would like them to come to the table as a single group for the final part of the meeting, as we are a bit tight for time.

I thank the witnesses for coming. Colleagues will ask questions and if you feel that anything has not been covered, feel free to add your comments. So far today, we have heard about what happens on the acute side in a specialist centre. We have repeatedly heard that it is a west of Scotland service, not just a Glasgow service. Therefore, we are interested to hear how Ayrshire and Arran Acute Hospitals NHS Trust fits into the regional network and how you work alongside your colleagues at the Beatson centre, as well as about cancer service delivery generally in your part of Scotland. The first question will be asked by someone whom you will know very well—one of your local MSPs, Margaret Jamieson.

Margaret Jamieson: Obviously I am aware of the services that are available in Ayrshire and Arran, but patients in Ayrshire and Arran also require treatments from the Beatson oncology centre. What effect has that had on the provision of cancer services for patients in Ayrshire and Arran?

Mr Brian Sugden (Ayrshire and Arran Acute Hospitals NHS Trust): I am a clinician in north Ayrshire. By and large, the problems in the Beatson over the past six months have not impacted a great deal on us as clinicians. There has been a bit of reorganisation of clinic-type work, as the clinicians in north Ayrshire have had to do more follow-up clinics to free up time so that oncology colleagues can see our new patients. We have got through that period without there being a major impact on the extent to which the oncologists can see our patients. We have had to do a bit more work in administration and organisation, but I do not think that patients have suffered.

We have always had a good day-to-day working relationship with the Beatson oncologists and they have seen new patients. Oncologists spend one day in Crosshouse hospital in Kilmarnock and one day in Ayr hospital. During those days, they attend meetings and have clinical and pathological conferences with us on colorectal cancer and breast cancer. I am not involved in gynaecological or lung cancer, but I am sure that there are similar meetings with specialists. There is a constant to and fro: patients are discussed, passed on and referred for oncological treatment when required.

Margaret Jamieson: Will Mr Greep tell us how the situation of which Mr Sugden has advised us has impacted on the waiting list for those individuals who have yet to be diagnosed with cancer or another illness?

Stephen Greep (Ayrshire and Arran Cancer Planning Group): Let me follow on from what Mr Sugden said. We welcome the impact that Dr Bryson has had. He has spent quite a bit of time in Ayrshire explaining at first hand the situation at the Beatson oncology centre. Managers and clinicians have welcomed the leadership that he has provided, which has enabled us to plan locally to ensure that any difficulties at the Beatson have impacted to a minimal extent. I should also pay tribute to our own clinicians, who have managed to ensure that the impact on patients has been minimal. It is fair to say that I am not aware of any issues with waiting times in the short term that have arisen from the problems at the Beatson.

Margaret Jamieson: I want to address another part of the same question to Dr McCallum. How has that situation impacted on general practitioners' access to first appointments for patients whom they suspect as having cancer?

Dr Huntly McCallum (Ayrshire and Arran Cancer Planning Group): The Ayrshire service's referral patterns are really divorced from the Beatson, but I have noticed an impact on patients going there, apart from patients who have been given priority access. However, the appointments that I seek for my own patients are generally with clinicians from Ayrshire and Arran Acute Hospitals NHS Trust. There are areas of the service in which one would want more rapid access than we have at present—there is no question about that—but, overall, the access is fairly reasonable for a number of services.

Margaret Jamieson: I want to move on and ask another question. What improvements have been available to Ayrshire and Arran patients since the action plan for the Beatson was drawn up?

Stephen Greep: I will kick off. The biggest benefit in recent months is the additional resources that have been put in place for cancer services. The ring fencing of that money, the

benefits of which were referred to earlier, has enabled us to focus on our priorities in local planning for cancer services as well as in regional and national planning. That has been a significant benefit for us.

Members will have seen our written evidence, which describes how our whole approach to the delivery of cancer services is multidisciplinary and multi-agency. All our groups involve all the agencies, including the Beatson oncology centre. Dr Bryson himself sits on our steering group.

Improvements have been and continue to be made not only in primary care but in specialist nursing. Breast cancer has been at the top of our priority list for the recent moneys. We have been able to invest significant amounts of money in the development of breast cancer services. Members of the committee may know that, over the past nine months, breast cancer services have been the focus of one of our redesign projects. That project is now just about complete. Once the final service has been agreed, it will have benefits for the rest of Scotland.

Margaret Jamieson: Given that Mr Sugden and his colleagues are now dealing with referrals, has he seen any improvement in his professional development?

Mr Sugden: The extra resources that have been made available have had an impact on diagnostic tests. Waiting times in radiology for barium-type X-rays are down on the figures from a year ago, when we were involved in a great deal of activity in relation to the waiting list initiative to keep waiting lists down. Endoscopy waiting times have also come down, although they are not yet entirely acceptable.

Over the past 12 to 18 months, clinical networks have come on board. I am involved in the colorectal cancer clinical network, the creation of which has led to an improvement in the way in which patients are managed. The case of every new patient is now discussed at a multidisciplinary meeting. The network involves all the surgeons in Ayrshire, oncologists, oncology nurse specialists, endoscopy nurse specialists, pathologists and radiologists. There is also joint discussion of each patient's management plan. In the case of many patients, drawing up a management plan is fairly straightforward, but in the case of problem patients it is helpful to get input from colleagues. Although clinical networks are not related specifically to the problems at the Beatson, their establishment has had major benefits.

Through the networks and Clinical Standards Board for Scotland reviews, we are beginning to receive feedback on how well we are following guidelines and caring for patients. These are early days, but we will receive more feedback in the future. This afternoon, I should have been at a meeting that is considering Clinical Standards Board guidelines for the treatment of colorectal cancer. The aim is to assess how we are performing and to examine what we can do to fill the gaps. The benefits of that work should be apparent in the next 12 months.

Margaret Jamieson: As an Ayrshire MSP, I consider very closely the reports that are submitted to trust management team meetings. Those reports indicate the extent to which you are meeting Clinical Standards Board targets. I am happy to note that you have nearly met your targets and I commend you on that.

The Convener: Will witnesses describe their experience of working with the west of Scotland regional cancer advisory group on the planning of services for the area? What are the strong points of the relationship? What difficulties have been encountered? The minister talked about the new funding arrangements, which involve asking people on the ground what services they want. Have the witnesses been involved in that process?

Stephen Greep: The big benefit of the new arrangements is that they allow people from other areas to comment on our plans. Sometimes it is easy to become too involved in one's own work. When setting priorities, we have benefited from hearing the views of clinicians from outside Ayrshire and Arran. The fact that Ayrshire and Arran now has the opportunity to contribute to planning on a regional basis is a big plus.

Last year we welcomed the publication of the national cancer plan, because that provided us with a framework within which to plan our work. Because we have a local steering group, a west of Scotland steering group and a national steering group, some of the people on the ground feel that ultimate decision making is too far removed from the patient. My intention is not to criticise the work that is being done, but to give the clinicians' view. The existence of three steering groups sometimes extends the time scales for agreement of funding.

The Convener: Is that the view of clinicians at the primary care level, the acute level or at both levels?

Stephen Greep: I speak as chair of the steering group and as a chief executive. Perhaps a clinician would like to comment on that.

Dr Carol Davidson (Ayrshire and Arran Cancer Planning Group): I am a director of public health. We have seen a definite change in respect of ownership, which was mentioned earlier, and the Beatson's being a sort of Glasgow service. All NHS boards now have ownership—the service is our service and a service for our patients. There has been a change of mind in that respect.

Nicola Sturgeon: We have been interested in the balance between prevention, detection and treatment of cancer in the cancer plan. Is the balance right in the plan and in your delivery mechanisms?

16:30

Dr Davidson: Recently, we looked at all the recommendations in the cancer plan and mapped out where we are locally against those recommendations. We are still doing that, so I am not sure whether I have an answer to what we think about the balance. We must ensure that we concentrate on the prevention, lifestyle and life circumstance aspects of cancer. Only by doing that will we prevent people from getting cancer in the first place. There is a local cancer prevention strategy and we are working towards implementing it. We also have a strategy for reducing smoking.

As I said, we are mapping out where we are and we hope to finalise a report shortly for our local steering group to see exactly where we are. We can provide evidence to the committee later, if that is acceptable.

Dorothy-Grace Elder: What other changes or developments would help to improve cancer services in the west of Scotland?

Stephen Greep: That is probably a question for us all. The major issue is that the Beatson oncology centre should be secure and have a bright future, as it provides us with regional support. That is important for us locally.

I have answered from my perspective, but perhaps my colleagues would also like to answer the question.

Mr Sugden: I support that. I was also encouraged by what Adam Bryson said about looking at how the Beatson functions in other areas in the west of Scotland. We can provide much locally—we already do. We have been quite advanced in Crosshouse in respect of surgical oncology units since the 1980s. We must seriously consider what else can be provided locally to ease some of the burden in Glasgow. We cannot provide everything, but we can provide a lot.

We also need resources. I do not simply mean equipment and staff—buildings are also required. Our hospital buildings are not coping. Staff, X-ray departments and endoscopy departments are at full stretch, yet the work is increasing year after year. If endoscopic screening for bowel cancer is introduced in the next year or two, it is difficult to imagine how we will be able to provide it. There is a resource problem, not just in respect of people, instruments and money for drugs, but in the building structures. That worries me.

Dorothy-Grace Elder: You said that a lot can be provided locally to ease the burden in Glasgow. Several people have said that the shortage of scanners is a major problem in Glasgow. Do you have any spare capacity that could be better used to ease that burden?

Mr Sugden: I do not think that there is any spare capacity. We have a CT scanner and an MR scanner. We can get appointments for cancer cases, but one must go out of one's way to make an arrangement with the staff. The staff are working non-stop during the working day and are under extreme pressure. If anything, we need another scanner, because the MR scanner that we have is becoming obsolete, and we need a new one. Time moves on.

I do not think that there would be any spare capacity to help out Glasgow. One might argue that some of the delays on the radiotherapy side are to do with planning scans. Some of our patients have had scans in Ayrshire and if those are suitable for use in Glasgow, there is no reason why they cannot be used, but apart from that type of help, we need more scanning ourselves. It is a problem all over.

Dr McCallum: The thought of lots of patients moving around from one health board area to another strikes me as being an absolute nightmare. As a primary care clinician, if I end up with patients seeking to go to Edinburgh, Tayside or wherever to access investigations, I think that it will make my work load extremely difficult. We have undertaken one or two local initiatives on ultrasound scanning and have managed to provide a rapid access service for primary care clinicians. If that service was suddenly swamped by other areas that do not have such a tight access procedure to ultrasound, that would negate any developments that we have undertaken.

I would approach from a slightly different angle the issue of regional cancer services and what would help patients and the service. The patient's priority when they have a tumour is to move as rapidly as possible along the diagnostic pathway. They want us to diagnose and identify the tumour and set out a treatment plan as quickly as possible. They want to move quickly from first presentation in the surgery to the next stage. That is what alleviates patients' anxieties. It is extremely difficult if they are left hanging around for a long time and the process is slow.

We need to have fast access for patients through primary care. That has a resource implication for our buildings, our staffing and all the rest of it. It also relates to the amount of time that is spent with GPs. It should be remembered that cancer can be a difficult illness to diagnose. It can be an insidious illness and it sometimes takes time for it to dawn on one that the patient's

problem is cancer. Time with patients is needed, as well as rapid access.

Dorothy-Grace Elder: Do you have a prescribing problem in relation to anti-cancer drugs? You mentioned your interest in colorectal matters, Mr Sugden. Do you have a problem, in that you are unable to get funding for the new drugs that are available in that field?

Mr Sugden: I do not think that that debate has hit Ayrshire yet.

Dorothy-Grace Elder: It has hit Scotland.

Mr Sugden: It is more of an oncological problem than a problem for us as general surgeons. There are not only problems with cancer drugs; there are expensive drugs in non-cancer specialties about which the debate on what should get funding priority comes up at the health board every year. That is a problem.

Dorothy-Grace Elder: What about the comparisons with the five-year survival rate in Europe?

Mr Sugden: I am not sure that drugs will be the answer to that. The prevention of cancer and early diagnosis are equally important.

The Convener: Could you give us more information on prevention, because your paper touched on a lot of work that you are doing on the cancer prevention strategy, and on what you are doing with money from the New Opportunities Fund and the health improvement fund? Prevention is an important part of the plan.

Dr Davidson: We have an overarching health promotion strategy in Ayrshire, but specifically we have a cancer prevention strategy that has been developed with professionals as well as the public through various consultation exercises. We also have a strategy to reduce smoking, which is specific and addresses the introduction of lots of smoking cessation support in the area. We work very much in partnership with our local authorities and voluntary groups, as well as the public, to develop strategies and produce implementation plans for them.

With regard to the messages that we have to try to get over, and the information that we want to be able to give to patients, we are fortunate in that many of the messages about different cancers are the same as those about having a healthy lifestyle.

As a result, we have identified several preventive areas such as healthy eating, sexual health and sun awareness. With money from the health improvement fund and the New Opportunities Fund, we have set up projects on a partnership basis. Indeed, our local authority partners have been delighted that we have been able to use health improvement funds to set up breakfast clubs and to work with new community schools on these issues. We are very fortunate, because lifestyle matters involve other areas, such as coronary heart disease and cancer prevention.

The Convener: That is all very encouraging. I think that Margaret Jamieson would certainly be a candidate for your smoking cessation programme.

Shona Robison: I have a fairly general question. Do you feel that you have the resources to implement the cancer plan in your area?

Stephen Greep: There are two answers to that question. As I have said, the extra ring-fenced resources have been a huge benefit. I want to pick up Dr Bryson's comment that we are talking not just about resources but about the ability to recruit in certain areas. In Ayrshire, we have been quite fortunate in that we have always managed to recruit good members of staff. However, the national staff shortage in some areas will have an impact on us. For example, there is a national shortage of radiologists in the acute sector, and one of our priorities for the tranche of funding that the minister recently announced is to recruit radiologists for cancer work. However, because the funding has just been announced, we have only just advertised the positions. As I said, this is a national shortage that does not affect just Ayrshire and Arran. The shortage of consultants and radiographers could have a big impact on service delivery.

The significant sums of additional money that have been made available over the past year or so have had a huge impact on the way in which we deliver cancer services locally in the acute sector and in primary and palliative care. However, although we could always use more resources, recruitment is one of the biggest issues for us.

The Convener: Sorry. I have to make a quick getaway for a moment.

The Deputy Convener (Margaret Jamieson): I will carry on the questioning. What is being done to link up Macmillan nurses, primary care nursing staff and nursing staff in hospices with oncology nurses, particularly at Crosshouse hospital?

Roseanne McDonald (Ayrshire and Arran Cancer Planning Group): I am the lead nurse for the acute trust and Janie Neilly is a cancer nursing adviser in primary care. We are fortunate in Ayrshire in that primary and acute care senior nurses regularly meet the lead nurse from the Ayrshire Hospice and the voluntary sector nurse to plan support services for patients throughout the health board area. At the moment, we are examining how we can skill primary care nurses to look after patients when they are first diagnosed. Such patients might not have access to a nurse specialist and we want them to be able to access some nursing support right at the point of

diagnosis. As a result, we have established a working group involving district nurses, health visitors and four key people to develop matters. Although things are still in their early stages, we are very active and a lot of good work is going on.

The Deputy Convener: Does that work link into voluntary groups?

Roseanne McDonald: Yes. Irene Wilson, who is the nurse co-ordinator for the voluntary sector, has close links with us. For example, she is very involved with one of the NOF projects that support breast cancer patients at the point of diagnosis and after treatment. Although she works for Ayrshire Cancer Support, she links in with all the voluntary groups in Ayrshire. Indeed, she does very good work in that respect.

The Deputy Convener: Is there anything else that you want to tell us, Mr Greep?

Stephen Greep: I was just wondering whether Roseanne McDonald could say something about our work with patients.

Roseanne McDonald: We have a working group for patient and public involvement, which reports to the cancer steering group. The working group is newly convened and its members represent acute primary care, the voluntary sector and the health board. We have met several times and we are considering several projects for involving patients more. We are considering an NOF bid for a project that would support patients better through the cancer pathway. That is in its early stages.

Dr Davidson: A couple of years ago, we held two successful stakeholder conferences, which were well received. One was more for professionals in cancer services and one was for patients and the public. Much of our information about how we would like to develop our services came from those stakeholder conferences and from the patients and the public.

16:45

The Deputy Convener: Thank you very much.

Our next witnesses are Dr Harry Burns and Dr Charles Clark from the west of Scotland regional cancer advisory group and, from the Scottish Cancer Group, Dr Anna Gregor, who is its lead clinician and chair, and Liz Porterfield, who is its cancer services co-ordinator. The convener is back.

The Convener: I thank the witnesses for coming. I hope that you do not mind doubling up, but we are rapidly running out of time in what has been an interesting and packed day. The regional cancer advisory group's six-monthly monitoring report was published today, so we have not had a chance to read it. Will you summarise how well the cancer advisory group thinks that things have gone?

Dr Harry Burns (West of Scotland Regional Cancer Advisory Group): We have made much progress. In the past couple of years, the west of Scotland has struggled a bit, largely because of some of the problems that the committee has heard about. The Beatson has been a huge issue. Since we started to organise matters regionally and achieved a sense of common ownership of the Beatson as a common asset for cancer care in the west of Scotland, the relationships between health boards have been productive.

The way in which the regional cancer advisory group has got together and started to tackle problems has been encouraging for most of us. The new investment is starting to make possible some of the developments that most folk recognise have been badly needed. It will be another six months before we can say whether patients will feel benefits, because there have been difficulties with filling posts and with other matters that the committee has heard about. However, there is optimism in the west of Scotland that we are turning a corner.

The Convener: I will ask a basic question. Fundamentally, what stopped people in the west of Scotland from doing that before? Did you not talk to one another?

Dr Burns: We talked to one another and occasionally shouted at one another, too. Much of the problem relates to the way in which the health service was organised in the past decade. Trusts have had close control over what goes on in trusts and operational change has been difficult to influence.

When trust chief executives say that they want to sort out a problem their way, it is difficult for health boards to have influence. Health boards are supposed to be strategic and to generate ideas and trusts are supposed to get involved in the nitty-gritty of managing services. It has been difficult to influence that situation.

Different health boards have different aims and ambitions. Only with the creation of regional cancer advisory groups have we had a formal arrangement with the blessing of the Scottish Executive and its support in advancing regional planning. We laboured with some of the structures that have not lent themselves to planning on a regional basis until now. That is why the cancer plan and the ring-fenced money have made all the difference. I do not underestimate the importance of the ring-fenced money in making collaborative working successful. Generally, the Scottish health service does not provide ring-fenced money. The health service tends to distribute money to health

boards and it is up to the boards to deal with local priorities. It has been clear to us for some time that unless money was ring-fenced for cancer treatment, some of the expected radical changes would not happen.

The Convener: Dr Gregor, my question might be unfair because you are sitting next to representatives of the regional cancer advisory groups, but do you feel the groups are functioning well now? What improvements can still be made?

Dr Gregor: We are 10 months into a three-year implementation programme so it is early days yet. I echo everything that Dr Burns said. The whole process that we are using to implement cancer treatment in Scotland has encouraged changing behaviours and habits.

The ring fencing of the money is fundamental. So too is the ability to encourage regional collaboration with a major clinical buy-in and to link that clinical buy-in to visible regional action. That has had a positive effect on the morale of all sorts of partners, and on their ability and willingness to contribute to the debate. We must ensure that the monitoring is accountable, public and visible. I encourage members to take an interest in what is happening in their local areas because the situation is fragile. This is the first time that a health service anywhere in the United Kingdom and certainly in Scotland, has undertaken such a programme. We must not underestimate the difficulties it causes in certain well-established quarters because it limits options, so please help us to monitor the programme and ensure that it gets built into the infrastructure.

Mary Scanlon: Could you outline the main difficulties that you have experienced in working towards managed clinical networks in planning services throughout the region? Could you update us on the position on managed clinical networks? According to the cancer plan, networks should be in place for all cancers by the end of 2002. Will that be achieved?

Dr Charles Clark (West of Scotland Regional Cancer Advisory Group): I will start because I am more optimistic about the role of the managed clinical networks in the west of Scotland than were some of my colleagues from the Beatson earlier.

Members of the managed clinical network for colorectal cancer have been working together for about 18 months. The network draws together specialist surgeons who are involved with colorectal cancer from throughout the west of Scotland. Over the past year, they have pooled data on all the patients whom they have seen this year and have prepared exactly the sort of information that the Clinical Standards Board for Scotland was seeking last year but was unable to get hold of. That means that, as a result of the work of the managed clinical networks, the comparative data across hospitals that the Clinical Standards Board wants are available.

Mary Scanlon: Do you feel that there is now a better relationship with GPs and that the relationship is now integrated in a way that will allow cancers to be treated at an earlier date? Does the network help to train, support and include GPs?

Dr Clark: Yes, very much so. We have an active general practitioners sub-group as part of the managed clinical network. We also have a patient information group and a clinical specialist group. Along with the rest of the network, the general practitioners sub-group is considering what the appropriate referral criteria should be to ensure that referrals from GPs to specialists are more sensitive and more specific and use clinical resources to their best.

Dr Burns: I want to make a point about the difficulties of managed clinical networks. It fell to me to do the legwork across Scotland to set the network up. I must have visited every hospital in Scotland about three times. I felt like Billy Connolly as I embarked on my third tour of Scotland.

Members should not underestimate how radical the managed clinical network idea is. The reason why it took longer to set up is that it threatens fundamentally management control of the system. It was obvious to many of us that clinical input into decision making was not as good as it should be in the health service generally. When we set up the network, managers expressed concern that their clinicians, for whom they were responsible, would have to work in a network with clinicians across the country. The fact that they were responsible for the spend in relation to those clinicians concerned them. Management effort in the health service is too often focused on the control and containment of spend. That is entirely appropriate, however, as the one thing that managers can get sacked for is running a trust that overspends.

Establishing the proper balance between clinical input and management control of resource is at the heart of the managed clinical network. It is radical and quite subversive to the present way of thinking within NHS management in general. It is important that it is allowed to mature. Destabilisation of the arrangement will lose huge benefits. I believe that, five years from now, the arrangement will give us a system that will be the envy of the world. However, we have to let the clinicians, oncologists, surgeons, GPs, nurses, pharmacists and the patients get together with the managers to develop the system. The delays came initially because managers could make neither head nor tail of the arrangements. However, we have now overcome that. We have

good managers in Scotland; it is just that the idea of the network runs counter to their nature. We need to let the process mature and develop.

Dr Gregor: I second that. There are various speeds and levels of development in different parts of the country. The process will take time and will involve the development of new and fundamentally different relationships. I will give two brief examples of the way in which the situation is moving forward.

The second Scottish managed clinical network conference was held two or three weeks ago. The atmosphere was palpably different to that at the first conference as people had experience of the system working.

Members have been given a good practical example from Ayrshire and Arran of how the system operates. It is more difficult for services to restructure themselves if they are in stressful situations such as that which the Beatson currently faces. If for a long time people have worked co-operatively in a small environment and suddenly their horizons are widened, it is difficult for them to adjust. If they are merely surviving, it is difficult for them to take a longer strategic view. There are many reasons for the failure of the west of Scotland to get off the starting blocks in the first wave. However, the region is catching up very quickly.

17:00

Dorothy-Grace Elder: Are the clinical networks being told that staff must be free to point out problems and that they will be listened to? It took the resignation of four consultants to expose the problems at the Beatson, which had existed for years. From now on, will you encourage and protect whistleblowers?

Dr Burns: Whistleblowing should not be necessary. All staff need to be involved all the time in shaping and developing services. That can be done only through clinical networks. If we have a hierarchy presided over by a manager whose task is to make the books balance at the end of the year, it is far less likely that concerns will be raised and discussed.

Earlier, Stephen Greep talked about local health board cancer groups, regional cancer groups and national cancer groups. One of the big advantages of such a system is that it involves a large number of people who meet round a table to discuss issues. When we first set up the Scottish Cancer Group, the concern at the back of everyone's mind was to identify rogue clinicians—those who were practising oddly. We quickly discovered that, although folk do things differently, there are no rogue clinicians to be identified. The way in which to bring everyone up to the level of the best practitioners is to ensure that people talk and share views on what they are doing. Clinical networks make that possible.

Networks are not being set up to control services, but to develop, encourage and improve them. I share Anna Gregor's optimism about the direction in which we are headed.

The Convener: I have a question about work force planning issues, which have peppered our day both at the Beatson and at this afternoon's meeting. We have talked about the professions allied to medicine and about clinical oncologists. Fairly recently, at a conference held at the Edinburgh International Conference Centre by the cross-party group in the Scottish Parliament on cancer, Dr Gregor said that, even if she were given the money that she had requested, a lack of staff would prevent her from doing many of the things that she wanted to do. If the money, the hardware and the infrastructure are available but we do not have the necessary staff, we cannot deliver the service. What are your thoughts on that issue?

Dr Gregor: I would like to share some thoughts with the committee; I am sure that Harry Burns will chip in.

The cancer service is the first service in the investment block for the NHS. The committee has already heard about the cancer-specific staff shortages that exist, such as the shortage of clinical oncologists. We are testing the results of the centralised planning economy of the NHS, which has left us with serious manpower problems. The shortages are not limited to cancer services, but affect radiology, pathology, surgery and nursing. Under the planned expansion of staff numbers in the UK, by 2004 staffing levels will still be well below two thirds of the 1997 European Union average.

It is quite clear to all of us who have spent some time thinking about it that the old models of health care delivery will not work. Given the fact that we are putting in substantial investments, that presents a huge challenge. We are not alone in saying that. The Temple review will say pretty much the same thing and the Wanless report and the reviews in England and Wales are critically addressing that issue. However, no one knows exactly how to do that.

Cancer services have at least one great advantage: they are looking to the multidisciplinary provision of care for a population of patients. The networks will allow us to identify the individual contributions of the various members of the team. We will be able to identify the role of the GP, the role of the specialist nurse, what the surgeon does and where the oncologist comes in. The biggest challenge for us will be to use those resources in

an optimal way such that we can make them stretch further.

The learning curve will be huge. The continuity of care and the emotional dependence of clinicians on their patients and patients on their clinicians may be tested in that, but the challenge will be to provide a service in which the quality of care is maintained and enhanced. We need to provide services that are run in a seamless fashion so that patients do not fall through the cracks during handover. Given Scotland's size and relatively protected manpower structure, we have a huge opportunity to raise our game and create the best health service in the world—despite the constraints. However, we are not alone in this.

Margaret Jamieson: Is there not a crying need for total service redesign? Do we not need to look at the whole service from the first point of contact through to cure?

Dr Gregor: Absolutely.

Margaret Jamieson: We need to do that not only for cancer services but for everything. For example, we have nurses who are qualified to a higher level but, because they are not allowed to practise to that level, they cannot keep up their skills. If those nurses were allowed to practise at the right level, that would release others to move on.

The Convener: Shona Robison has a supplementary on that point, which perhaps Harry Burns will be able to answer.

Shona Robison: My question fits in at this point anyway. How do we ensure consistency and equity across Scotland in the delivery of cancer services? Perhaps that is what Dr Gregor is getting at in what she said about what Scotland's future cancer provision will look like. Earlier, in the first part of the meeting, Dr Gregor replied to a question about rezoning by saying that a review of cancer services should look at what is required strategically rather than simply be a reaction to a resource problem. What picture does Dr Gregor have in her head of how cancer services will be delivered in 10 years' time? She has said what requires to be done, but what will the service look like?

Dr Gregor: Patients will be cared for by networks of professionals. Patients' allegiance will move from a hospital to a service. Primary care will be the entrance and supporting mechanism for the patients to provide continuity in their journey of care. Equity does not necessarily mean that everybody should get the same thing, but that nobody should be disadvantaged by their distance from a specialist service, or by their gender, age and so on. People should get the best quality of clinical care that is required. We will achieve that only if we are prepared to travel for some parts of the service, but that will be as a component of the overall journey of care for the patient, supported by the accommodation and the resources that are needed to support the travel.

The guarantee of quality is the open, shared process of evidence-based protocols of care and the audit of the activity that is going on, which will measure both the process and the outcome of the service delivery for each of those components. Increasingly, we will move away from breast cancer services in hospital X to breast cancer services in the west of Scotland. Parts of the service will be provided in hospital X, parts will be provided in the GP surgery and parts will be provided at home, with an outreach service involving a nurse, depending on what is needed.

Dr Burns: The critical difference in 10 years' time will be the way in which the service is managed. That will be radically different. At the moment, the patient bounces between boxes—the general practice, the district general hospital, the regional cancer centre and perhaps a social work department. The patient sees that journey as a set of movements in which we manage only the boxes that they bounce into. We manage only the cancer centre or whatever. Nobody is managing the patient's movement among those boxes.

In 10 years' time—potentially a lot sooner—instead of a trust manager there might be a lung cancer manager. As soon as the patient presents to a GP with a sinister symptom, the lung cancer manager, who looks after the 500 lung cancer patients in the west of Scotland, will take over. If he spots that Mrs Jones has waited three weeks for a bronchoscopy, which is not good enough, he will pick up the phone. If no slot is available at one hospital, he will arrange for the treatment at another hospital. If he spots that a GP has not received a letter back within 24 hours, which is unacceptable, he will get that letter. The cancer manager will manage the patient through the process and become a sort of guardian angel to the patient.

It seems to me that we do not manage health care in this country; we manage boxes and institutions. The information technology and the systems of working are coming together. That is what I mean by saying that managed clinical networks have a radical underlying possibility. I urge people not to come up with a radical disturbance of that type of network, as it is evolving. Between them, the clinicians and the patients will make that happen. It is very exciting and other countries are watching closely what we are doing.

The Convener: How important is it for us to be able to get access to the best possible data and to audit what we are doing properly?

Dr Gregor: It is essential. I shall expand a little on what Harry Burns has said about IT. As well as having a process manager, we need to empower the patients to know exactly what to expect and demand from the service. The only sensible way in which to do that is by allowing them access to locally relevant information in real time. Although not everybody would be able to print the details from the internet, their district nurse might be able to do that. Their GP certainly would. We must provide a real-time pathway of care.

People can go to travel agents and, in 10 minutes flat, find a schedule to get to New Zealand, if they have the greenies. Why can people not find a pathway through the care process for their breast cancer? If they could do that, they would not fall through the cracks, as they would know what to expect. If those expectations were met, that would increase their ownership of the process and their satisfaction with the process. It would probably also improve the outcomes, as it would allow people to take charge of their own disease.

Mary Scanlon: I am looking at the submission from Dr Harry Burns. I am sorry if I digress slightly, but I find the figures shocking. I am especially shocked about the predicted number of cancers in males, between head and neck, colorectal and, in particular, prostate cancer. Part of our work is to consider cancer prevention strategies. Do men not look after their health as much as women do? The predictions seem to show a far greater increase in the number of cancers in males than in females, apart from the figures for lung cancer. The extent of the predicted increases is frightening.

17:15

Dr Burns: There are different reasons for the different trends in each of the cancers that are shown. The data is taken from work that was commissioned by the Scottish Cancer Group on future cancer scenarios for Scotland. In general terms, the incidence of cancer is increasing across the board because of the aging population. Cancer tends to be a disease of the elderly. If someone has been around a lot longer, their DNA is likely to be severely damaged by whatever is damaging it.

The colorectal cancer risk in females does not rise as steeply as it does in males. It is probable that hormone replacement therapy reduces the risk of colon cancer. We are not predicting the same rise in colorectal cancer in females as is happening in males. All over the world, the incidence in prostate cancer is going up, but mortality is not going up. That is the result of an interesting biological feature of prostate cancer, which is that most prostate cancer does not kill.

If males of 80 years of age are studied, 70 per cent of them have a small focus of cancer in their prostates. Only a tiny minority of that percentage of cancer grows and causes difficulty. We now have a test that can detect tiny amounts of prostate cancer, so the incidence is rising because it is being detected more often. The danger is that we are detecting a lot of cancers that would not have troubled people and that can lead to a risk of over-treatment.

As far as head and neck cancer is concerned, it is not entirely clear why there is an increasing incidence of that cancer. Head and neck cancer is traditionally associated with smoking. However, the pattern of the incidence of head and neck cancer is changing. People are being diagnosed younger. It is thought that viruses, including the human papilloma virus, may be one explanation for that, but that possibility is still under investigation.

The Scottish Cancer Group has a prevention sub-group that is beginning to think about areas such as whether hormone replacement therapy protects against certain cancers. I could say, "What does that mean for me?" That may be all right for half the population, but for the other half it is not an option.

Mary Scanlon: Do not assume that all women are on HRT, although I might go out and get some now that I have heard what you said.

Dr Burns: At least women have the option. To be honest, I was never much of a boy soprano.

Other avenues exist for us to prevent cancer, but the single biggest thing that we could do in Scotland to prevent cancer is to tackle smoking. The committee has to follow through on that, as to tackle smoking would be to make the single biggest public health intervention.

Margaret Jamieson: Would we be sitting around the table today discussing new ways of working and the opportunities that are available to eradicate some cancers if we had not had the crisis at the Beatson?

Dr Burns: The Scottish Cancer Group antedated the Beatson by a few years. The thinking on the subject has been going on for a while.

Margaret Jamieson: Perhaps it was being thought about, but we would not have seen the action that we have seen since last year. Things have moved on significantly.

Dr Gregor: Certainly in the west of Scotland the crisis at the Beatson focused minds and put some urgency into the thinking. The east side of Scotland has been moving along. The situation provides an important opportunity for the west to fundamentally rethink how to provide cancer services to the large population. They are on their way. Over the past six months, a lot of positive

things have happened.

Dorothy-Grace Elder: But before we knew about the situation at the Beatson, our survival rates were terrible and were compared in the past—never mind now—to the worst outside the former eastern bloc countries. For years, something radical needed to be done.

I return to a subject that I have raised with almost all the witnesses: the postcode denial of certain drugs, including colorectal drugs, to which Dr Harry Burns and others referred. Surely to goodness, as we have an increase in that type of cancer—never mind others—we should be giving people the best possible treatments, yet the HTBS excuses turning down the use of those treatments by saying that cancer in Scots is in a more advanced stage anyway, as if it did not matter. Surely it does matter. We should get better treatment, because we are further down the line.

The Convener: Both witnesses do not have to jump to answer that question at the same time.

Dr Gregor: I have drawn the short straw on postcodes and the HTBS. Harry Burns will address the mortality figures.

The HTBS, NICE and the Scottish medicines consortium are all attempts to even out decision making. Until they were formed, each health board struggled with the issue of which of the new technologies they were going to implement, at what level, at what frequency and at what cost, often with inadequate decision making. We certainly had lots of different postcodes.

The national advice that the evidence review bodies create is only advisory. Nevertheless, it removes at least one of the hurdles in local decision making. The problem is that the advice does not come with money. The funding decisions still rest on the priorities of the local health services and the local boards. I put it to the committee that there is incompatibility between having local decision making and national consistency in implementing some expensive technology.

Dorothy-Grace Elder: Excuse me, but NICE and the HTBS have failed to approve drugs that other countries have used. The House of Commons Health Committee had a bruising encounter with NICE, and we are about to have one in the Scottish Parliament with the HTBS, because it has rubber-stamped every decision so far, except about eye drops.

Dr Gregor: Let me share with you another example. France spends—and it is a well-known figure—five times more on cancer chemotherapy than we do. Its results are not five times better than ours. It is important that we consider drugs in the context of the overall care of patients. There will always be priorities when spending resources. There is no doubt that there will be a necessary increase in the use of cancer drugs, but let us not get focused on cancer drugs alone.

The Convener: Harry, we will take a final contribution from you.

Dr Burns: I am grateful that somebody has given me the chance to say something about Scotland's mortality data. The evidence that Scotland has poorer mortality than any other country does not exist. I am happy to give the committee my 40-minute lecture on that on another occasion.

The Convener: Only not this afternoon.

Dr Burns: The data that the mortality statement is based upon are deeply flawed. Scotland, Denmark, Finland and Estonia are the only four countries in the world that collect cancer registration statistics the proper way. All other countries, including England, have a bias in the way in which they collect data that tends to overestimate survival.

I have a brief anecdote. In Switzerland, the best way to survive cancer is to be a Turkish immigrant worker. Those workers get their cancer diagnosed and that information goes on to the cancer registry in Geneva or Zurich. They then cannot afford the health care, so they go back to Turkey, but their death is never linked to their cancer registration data. They remain in the Swiss cancer register as survivors. Nobody in Germany knows how many people die of cancer there, because published German figures are based on 1.7 per cent of the population.

The notion that we are poor at treating cancer in Scotland is not based on good evidence. Even if it were, our treatment systems would not be the first place one would look for the explanation. The stage at presentation in Scotland appears to be much more advanced than in other countries. The phlegmatic Scot holds on to his symptoms a lot longer.

Dorothy-Grace Elder: There is a five-year pattern. We know that there is a discrepancy in the way that figures are collected.

Dr Burns: There is a discrepancy, which tends to overestimate five-year survival in all other countries.

I will finish with a study that was explained to me recently, which compared breast cancer survival rates in centres in three countries: Germany, France and England. Survival in the centres in those countries was identical. The use of chemotherapy varied sevenfold, with the English centre having the lowest use of chemotherapy and the French centre having the highest use of chemotherapy. The only determinant of the use of

chemotherapy that the investigators could find was the number of medical oncologists working in the centre. The more medical oncologists there are, the more likely you are to get chemotherapy, but in the study that made no difference to outcome.

Do not assume that if we use more chemotherapy we will get better survival rates. There is a long way to go. We may have better pain control, better symptom control and all the rest of it, but it is a complicated system.

The Convener: Do not get Dorothy-Grace Elder started on pain.

I am sure that committee members would love to see Dr Burns's 40-minute lecture in writing. Thank you for coming along and sharing your evidence with us, and thank you for your continuing work in cancer services in Scotland. I also thank committee colleagues for what has been a long day. I hope that it has been useful to us all. I thank members for their attendance and hard work.

Meeting closed at 17:27.

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