HEALTH AND SPORT COMMITTEE

Wednesday 10 September 2008

Session 3

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HEALTH AND SPORT COMMITTEE
20th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Elaine Finlayson (NHS Highland)
Dr Patricia Fitzsimons (NHS Greater Glasgow and Clyde)
Elaine Harrower (NHS Greater Glasgow and Clyde)
Joanna Keating (Scottish Government Legal Directorate)
Helen McIntyre (NHS Highland)
Ben McKendrick (British Heart Foundation)
Shona Robison (Minister for Public Health)
Amanda Smith (NHS Highland)
Anne Wotherspoon (Chest, Heart and Stroke Scotland)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 10 September 2008

[THE CONVENER *opened the meeting at 10:02*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning and welcome to the 20th meeting in 2008 of the Health and Sport Committee. I remind members and everyone else in the room to switch off mobile phones and BlackBerrys, please. No apologies have been received.

Agenda item 1 is to decide whether to take in private agenda item 6, which is consideration of our work programme. Doing so would be in line with our usual practice. Do members agree to take item 6 in private?

Members *indicated agreement*.

Subordinate Legislation

Mental Health (Absconding Patients from Other Jurisdictions) (Scotland) Regulations 2008 (Draft)

10:02

The Convener: I welcome to the meeting the Minister for Public Health, Shona Robison MSP, who will give evidence on the draft Mental Health (Absconding Patients from Other Jurisdictions) (Scotland) Regulations 2008. She is accompanied by Joanna Keating, who is a legal adviser in the Scottish Government's legal directorate, and John Williamson, who is a policy officer in the Scottish Government's mental health division.

I welcome the minister back to the committee after what was, I am sure, a busy recess for her, as it was for the rest of us, and invite her to make some introductory remarks.

The Minister for Public Health (Shona Robison): Thank you, convener. It is a pleasure to be here.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): That is worrying.

The Convener: We will take the minister's comment as being honest and direct.

Shona Robison: It was sincerely meant.

Ross Finnie (West of Scotland) (LD): It was said with moving sincerity.

Shona Robison: At its meeting on 23 April this year, the committee considered a set of draft regulations that were made under section 309A of the Mental Health (Care and Treatment) (Scotland) Act 2003. Those regulations, which became the Mental Health (Cross-border Visits) (Scotland) Regulations 2008 (SSI 2008/181), dealt with powers and provisions specifically for escorts to restrain and retake escorted mental health patients who are visiting Scotland while on short-term leave of absence from hospital. The draft regulations that we are considering are made under a different provision of the 2003 act, in section 309, which deals with the power to make regulations that cover a wider class of mental health patients who abscond to Scotland from the other jurisdictions in the United Kingdom, the Channel Islands and the Isle of Man. Those are patients who are subject to a civil or criminal mental health order, whether they are detained or in the community, and who abscond.

The statutory position at present is that persons who abscond from hospitals or in other circumstances from England and Wales are liable to be taken into custody in Scotland and returned to England and Wales under section 88 of the Mental Health Act 1983. A related provision in section 128 of the 1983 act makes it an offence to induce or assist a person who has been detained under the act to absent themselves without leave from detention in hospital or to harbour such a person. Provision has been made to repeal the application of those sections of the 1983 act in Scotland. The repeal will come into force on 3 November 2008. In addition, there is currently no statutory provision for the taking into custody in Scotland of mental health patients who abscond from Northern Ireland, the Isle of Man or any of the Channel Islands.

The purpose of the draft regulations is to make provision for the taking into custody of patients who are subject to compulsory measures under the law of England and Wales, Northern Ireland, the Isle of Man or any of the Channel Islands, and who are found in Scotland as a result of their having absconded or otherwise having failed to comply with the requirements of the order or other measure to which they are subject. The draft regulations are being made under the absconding provisions in sections 301 to 303 of the 2003 act, which relate to patients who are subject to measures in other territories that correspond or are similar to both civil and criminal orders, directions and other mental health measures.

Prior to the 2003 act, the provisions relating to patients who absconded to Scotland from England and Wales were contained in the Mental Health Act 1983 rather than the Mental Health (Scotland) Act 1984. The 2003 act did not alter such provisions. While wider reform of the 1983 act was pending, the approach was to continue in force certain provisions of the 1983 act that extended to Scotland. When the Department of Health considered amendments to the 1983 act, the opportunity was taken to co-ordinate amendments to ensure that each legislature made provision in relation to absconding persons from other jurisdictions within its own territory.

The effect of the draft regulations will be to allow a person who absconds to Scotland from another UK territory to be retaken and returned to their territory of origin. They will also put beyond doubt that escorts from other territories have a power to escort the patient while in Scotland.

The draft regulations, along with the Mental Health (Cross-border Visits) (Scotland) Regulations 2008, are intended to bring within the scope of Scottish mental health legislation provisions dealing with persons in Scotland who abscond or otherwise fail to comply with requirements that have been imposed under mental health measures that are applicable in one of the other UK territories. Only a small number of patients abscond each year. Most are civil patients who generally have more freedoms while in hospital.

I am happy to take questions.

The Convener: This is, of course, an evidence session, so members may ask the minister or her team questions.

Ross Finnie: I have a minor question, minister. You said, as the Executive note does, that the relevant provisions of the 1983 act will be repealed. How will that be effected?

Joanna Keating (Scottish Government Legal Directorate): The UK Government amended the 1983 act through the Mental Health Act 2007. There is a commencement order for the provisions of the 2007 act, on which we are liaising with the UK Government so that everything hits the same deadline of 3 November.

Ross Finnie: So when the 2007 act comes into force, it will repeal the provisions in question.

Joanna Keating: Yes.

Dr Simpson: The draft regulations cover the transfer between various areas of the UK of patients who are subject to compulsory measures. How do they relate to patients who abscond to other territories in the European Union? Are they covered in any way? I do not need an answer to that question at the moment.

Shona Robison: There are no similar arrangements for patients who abscond from elsewhere in the European Union.

Joanna Keating: That is right. At present, the domestic legislation covers Scotland, England, Northern Ireland, Wales and the Channel Islands. There is no provision for patients who abscond abroad.

Dr Simpson: That is interesting.

The Convener: As there are no more questions, and it seems that no member wishes to debate the draft regulations, I invite the minister to move motion S3M-02494.

Motion moved,

That the Health and Sport Committee recommends that the draft Mental Health (Absconding patients from other jurisdictions) (Scotland) Regulations 2008 be approved.—[*Shona Robison*.]

Motion agreed to.

Official Feed and Food Controls (Scotland) Amendment Regulations 2008 (SSI 2008/218)

National Health Service Pension Scheme (Scotland) Regulations 2008 (SSI 2008/224)

National Health Service Superannuation Scheme (Additional Voluntary Contributions, Injury Benefits and Compensation for Premature Retirement) (Scotland) Amendment Regulations 2008 (SSI 2008/225)

National Health Service Superannuation Scheme (Scotland) Amendment Regulations 2008 (SSI 2008/226)

The Convener: We move on to other Scottish statutory instruments. We have before us four negative instruments: SSI 2008/218, SSI 2008/224, SSI 2008/225 and SSI 2008/226.

The regulations in SSI 2008/218 add the Guar Gum (Restrictions on First Placing on the Market) (Scotland) Regulations 2008 (SSI 2008/176) to the definition of "relevant feed law" in the Official Feed and Food Controls (Scotland) Regulations 2007 (SSI 2007/522). The Subordinate Legislation Committee did not draw the instrument to this committee's attention.

The regulations in SSI 2008/224 set out new pension arrangements for those already employed, or intending to be employed, in the national health service in Scotland. The Subordinate Legislation Committee drew the instrument to this committee's attention on the grounds of numerous minor errors, which the Scottish Government has undertaken to correct.

The regulations in SSI 2008/225 make consequential amendments resulting from the changes outlined in SSI 2008/224 to existing regulations relating to additional contributions and compensation schemes associated with NHS pensions in Scotland. The Subordinate Legislation Committee drew the instrument to this committee's attention on the ground that it had raised two drafting points with the Scottish Government and was satisfied with its response.

The regulations in SSI 2008/226 amend the NHS Superannuation Scheme (Scotland) Regulations 1995 (SI 1995/365) to bring into force new arrangements for NHS pension schemes. The Subordinate Legislation Committee drew the instrument to this committee's attention on the grounds that there is an unusual use of an enabling power to remove retrospectively the right to buy back a pension; that there appears to be doubt over whether the regulations are intra vires; and that there is a question as to how those who joined the scheme between April and June 2008 will know what the elements of the new scheme are.

Information on all the instruments and on the Subordinate Legislation Committee's reports on them was intimated to committee members on 11 August, and members were asked to contact the clerks if they had questions. However, no questions have been raised, no comments have been received from members and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendations on the instruments?

Members *indicated agreement.*

The Convener: I suspend the meeting for five minutes to rearrange the seating for the round-table discussion.

10:12

Meeting suspended.

10:16

On resuming—

Health Inequalities Inquiry

The Convener: Our next item of business is oral evidence, which we will take in round-table format, for our health inequalities inquiry. I am pleased to welcome Ben McKendrick, Anne Wotherspoon, Elaine Finlayson, Helen McIntyre, Amanda Smith, Dr Patricia Fitzsimons and Elaine Harrower to our round-table discussion. I will get you to introduce yourselves in more detail shortly.

Members will forgive me for reminding them that this session will have a more discursive format. I know that, to allow interaction among the witnesses, members will sit back more than they do in the question-and-answer sessions that we normally use when taking evidence. I remind the witnesses that, as the official report is covering the session, it would be helpful if only one person spoke at a time.

I ask everyone to introduce themselves. I will start. I am Christine Grahame, convener of the Health and Sport Committee.

Amanda Smith (NHS Highland): I am team leader of the heart failure service in NHS Highland.

Helen Eadie (Dunfermline East) (Lab): I am a member of the Health and Sport Committee.

Elaine Finlayson (NHS Highland): I am the long-term conditions case manager in Inverness for NHS Highland.

Dr Patricia Fitzsimons (NHS Greater Glasgow and Clyde): I am a general practitioner in Glasgow. Our practice has a split site, and our keep well project is in the north site, where we have a population of approximately 3,000 patients. It is a family practice that was set up in 1948, so we have been in the business for 60 years—although I have not been.

The Convener: No one was thinking that.

Dr Fitzsimons: I have been in our long-established practice for 23 years.

Helen McIntyre (NHS Highland): I am the cardiac and stroke support nurse for NHS Highland, but I also cover the Cowal and Bute rural areas.

Mary Scanlon (Highlands and Islands) (Con): I am a member of the Health and Sport Committee.

Ben McKendrick (British Heart Foundation): I am policy and public affairs manager for the British Heart Foundation in Scotland. I am also involved in training and in promoting among staff an understanding of inequalities.

Ian McKee (Lothians) (SNP): I am a member of the Health and Sport Committee.

Anne Wotherspoon (Chest, Heart and Stroke Scotland): I am the young stroke support worker for Lanarkshire. My post is the result of a partnership between Chest, Heart and Stroke Scotland and NHS Lanarkshire.

Dr Simpson: I am a member of the Health and Sport Committee.

Elaine Harrower (NHS Greater Glasgow and Clyde): I am a practice nurse in the north of Glasgow. I work for a single-handed GP, and we work in the keep well project.

Michael Matheson (Falkirk West) (SNP): I am a member of the Health and Sport Committee.

Rhoda Grant (Highlands and Islands) (Lab): I am a member of the Health and Sport Committee.

Ross Finnie: I am a member of the Health and Sport Committee.

The Convener: Thank you all very much.

You will know that the committee is inquiring into health inequalities, particularly in the cardiovascular area. We want to get at your experiences in the areas that you come from. We will have NHS boards in front of us in subsequent weeks. Perhaps someone can start off and give the committee guidance on what we should be looking at. Amanda Smith looks as if she is ready to start.

Amanda Smith: I was looking at Ben McKendrick, actually.

The Convener: Feel free.

Amanda Smith: I run the heart failure service in NHS Highland, which is a new service that has been up and running for two years. We receive a grant from the BHF, so it pays our wages, but we hope that NHS Highland will take the service further when the money from the BHF stops. The heart failure service is worth while, because many patients with heart failure do not get support and understanding from other people. Basically, heart failure nurses go out into the community and work with patients to promote self-management, so that the patients take on the onus for dealing with their disease, but have the support of others to give them guidance and advice. As I said, the service works well at present, but we are still in the early days. We can achieve many of the aims of the keep well programme through our work on self-management and promoting healthy living.

The Convener: Can you give examples of the support that you provide and of what patients learn to do for themselves?

Amanda Smith: My background is in coronary care, which is where most people go if they have had a heart attack. The patients whom we deal with have had either a heart attack or heart surgery and their heart is not working as well as it should do—it is not pumping as well, so they feel tired, lethargic and breathless. We work with patients to make them understand what is going on with their heart and body and to ensure that they are on the right medication. A big part of our work is educating patients about eating well, keeping up exercise and improving their quality of life. Usually, their quality of life is very poor, but we can improve it by providing support and education, and therefore, we hope, make them live a little longer.

Ben McKendrick: The service that Amanda Smith provides is fantastic. The BHF believes fundamentally in heart failure nursing, which is why we have pump-primed a number of posts. The work achieves a significant reduction in premature mortality for heart failure patients and keeps them out of hospital, which is important as it reduces the burden on the health service. One issue that the committee could consider is what happens out of hours and at weekends, because the service is limited. Inevitably, if patients have an event or a concern outwith the times when the service is available, that has a knock-on effect on the health service.

Ross Finnie: Will you say a little more on that in relation to inequalities, rather than just the generality of the population?

Ben McKendrick: The reality is that a higher proportion of people with heart failure live in deprived communities.

Ross Finnie: Yes, but if we accept that proposition, the issue is how we specifically address that issue. We are trying to drill down into that.

Ben McKendrick: The service benefits the population at large. Therefore, I suppose that we would say that it needs to be targeted specifically at high-risk groups, in whatever ways would seem feasible. It is difficult to talk about the practicalities, but our argument is that the service must be opened up to everybody and focus on groups that are particularly hard to reach.

Rhoda Grant: How do people find out about the service?

Dr Simpson: I wanted to ask that, too. How are your patients referred to you?

Amanda Smith: We have quite a strict guideline because we are a new service. All patients come to us after a hospital admission. At present, we do not anticipate problems, which is something that we would like to change. We would like to work more with general practitioners and find out whether, if we step in and help GPs provide support to patients who attend frequently, that would save them going to their GP all the time and may stop them ending up in hospital all the time. Highland has a very wide rural area, especially on the west coast. That is a difficulty, because travelling to see patients is a nightmare. It can take a whole day just to see one patient, whereas if patients came to us, a nurse could see perhaps seven patients in a day.

Another issue is our time allocation. We were lucky to get money from the BHF for three whole-time equivalent nurses. We had to break that down into six nurses in Highland, but I have a nurse on Skye who works only one day a week. How can she see all her patients working one day a week? That is not practical. Therefore, we are considering other ways in which we can work with the public and with other community staff in providing care for patients.

Rhoda Grant: I wanted to ask about rurality. Given that when you travel outwith Inverness, a nurse can perhaps deal with only one patient per day, does that mean that people who live some distance away do not receive the same service?

Amanda Smith: At the moment, yes. We have to look at where the patient is, what we can do and who we can use. We are good at providing telephone support and we are also considering using telemedicine. If the patient had the equipment in the house connected to a computer, a heart failure nurse could check the information every day. However, as Ben McKendrick said, we are available only from 9 till 5, Monday to Friday, so if something happens at the weekend, the patient ends up back in hospital. I would like to be able to provide a better and fuller service, but that may be impractical and I do not think that we will get that. That is why we are looking at whether using telemedicine and community nursing staff would help.

Rhoda Grant: Could telemedicine help to provide the weekend cover that Ben McKendrick mentioned, if one person provided cover centrally?

Amanda Smith: We have looked at using telemedicine and at using NHS 24 as a hub to look at the information. That is fine, but if NHS 24 discovers a problem, to whom should that problem be reported? We are still very much in the early stages, but we are hoping to develop.

The Convener: Before we move on, let me mention that the idea is that we take evidence not just from one person. I saw Ms Harrower nodding in agreement earlier. Did she want to comment, given her experience as a practice nurse? Please feel free to contribute. We will hear from Ms Harrower and Dr Fitzsimons before we hear from committee members.

Elaine Harrower: We screen 45 to 64-year-olds who are particularly at risk. I work in Possil Park, which is an area of deprivation. We have quite a good take-up rate of 76 per cent at the moment. We carry out a cardiovascular risk assessment on patients who suffer from alcohol and drug problems, unemployment and long-term chronic conditions. We work at the starting point by trying to screen such people.

Dr Simpson: I want to pick up on that point—

The Convener: I want to let Dr Fitzsimons contribute first.

Dr Fitzsimons: It is interesting to hear about the work of Amanda Smith and Ben McKendrick, which is a step beyond what we do in the keep well project. We work at the grass roots, in areas of deprivation, to screen people with a view to primary prevention. We aim to catch patients who are in the age group that Elaine Harrower mentioned. We seek to prevent ill health by getting people on to medical treatment, such as aspirin and cholesterol-lowering medication, to prevent the cardiovascular events that might occur in those patients.

The Convener: I think that Ms Wotherspoon also wants to say something.

Anne Wotherspoon: I want to ask Patricia Fitzsimons how she gets the patients to come to her.

Dr Fitzsimons: We have a split site, as I said. Our deprived site is in Possil Park. We run a very old-fashioned system of open access, so people do not have to book an appointment. They can turn up and be seen. If they are in before such and such a time, they know that they will be seen that morning. We have a high turnover of patients, so we have no problem getting patients to the front door. Where we have a problem is in getting the time to deal with the problems that we unearth. If a patient comes with a particular problem, the GP can deal only with that problem if there are 15 people in the waiting room. Keep well has provided us with the resource to spend more time with patients and to get them to engage with the project. The nurse can run through a full health screen and we can treat people following the cardiovascular risk assessment. For the most part, it is opportunistic. We send letters and make phone calls but, for the most part, in a deprived area the key is to know your patients. If you know that they will come, you can get them while they are there and do the work there and then.

The Convener: I am conscious that Ms McIntyre and Ms Finlayson have not contributed. Do they want to say anything about what has been said so far before I call on committee members?

Elaine Finlayson: My role is a bit more generic and is not specifically cardiovascular. We identify and deliver clinical care to the patients who are at the highest risk of acute exacerbation of their chronic disease. We hope to prevent hospital admission in the first instance, or the need for readmission. We anticipate crises that might occur and either put things in place to prevent them from happening or allow the hospital admission to go much more smoothly. We promote self-management strategies and help patients to recognise the signs and symptoms that their condition will deteriorate. Basically, we give them more autonomy in managing their condition.

Helen McIntyre: I deal with cardiac and stroke patients, but I see them only post event. Ours is a community hospital, so all our patients are taken to the mainland, which means that I see them only after their cardiovascular event, whether that is a stroke or cardiac related.

10:30

The Convener: I remind all witnesses to feel free to contribute at any point.

Michael Matheson: Elaine Harrower and Patricia Fitzsimons talked about the keep well programme and the anticipatory approach to health care. How do we identify those who live in deprived communities whom we know that we should target? I am conscious that a generic area might be said to be deprived, but it could have pockets of wealth where individuals whom you do not intend to target might live. My impression is that it is when people present at a surgery that you give them the opportunity to be screened. A take-up level of 76 per cent is quite high.

Dr Fitzsimons: We operate in both ways. We send patients letters and phone them and we have notices in our waiting room. The successes are those whom we have opportunistically offered a full health screen. The exercise has been worth while. Our uptake level has been 84 per cent. Our target population of 45 to 64-year-olds numbers about 680. We now have 100 patients on primary prevention treatment because their cardiovascular risk was more than 20 per cent, so I hope that 100 patients will benefit from the project.

We are finding not just cardiovascular risk, but layers and layers of problems. We are finding people who are diabetic, who have unrecognised angina or who are glucose intolerant. Many patients have chronic obstructive airways disease, and huge mental health problems have also been found. We are taking the lid off a raft of problems. The aim is to find and treat cardiovascular risk, but layers of problems exist. General practitioners and nurses have been able to spend time with patients and what we have done is worth while.

Elaine Harrower: Michael Matheson talked about pockets of wealth, of which there are a few. We spend an hour with each patient. Some people can be done in 20 minutes, whereas others might take two hours. We are targeting people and they have the time to discuss their problems with us.

Michael Matheson: How do you target patients? Do you send them letters or telephone them?

Elaine Harrower: We send letters, but approaches have been mainly opportunistic when people have come into the surgery. Our biggest uptake has resulted from that.

Michael Matheson: What is the general response from patients when they are offered a screening?

Dr Fitzsimons: The response varies from unhappy to very enthusiastic. Most folk require a little persuading and cajoling into an appointment but, in general, the initiative has been well embraced.

Elaine Harrower: Word goes round. Someone might have received something from a screening, for example.

Dr Fitzsimons: I would not say that people are queueing at the door for screening. The patients still have to be persuaded to attend, although they attend fairly regularly for other reasons.

Ben McKendrick: Fantastic work is going on as part of the keep well programme, but the committee could consider whether 45 is too late—Chest, Heart and Stroke Scotland has flagged that up, too. In some communities, the premature mortality rate is high and life expectancy is low. Evidence shows that the steepness of the fall in premature mortality from cardiovascular disease among the 35 to 54 age group is starting to stabilise, so the keep well programme could consider that for the future.

Mary Scanlon: I was in the queue for questions, so I return to Amanda Smith from NHS Highland. I did not understand what was said about the roll-out of the service and the requirement for it to be available at weekends. From what she said, I understand that the programme is a self-management programme, which sounds wonderful. However, I am not entirely sure how the self-management programme fits in if someone calls the ambulance service because they have heart failure out of hours or at a weekend. I am not entirely sure how the programme reduces hospital admissions in such situations, because I imagine that anyone calling an ambulance would be taken straight to Raigmore. I want to try to understand better the self-management, anticipatory approach and how hospital admissions are reduced if someone has heart failure on a weekend.

Amanda Smith: We try to do self-management but many patients with heart failure develop severe pulmonary oedema quite quickly. It could be related to the rhythm of their heart at that moment, which we cannot anticipate. If a patient’s heart is in a normal sinus rhythm, they are fine, but if it goes into atrial fibullation—which is an irregular rhythm—or even a dangerous rhythm of ventricular tachycardia, that puts it under more stress and they develop pulmonary oedema. In that case, we have to get them into hospital.

There is no way that we can anticipate that. We can try to control it better with medication, but there will always be the odd occasion when a patient’s heart fails, and it always seems to happen at night or at the weekend. Many cardiac patients, when they become breathless, tend to panic and phone the ambulance, which takes them into hospital. If they become breathless during the week, they can phone us and we will talk them through the condition and find out what is going on. We ask them whether they have taken their medication and whether the breathlessness is new, has happened suddenly or has been gathering over the past couple of days. If it has been gathering over the past couple of days, we can usually titrate their medication to get rid of all the fluid, which saves them coming into hospital. However, sometimes we do not have an option and the patient has to come in.

Mary Scanlon: Do you envisage that, if the service is extended, you will be available to be called out to someone in Sutherland, Skye, Badenoch or Strathspey who phones NHS 24 out of hours or on a weekend, rather than an ambulance being called out to take them to hospital? That is what I do not understand.

Amanda Smith: It depends on what the patient is like. If it is a definite acute exacerbation, there is no choice and the ambulance is the first priority. That is what we say to our patients at the moment. We tell them that, if they become severely breathless at night or over the weekend, they should not hesitate to get an ambulance.

Mary Scanlon: I am just trying to understand why there is a need for the service to be 24/7. It is a wonderful service, but my understanding is that it is an anticipatory, self-management programme and I am trying to understand whether we need another 24/7 helpline in every health board area.

Amanda Smith: I would like to work with NHS 24.

Mary Scanlon: I can see that that could work.

Amanda Smith: Yes. The ideal way to go would be to get the telemedicine service up and running and working with NHS 24. However, as I said, we are still in early talks about that, and I cannot give you an idea of what will happen.

The Convener: I would like to move on because two medical practioners on the committee—Richard Simpson and Ian McKee—are itching to get in with questions.

Dr Simpson: I am getting slightly confused because we seem to be talking about primary, secondary and tertiary prevention, which are slightly different things. From what Dr Fitzsimons said, it seems that the primary end—the keep well programme—is producing a huge number of extra cases, which is fine because it means early diagnosis and early secondary prevention, but I am concerned that it will produce a huge extra weight of work in the deprived areas, in which the cover of general practitioners is no more intense than it is in other areas. I would appreciate a comment on that.

We have had figures of around 70 per cent on screening for blood pressure since Hamish Barber and I did the study in 1979, which showed, on an opportunitistic basis over three years across a variety of practices, that 70 per cent of the practice population would come in and accept a basic screen of their blood pressure and weight. We are 30 years on, and 76 per cent is not a big advance. I am always interested in the other group—those who are not attending—and how we follow them up. How are the witnesses coping with that?

The Convener: Before Dr Fitzsimons answers that question, can she tell me—I have raised this with the deputy convener—whether screening is incentivised. Do practices get paid for it in any way—through special funding, for example?

Dr Fitzsimons: There is the keep well funding stream, but screening is part of our new general medical services contract. The quality and outcome frameworks will produce a significant improvement in health over the next 10, 15 and 20 years. There is no doubt that measuring blood pressure and ensuring that it is at an acceptable level, and measuring cholesterol to ensure that it is as low as possible, works. Health will improve as a result of the new GMS contract.

Ross Finnie: I do not doubt that improving and stating the quality standards that are to be measured will have an impact, but we want to know whether the keep well programme funding allows you to spend more time on the project. You might also wish to comment on the availability of practice nursing within that. Can you clarify that the important additional funding is currently available and that it allows you to do what you want to do? Can you suggest, in the light of your experience, how things might be done differently?

Dr Fitzsimons: Certainly: £1 million was put into the Glasgow area each year for two years, and each practice had to bid for what it felt was an appropriate amount of funding, to be split between GP, nursing and administrative time. It was fairly generous, but I have been back twice to say that we need more nursing time and more GP time. It is taking a lot of time—more than I, and other practices, thought—to do the project well, because everything has to be documented and measurable. It does not just involve face-to-face consultation; there is a lot of audit and administrative work, which none of us realised at the beginning was going to be quite so tedious, although it is definitely worth doing.

To return to Dr Simpson’s question, we are now seeing a lot more chronic disease, although at an earlier stage—I hope—when we can be proactive and do something about it. Our workload will of course increase in the long term: the project initially runs for two years, and we are currently putting forward business plans for a third year, but I am concerned about where it will go after that. Will we suddenly stop spending time with patients in a deprived area? We need more resources in such areas.

When the GP contract was negotiated, there were promises to revisit, in the second round, areas of deprivation, areas with a high ethnic mix and areas with split-site working. None of that was revisited, however, as other issues were considered to be more important, and we are left in a funding void.

The Convener: Can you explain what split-site working is?

Dr Fitzsimons: I have two premises from which I work. It would be a lot easier to work in one place, with one group of staff and one set of electricity bills, but we have had two sites, for historic reasons, since the practice was set up.

Elaine Harrower: As Dr Fitzsimons said, we did not realise what work would be involved in the project. The people who are coming in have housing, benefit and literacy problems. We spend time with them and make referrals, and we have a tracking tool, but it involves a lot more time than we originally thought.

The Convener: Dr Fitzsimons, you said that you had to go back for more funding. How do you make long-term plans for staffing, and the staff nursing time that you will require, if you have to go back for further bites?

Dr Fitzsimons: We were fortunate, as one of the nurses in our practice was not full time. She had the flexibility to take on two sessions, and she was happy to take on a third. We have always had to get nursing and GP help from outside. With the logistics of having two places, things can be quite tricky. The keep well team have been very supportive, and have complied with the funding requests.

10:45

Ian McKee: I have two questions, one for Patricia Fitzsimons and one for all the witnesses. I worked for many years in a practice area that sounds similar to yours, so I understand exactly what you are talking about. You say that you have open access, so you can give opportunistic advice, make suggestions for screening and so on. The tendency, however, is to have more formalised appointment systems, with triage and so on. If practices in areas of deprivation moved to that sort of system, would that make it difficult to run your programme with the same success? Would you find other ways of picking up people?

Dr Fitzsimons: There would probably be a riot if we suggested having booked appointments—albeit with 48-hour access, booking on the day or whatever. We surveyed our patients, and they like the current system. I suppose that people do not like change. If something works, why change it? Our patients come to us, and we know them well. I have been there for 23 years, and two of my colleagues have been there for about 20 years. We see a lot of trivia, perhaps, but we deal with that quickly.

There are opportunities to deal with health promotion, and we should be doing a lot of that work in a good general practice. We went into our project hoping to do a bit of health promotion work, and we did. Now, we are doing a whole load more. I do not think that changing to more modern access arrangements would be terribly productive, certainly not for one site, although there is a book-on-the-day, 48-hour access system for our other site, which works fine. The patients like our open access system, however. We have surveyed them, and they are keen to keep it.

Ian McKee: The committee should note that point. There is a great deal of pressure on you, with suggestions that you are a bit old fashioned or out of date if you have open access. In certain areas, open access is probably the best option, as you have emphasised.

We know that when a relatively new service that benefits people in the community is brought in, there is greater take-up by people who live in more affluent areas, because they are more switched on to co-operating with something new. Therefore, quite a large health benefit might be gained, although we run the risk of increasing inequalities, as the people in the more deprived areas will not take up the new service at the same level. On the other hand, if a finite resource is focused on people who live in deprived areas to reduce inequalities, that might prevent us getting the full health benefit for our buck, which we would get if we took the low-hanging fruit from the trees—if we went to the people in the more affluent areas. What are your views about that? Is there a practical problem, rather than a theoretical one? Which comes first: reducing health inequalities, which is what the committee is discussing, or raising the health of the population in general?

Anne Wotherspoon: The problem is primarily one of attitude. I will give an example. As I said, I work with younger stroke patients. A couple of years ago, two women in their late 30s came in, with very similar deficits following their strokes. One lady worked as a classroom assistant and stayed in Airdrie. The other lady did not work. In Lanarkshire, she would probably be affectionately known as a jakey: she drank a quarter-bottle of vodka every day and said that she did not realise that it had any detrimental effect on her health. We have stroke nurses in Lanarkshire who work on follow-up. Every person in Lanarkshire who is admitted and discharged from hospital after a stroke is followed up at home by a stroke nurse, for anything up to a year.

I will explain where I think the inequality comes. The lady from Bellshill does not have a real problem with her health, in so far as she feels that something is going to get her anyway—her mother had a stroke, or her father died from a heart attack. Her attitude to her health is, “Well, I’ve got to die of something.”

The reaction of the lady from Airdrie was at the opposite end of the scale: she was devastated by her stroke, because it meant a massive lifestyle change for her, in terms of her ability to work and look after her young family. I spent more time with her, because her aspirations were higher. She felt that she had lost a lot and needed a lot of support to get her life back on track, whereas the Bellshill lady was quite happy to take our advice but then go home and live her life as she did before her stroke. It is about attitudes. I do not know whether spending more time with the Bellshill lady would help. I could visit her on numerous occasions to try to support her, but would she take in what I say?

The Convener: We can carry on talking about screening, but I am conscious that some of our witnesses work in rehabilitation, so members might want to ask about that.

Rhoda Grant: If about 70 per cent of the population come to the practice for screening, how do we reach the other 30 per cent, which includes people such as Anne Wotherspoon’s lady in Bellshill? That lady does not have great aspirations to good health, as long as she can get by. She probably suffers from the same colds and flus that everybody else gets but she does not bother to go to the doctor. Men are probably more likely to behave like that—

The Convener: That comment brought a withering glance from a committee member.

Ross Finnie: I will talk to her later.

The Convener: He said that sotto voce.

Rhoda Grant: I am ignoring him—but it is true that many men do not seek health care in the way that many women do. That is a big problem, and men are more likely to be affected because they have not come through the door and been given screening and advice. I am not criticising the work that the witnesses do; you probably could not cope with more people coming through the door, but if the committee is to change anything we must consider how we reach the 30 per cent of people who are not currently being reached.

The Convener: Is there a male-female divide in that regard? In women's lives, events such as pregnancy mean that they go along to the doctor at some point.

Mary Scanlon: In his submission to the committee, Ben McKendrick said that, in general, cardiac rehabilitation is offered to men much more than it is offered to women. We should acknowledge that.

The Convener: We seem to have opened up the battle of the sexes.

Dr Fitzsimons: Of our core group of about 650 patients, about 180 are hard to reach, but there is not a great age-sex difference between our core group and that group, which is surprising, given that other practices have found it more difficult to reach young males, for example. We found that 28 per cent of our hard-to-reach group have a mental health problem, which makes things difficult. Our task in year 2—the current year—and year 3 is to try to engage hard-to-reach patients. We have reached 84 per cent of the practice population, but we are trying to do more.

Michael Matheson: Can you explain what you mean by a hard-to-reach patient?

Dr Fitzsimons: Patients who do not come into the practice.

The Convener: Perhaps Ben McKendrick will start our discussion about rehabilitation. Are services patchy? Are white-collar workers and professionals more likely to be proactive in accessing services?

Ben McKendrick: They absolutely are. On cardiac rehabilitation, which we targeted in our campaign with Chest, Heart and Stroke Scotland, if we are to tackle inequalities we must ensure that services are as flexible as possible. People who live in remote and rural or deprived communities are less likely to benefit from services that are set up to be solid and fixed. People who have transport and are relatively affluent are much more likely to participate.

Our focus has been on trying to make services as flexible as possible, perhaps including home-based rehab, to maximise the number of people who make use of them, particularly those in hard-to-reach groups. I heard someone say recently that such groups are not to hard to reach for McDonalds, so why should they be for anybody else?

The Convener: Will you give an example of what "home based" means?

Ben McKendrick: BHF has done some work on a heart manual, which is a self-management tool supported by clinical staff that enables people to manage their conditions at home. Effectively, it is a book that they take home with them, so people in remote and rural communities can use it too. It enables them to see the warning signs, which comes back to what we discussed earlier about training patients to be aware of the warning signs so that they can call in help when they need to.

The Convener: You provide stroke support for young people, Elaine Harrower. Will you define that age range?

Elaine Harrower: It is people of working age from 16 to 64. Like Helen McIntyre, all the interaction that I have with patients is after the event, so we are talking about secondary prevention. I come from a therapy background, not a nursing background, so I have nursing support, but I take things a step further and see myself as a signposter.

I am a contact person who offers longer-term support post discharge from hospital so that people have somebody with a bit of knowledge who can point them in the right direction to help them achieve their goals. I am the only person in Scotland who does that job. There should be more signposters—people who are there for the person who is trying to manage their disease at home, and who will be able to go and see them or speak to them by telephone, spend a bit of time answering their queries and point them in the right direction.

The Convener: It would be useful if you gave us some examples—anonymous, of course—of what such signposting involves for individuals.

Elaine Harrower: Many people's goal is to re-enter employment, perhaps by going back to their old job or retraining and trying something new. People are not aware that job centres are quite hard to access—there are security men on the door, which is quite daunting and you need to use an appointment system—because they have not used such services before and they do not know how to go about it. Chest, Heart and Stroke Scotland employs somebody to work solely on benefits advice with patients with chest, heart and stroke illness. She works in Motherwell for those people alone and it would be to her that I would move such patients on because I know that they would get a good service from her. I can lead patients to water, but I cannot make them drink. It is about showing them what is available and allowing them to make a choice about what to do. It is about managing their illness or disabilities and moving on with their lives.

Michael Matheson: From my previous professional experience, but also from my experience with constituents, I know that after someone has had an episode, been in hospital and then been discharged, there is often limited access to rehabilitation for about four to six weeks but, thereafter, it dries up despite the fact that the patient would probably benefit from on-going rehabilitation. In my professional and political experience, I have learned that it tends to be those who fight for more access to services who get an extension.

There is also an issue about people from different backgrounds who continue to participate in rehabilitation programmes. Does it continue to be the case that it is the people who push to get more physio, occupational therapy, speech therapy or whatever it might be after their initial slot of treatment, who benefit more? Is there a problem with people falling away and not following through on their rehabilitation for a variety of reasons?

The Convener: Before I bring in Anne Wotherspoon, I will give Helen McIntyre and Dr Fitzsimons a chance to speak.

11:00

Helen McIntyre: I was going to make the point that Ben McKendrick made about the home-based cardiac programme. We received funding from the Big Lottery Fund for a home-based cardiac programme, which has been successful because of the rurality of our area—many patients have taken up the service. We support them to go through the programme at home.

Anne Wotherspoon talked about supporting young people who have had a stroke to go back to work. I am the only person with that role in my area. I spend a lot of time with employers on providing support for patients, such as phased returns to work and using annual leave. Patients are not always aware that they are entitled to such measures, and often the management does not offer them to patients. That work is about supporting people to return to what was normal for them prior to their event.

Dr Fitzsimons: I agree with Anne Wotherspoon about the level of expectation. In our area, people do not expect much—they do not expect to live long. Their parents may have died young or they may have handicapped children. Life is not great, so they do not expect very much. When they go into hospital or are discharged from physiotherapy, they do not know whether to fight—they just accept. The level of ill-health that people accept is staggering. I suspect that the more affluent patients push more for cardiac rehab, but our patients certainly do not do that. We become the advocate if they come to us.

I ask Ben McKendrick whether cardiac rehab starts only after someone has had a heart attack.

Amanda Smith: No.

Ben McKendrick: That is a good question.

Dr Fitzsimons: I ask because we have many patients who are newly diagnosed with angina and who have not been admitted acutely—they are still in the community. Is rehab available for them?

Ben McKendrick: In Scotland, people who have had a bypass or a heart attack are likely to get rehab, but people who have angina are very unlikely to get it. I think that 1 per cent, or possibly 3 per cent, of people with angina get rehab.

Dr Fitzsimons: It would be useful to improve that, because people who are diagnosed with angina pop back to their GP, but what do they do after that?

Ben McKendrick: That is crucial. To return to the point that Michael Matheson made, the way to tackle some of the issues is to embed in the standards provision on cardiac rehab for all heart conditions. NHS Quality Improvement Scotland is considering that. If it can embed an approach to rehab for all heart conditions, focusing on high-risk groups, that would be a fantastic way in which to tackle inequalities once and for all.

Helen McIntyre: That is what we are doing in our area. All angina and heart failure patients who are suitable for cardiac rehab, a pacemaker or any kind of cardiac intervention receive that. We also run a programme in which patients who are at risk are invited to join professionals and listen to what has happened to other patients and what could happen to them.

Amanda Smith: We are trying to do the same throughout NHS Highland. The heart manual has a related angina manual that is being rolled out. I believe that all the manuals are being put together to make just one manual that will work for any cardiac disease.

Helen McIntyre: Yes—it was launched last week.

Amanda Smith: The problem is getting out and identifying people and providing access to rehabilitation classes. Many classes tend to be held in areas with high population, so rural areas are missed out. The problem is taking classes and advice to people in rural areas.

The Convener: I have listened carefully to the evidence on attitudes. I have seen in my work different attitudes to health problems because of people's expectations in life. That is a huge issue, but we need to consider it if we are considering inequalities. Services can be available, but inequalities will still exist. Anne Wotherspoon highlighted individual differences between people. Some people just do not have the get-up-and-go because of the lifestyles in their families for generations. How do we deal with that?

Dr Fitzsimons: We have to go right back to school, education and public awareness. Ben McKendrick is right to say that 45 is too late for primary prevention schemes. Literacy is a big problem. We have heart and stroke manuals, but the keep well programme has unearthed the fact that, believe it or not, a huge proportion of people cannot read, and they are the people who have no expectations in life. We have to go back to schooling.

The Convener: Are the literacy problems that GPs face documented?

Elaine Harrower: That is in the tracking tool.

I want to go back to basics. Ben McKendrick spoke about transport and Dr Fitzsimons mentioned the uptake in affluent areas. We found that uptake is greater when services are provided on site. Our patients do not have transport, so having to travel somewhere for services is a major issue for them. They do not always get hospital transport.

Dr Fitzsimons: The more services we can give them in the place that they regard as their second home, with people they know, the better. We looked at providing spirometry on site, because our patients will come to us but do not want to go elsewhere. The situation is probably the same in other places.

Elaine Harrower: Many of them do not have the means to go elsewhere; a bus journey costs a lot of money if you do not have much.

Helen McIntyre: We find that, too. Because of our location, travel to hospital involves ferries, trains and buses, which is a huge expense. People do not always get ambulance transport. They have to pay for transport up front, and many of them are not made aware of the fact that they can claim the money back. The journey from Dunoon, which is a small town, or Rothesay, which is on an island, is huge and daunting by public transport. It involves taking a ferry—perhaps two, depending on where people are going—as well as trains and buses. Someone's appointment may be for 15 minutes, but because of public transport timetables they may be away for 12 hours.

The Convener: What solutions do you offer? This is your chance to put them on the record—speak now or forever hold your peace.

Dr Fitzsimons: The literacy issue stands out. It arises when we ask patients to complete mental health questionnaires or when patients ask us to sign the backs of their prescriptions. On closer inquiry, it becomes apparent that they cannot read, which they are very embarrassed about. We find that illiteracy is a problem for a staggering number of people.

Dr Simpson: Illiteracy is also a problem in prisons—not for all prisoners, of course, but for a major group of them. Recording of illiteracy is not a requirement in the Scottish Prison Service, but we know that the incidence of illiteracy in the offender group is massive. The first step is to identify the problem. The second is to say that all the programmes that we have run until now are for affluent people, because those people are literate, demand services and have aspirations to live for a long time, as their parents have lived for a long time. We must change the way in which services are delivered. Since the NHS was established, we have had a provider-oriented service. We must shift our approach completely, which will involve focusing resources on practices such as Dr Fitzsimons' in a way that has not been done previously. I worked in a practice where most patients were affluent, but there was a small but concentrated number of deprived people in the area, which meant that we received a significant level of deprivation payments. Other practices with massive deprivation problems had no more resources than we had.

Dr Fitzsimons: It was promised that deprivation would be considered in the new contract, but that never happened.

Ian McKee: I have been pondering the convener's question about how the situation could be improved. Perhaps there could be a better link-up between out-patient departments and hospital transport services. I know of cases in which there seems to be no such link-up. When a patient is offered an out-patient appointment, they ring the hospital transport service, which tells them that it is unable to provide transport for that time. The hospital offers the patient another appointment, but by the time the hospital transport service has confirmed that it can accommodate that, the hospital has given the appointment to someone else. Such incidents might be isolated, but do you think that there is scope for co-ordinating services, so that people who do not have their own transport can be more assured of getting transport to the hospital services that are on offer? Is that a problem?

Anne Wotherspoon: It is a constant problem. In Lanarkshire, hospital transport services meet management teams continually to thrash out some of the difficulties, but the availability of transport is not limitless. There are not great rural numbers in Lanarkshire—many of the towns are fairly close together—but there are still inequalities. People who live in towns still need transport, for example because they have disabilities. It is a huge problem.

Mary Scanlon: At a reception that Roseanna Cunningham hosted before the recess, I met a gentleman from Ballachulish who took it upon himself to set up his own cardiac rehabilitation sessions. He rented a hall in Cuil, which is quite a deprived area near Fort William, and went round all the doctors, who referred people to the sessions. As far as I am aware, they are highly successful. Sometimes, individuals can take that kind of work upon themselves successfully.

I appreciate that most of the witnesses, apart from Ben McKendrick, are from the NHS. Tackling inequalities can be successful only if it includes local government and the third sector. To expect GPs, nurses and support workers to provide all the rehab, fitness classes and physical activity is to ask too much. How supportive is local government of the third sector? In Moray, for example, there was GP prescribing for fitness classes at a local gym. That approach was highly successful and, as far as I know, continues. It does not happen in all areas, but it is an example of good working relations between local government and the NHS. “Equally Well: Report of the Ministerial Task Force on Health Inequalities” has a joint preface by Shona Robison and the Convention of Scottish Local Authorities, but none of the witnesses has mentioned the role of local government. I throw that round the table.

The Convener: COSLA will come to the committee, but it would be interesting if any of the witnesses wanted to make any comments in advance of that.

Mary Scanlon: I want to know about people’s experience with local government; I want to know how supportive and signed up local government is.

Anne Wotherspoon: I will speak from the point of view of stroke services. We have been working hard for a long time to build proposals in Lanarkshire for a service for stroke patients similar to the cardiac rehabilitation programme. That came on the back of a committee meeting to which patient representatives were invited. One lady stood up and said that, following her stroke, her GP had recommended that, to help with her general fitness, she should join the gym, but the gym would not take her because of her health background—another example of inequality. People who are motivated to take some responsibility for their health and wellbeing are being turned away from the door.

Mary Scanlon: Was it a local authority gym or a private gym?

Anne Wotherspoon: It was a council gym.

Mary Scanlon: It turned the woman away from rehab?

Anne Wotherspoon: She was turned away from joining the gym because the staff felt that they could not give her particular support because of her difficulties. That got us thinking about access. Many of our patients were saying that it was really difficult, because they had no access to facilities, to take up exercise although everybody was telling them that they should.

The gyms have been highly supportive, but their staff need to be trained. We proposed that, in Lanarkshire, we would have a post-stroke exercise group that would start off in the NHS with a trained physiotherapist. For something like six weeks, a group of people like the cardiac rehab patients would come along. They would all be screened and assessed, and their activities would be pitched at a level that would suit them and their disabilities. Then, at some point, a member of staff from the local gym would come along, take part in the sessions and then take the patients out to the gym so that, from then on, after the programme had finished, the patients would have access to the local gym and know that they would have support there.

Mary Scanlon: That would be quite a convoluted process if it were to be replicated throughout Scotland, would it not? It obviously works, but you have pointed out a huge obstacle.

The Convener: I disagree, Mary. There would be issues with normal gym staff not being educated enough to know how to deal with such patients, so the marriage seems a sensible idea. The question is whether it is being extended to places in Scotland where there is understanding about patients coming to the gym and whether staff feel secure that they know how to help them into fitness.

11:15

Anne Wotherspoon: People who do cardiac rehabilitation are trained by the British Association for Cardiac Rehabilitation. There is talk about having an educational programme, but I do not know whether it would be specific to strokes or whether it would cover other neurological conditions.

The Convener: Does anyone have other examples of work by local authorities?

Elaine Finlayson: A lot of patients in the keep well programme are referred on for exercise—Elaine Harrower will keep me right on this—but they cannot pay for one session at a time. They have to sign up for 10 sessions and part with £35 all at once. Few of our patients can afford to do that. That is an obstacle.

The Convener: Does Elaine Harrower want to say something about that?

Elaine Harrower: That is a particular problem. People can be referred to local authority gyms, particularly for exercise classes, but they have to pay £35 upfront.

Helen McIntyre: Our local authority gym now offers reduced rates for patients who are referred by a health professional and they can pay weekly as they go. Previously, the gym found that people were not going because they had to pay upfront and it was too expensive. We bring them in and do a session with them in hospital—a post-cardiovascular event. After that, someone from the gym—either the BACR instructor or one of the sports team—comes in and does a talk to encourage them to follow it up. If anyone who is referred by their GP is concerned about exercise, they are referred back to us and we introduce a programme in a hospital setting before they go back and join the gym again.

The Convener: So it is tailor-made. How reduced are the charges?

Helen McIntyre: I think that they pay £1 less than everyone else, so they pay £2 a session rather than £3.

The Convener: The reduction is not big.

Anne Wotherspoon: The fact that we want to set up and roll out such schemes relates to Michael Matheson's statement that rehabilitation is not limitless. We must empower our patients so that they do not leave hospital thinking, "The physio will cure me. If I have more physiotherapy, I'll find a cure." I return to the point that it is important to develop people's attitudes. The physio gives the person X hours of rehabilitation, but it is the individual's responsibility to go away and make further progress. The continuing support that they need should be provided, but schemes such as the physical activity one go a long way towards helping with that.

Amanda Smith: Most of the gyms in NHS Highland's area offer classes that unemployed people can attend for 50p a session, which is not a lot of money. In addition, GPs offer prescription exercise, which is free to patients. Most of the cardiac rehab classes that are not based in hospitals are based in local authority gyms, so people get the training there. A lot of patients who do the course go on to attend support groups that also provide exercise—Mary Scanlon mentioned the one in Ballachulish. There is one in Inverness, called braveheart, and there is one in Sutherland. The patients get so much out of them; they enjoy the exercise but they also get support to set up their own groups.

The Convener: Is training available for the staff in the gyms?

Amanda Smith: Yes—many of them go through a training course. Usually, one member of staff is the designated person, but in many cases there is also a BACR-trained physio in gyms that provide cardio rehab.

Helen Eadie: Should GPs be allowed to give prescriptions for people to go to the gym? After all, they prescribe expensive medicines from time to time.

Dr Fitzsimons: We have exercise programmes in Glasgow and throughout Scotland, but I think patients still have to pay a certain amount to attend them—they are not free. I am not a big advocate of giving patients everything free. If they have to pay a token amount, they are more likely to go to the gym and to value it. It is good to have reduced rates, but provision should not be free.

Elaine Harrower: It is not free in Glasgow.

Helen Eadie: You talked about the information technology that allows you to track patients across Scotland. Is that designed for one health board area, or is it universal? If it is, can the information that is held be analysed for every area in Scotland? Have you identified any areas of weakness in the IT?

Dr Fitzsimons: We use the general practice administration system for Scotland—GPASS—which is used by a large number of practices in Scotland. I think that pooling data and statistics from the system is reasonably straightforward. I think the tracking tool was developed in Glasgow and I am not terribly sure whether it is Scotland-wide, but I know that it allows information to be pooled locally. All the data are measurable.

Helen Eadie: Are there any gaps in the data? With experience, further down the line people often identify information that is missing.

Dr Fitzsimons: Part of the problem with being in phase 1 of the pilot was that, after nine months, we all realised that we should have been measuring things that we had not measured, so there was a lot of back-entry of data to make the statistics speak to us correctly. There has been a steep learning curve, which will continue into year 3.

Helen Eadie: Is there a way of feeding that information back into the centre, so that it can be modified?

Dr Fitzsimons: We have been doing that locally. We have two-monthly meetings at which everyone feeds back their learning experience.

Hopefully, at the end of the project, we will have something that is sustainable, if it is thought to be worth while and there is funding to sustain it.

Helen Eadie: So design teams in the centre will take account of the information and modify it?

Dr Fitzsimons: Yes, I hope so.

The Convener: On literacy, the problem is not only to do with people's ability to read; it is also to do with their confidence. As you said, people are ashamed of their lack of ability to read and do not want to let on that they cannot read. What happens about that? Can something be done in that regard?

Dr Fitzsimons: Elaine Harrower will be able to tell you more about the support that is given.

Elaine Harrower: Good support is available in our area, but uptake is not terribly good, because of the stigma that is attached. A few people have come back to me—albeit six months down the line—and said that they will accept the support.

Michael Matheson: How important is it to have a tracking tool when you are trying to target services at people who suffer the greatest health inequalities? If the tool is specific to Glasgow, we should be asking other health boards what tools they are using to identify those groups.

Dr Fitzsimons: As I said, I am not terribly sure whether the tracking tool is used Scotland-wide. It was developed as something small at the beginning, but it has grown into a giant mammoth. There is a lot in the tracking tool that we could shed if it were to be established permanently. Information about how we get the patients in, for example, might not be particularly interesting: as long as we get the patients in, does it really matter how?

The tracking tool is quite time-consuming to use, and I am not entirely sure whether its statistics match the statistics that we use in the practice. It is a starting point, but I think it could be modified and simplified. I think it has been a bit of a nightmare for the IT folk.

The Convener: I saw GPASS at work when I visited a surgery in Penicuick recently. Would it be helpful to the committee if we had a little note about how the system operates and what is done with the data once they are gathered? Is it correct that GPASS is voluntary and that not all GP practices are signed up to it?

Dr Fitzsimons: Practices will not necessarily use GPASS. They use other systems.

The Convener: It would be helpful if we could get a little note on what data are mandatory for GPs to gather and so on.

Dr Fitzsimons: I would be surprised if, under our new contract, any practice did not use an IT system.

The Convener: Of course.

Dr Fitzsimons: We have patients' details and registration and we try to summarise their main important conditions. Most consultations are now logged on a computer, as is medication, whether it is a repeat prescription or an acute prescription for penicillin, for example. Thereafter, the data that are recorded are height, weight, blood pressure, blood-test results, cholesterol levels and diabetes results.

Dr Simpson: That all relates to the quality and outcomes framework.

Dr Fitzsimons: Yes—that is basically QOF.

Dr Simpson: Use of GPASS is down to 64 per cent; the rate was 85 per cent when I was practising. It is not universal.

The Convener: I would like clarity about the data that are required by the various programmes. You mentioned that you now note literacy. What is mandatory and what is discretionary for GPs to record? What are you funded to provide? What incentives exist to record data? Where do the data go and what is done with them?

Dr Fitzsimons: I described the QOF data. There are subsets, which often relate to local incentive schemes—local enhanced services. Computer templates are developed locally and information is fed into them about literacy, whether a patient is employed, whether they have chest pain, whether they eat five portions of fruit and veg a day and so on. There are subgroups of the master system for each little system, such as the keep well project, the diabetic project, the stroke project, the alcohol project that is to be undertaken and the contraceptive project.

The Convener: Where does all that information go?

Dr Fitzsimons: If a practice wants to participate in QOF, I guess that it must agree to its information being used nationally.

Dr Simpson: GPs achieve 97 per cent of all the QOF targets. I am sure that the Scottish Parliament information centre could provide the list of data. When the new contract was negotiated, I warned the Government not that GPs would meet the targets with ease, but that they would certainly meet them. GPs were predicted to meet only 70 per cent of the targets, but in a short time, performance even by practices that deal with very deprived communities in which achieving the targets is more difficult has been up in the 90s.

There are three types of data: QOF data, national enhanced service contract data and local enhanced service data, which involves subjects that boards determine are important for their areas. Not every GP is involved in NES or LES activity, but they all do QOF.

The Convener: It helps to have practitioners on the committee to give evidence.

Dr Simpson: That has developed since I was in practice.

The Convener: I am pleased to have the information.

Helen Eadie: What has been said helps, but I am still not clear about where the QOF information goes. Does it go to the health board or the Cabinet Secretary for Health and Wellbeing? Is signing up to that arrangement voluntary?

Dr Fitzsimons: We would have no wages if we did not sign up to QOF.

Helen Eadie: I did not mean QOF, but sharing information with other people.

Dr Fitzsimons: For the keep well programme, we had to sign to say that we were happy for anonymised data to be extracted. If we want to participate in any enhanced schemes, we must allow the data to be viewed. I guess that local stuff is viewed locally and that national stuff is viewed nationally.

The Convener: It is not mandatory—it is no skin off our nose—but it would help the committee if somebody did a little note for us on the different levels of data, which have—thankfully—been explained, and their destinations. Data might go to a local health board or to central Government to inform policy and funding decisions.

Dr Simpson: I will ask about gender and ethnicity inequalities. We know that, for example, women's hypertension is not treated as well as men's is. I would like to get a feel from our colleagues of how they deal with gender inequalities.

We know that areas that have fewer cardiac surgery centres generate fewer procedures, so there is an equality issue to do with rural or non-academic centres versus academic centres. We also know that there are higher levels of cardiovascular problems in certain subsets of ethnic minorities. The data in Scotland on that are not good, but Professor Raj Bhopal gave us basic information and we know about the issue from other studies. We have tended to consider inequality in the context of deprivation, but in the more global sense of inequality how are other issues dealt with?

11:30

The Convener: Who wants to answer? I was distracted for a moment and silence has fallen.

Helen Eadie: May I add to Dr Simpson's question? I found out from constituents that some GPs are reluctant to give women cholesterol-lowering drugs. Is that for reasons of efficacy or for other reasons? A person's cholesterol level dictates their likeliness as a candidate for a stroke or heart attack.

Dr Fitzsimons: Some papers have suggested that the approach is not as effective in women or is more dangerous for women, but in our practice we do not discriminate at all. Under the keep well programme we treat on the basis of risk plus 10 years, to take account of deprivation. That means that we assume that patients are a bit older when we calculate their risk.

The Convener: I sense that we are running out of steam—members are indicating that they have not run out of steam. How dare I say such a thing?

Ross Finnie: Richard Simpson asked a question.

The Convener: I am sorry; I was distracted.

Dr Simpson: I know part of the answer to my question. I should declare an interest: my son does the ISD Scotland statistics. The quality and outcomes framework data indicate that the number of women being treated is increasing. Are witnesses aware of inequalities in that regard? Such issues are relevant to the committee's inquiry.

Dr Fitzsimons: I guess that we are aware of such inequalities. As you say, QOF is bringing people in to get their blood pressure measured routinely.

Dr Simpson: Will QOF be enough to sort the problem?

Ben McKendrick: If I may take a step back from primary care for a second, I absolutely agree with Dr Simpson that ethnic groups need to be targeted for risk assessment. We have done much work with the south Asian community, in which I think that there is a 50 per cent enhanced risk of cardiovascular disease. We should continue to focus our efforts on that high-risk population.

Dr Simpson: Does the keep well programme collect data specifically on ethnic groups such as the south Asian population in Glasgow?

Dr Fitzsimons: The ethnicity of every newly registered patient is recorded, but many patients were registered at a time when that information was not provided.

Michael Matheson: Witnesses talked about screening take-up levels of 76 per cent and 84 per cent in the keep well programme. Are those data broken down by gender and ethnicity? When you ask individuals whether they want to come in for screening, do people react differently, depending on their gender or ethnicity?

Dr Fitzsimons: There is no huge difference in our practice. A GP who did a presentation found that young males were not coming in, but we are not sure whether that was because the young men were working or because they were apathetic. We have not found a great age-sex divide in our hard-to-reach group—the divide is pretty much 50:50—although 28 per cent of those patients have mental health problems, as I said.

Elaine Harrower: Our experience is similar.

Mary Scanlon: My question is not on QOF or ethnicity. It is about the implementation of the review of health visiting and Dr Fitzsimons' comments about education and young people. I understand that, because of comments, criticisms, and petitions from GPs and patients, there is a six-week moratorium on the roll-out of the new health visiting role, which will concentrate resources in areas of deprivation. As it is mentioned in paragraph 5.1 of the NHS Greater Glasgow and Clyde submission, I wondered whether Dr Fitzsimons or the other witnesses wanted to comment on it, or advise us what is happening and what the concerns are.

Dr Fitzsimons: I do not want to step on political toes, but I would be distressed if our health visitors were taken away from the practice. They know the patients, they see them in the waiting room, they know who did not turn up last week and they immunise them on an ad hoc basis. They are an invaluable resource if we want to keep general practices as family-based units—our practice has traditionally been viewed as a family practice.

Mary Scanlon: I have visited some of the pilot schemes in the Highlands. Am I right in saying that the plan is to move health visitors away from GP practices and into the NHS boards, so that they will have no contact with the patient and will not be able to address on a day-to-day basis the problems that you have raised?

Dr Fitzsimons: The idea is that they will have contact with the patients, but perhaps in a different setting, outwith the general practice. They will be away from GPs, nurses and reception staff who all know the patients and the problems, and they will not be in the next room if we have a problem.

The Convener: There is some dispute about whether that is the case.

Dr Simpson: We have to be very careful here for the record. The RNIC—the review of nursing in the community—to which Mary Scanlon refers in relation to the pilots in Highland, Lothian, Borders and Tayside is quite separate from the issues in Glasgow. NHS Greater Glasgow and Clyde proposes, under "Health for all Children 4"—Hall 4—to change the basis in some areas of health visiting to be geographic rather than having health visitors attached to specific practices, in order to link them much more strongly to social work.

It is true that Tom Divers has written to me and to others to say that the implementation has been suspended for six weeks because the consultation process was inadequate. However, it is important that we retain universal health visiting provision. Linda Fabiani gave that assurance in the getting it right for every child debate the other day.

The Convener: Sorry—did you say Linda Fabiani?

Dr Simpson: Linda Fabiani indicated in the GIRFEC debate that health visitor provision would remain universal. She has spoken on behalf of the Government and given the specific reassurance that we sought. We have heard from many witnesses, however, that the need to intensify the support in areas of deprivation is important, but not at the expense of universal provision. The fears to which Dr Fitzsimons referred with regard to detaching health visiting from general practice to attach it to social work are reasonable.

The Convener: I appreciate that what is happening in the Borders is distinct from what is being discussed here. I do not want to go down that track just now—we should keep to our two clear lines of investigation. One was the screening, which brought up some interesting issues, and the other was rehabilitation. You have raised important issues in those areas, and I would rather keep the discussion to those if the committee is content to do so.

Ross Finnie: But Dr Fitzsimons is a witness, and what is happening in Glasgow is relevant. NHS Greater Glasgow and Clyde may wish to suspend the implementation, but it changed the geographic patterns before the consultation ended. That is true not only in Glasgow, but in Paisley South and other areas of deprivation, and it is a cause of real concern. Dr Fitzsimons' comments are pertinent and I am grateful to her for raising the issue.

The Convener: By no means was I dismissing your comments, Dr Fitzsimons. While accepting them, I wanted to keep to the question of the impact on rehabilitation. I am grateful for your contribution on that line—but this is not to investigate the two different projects that are going on, in their respective ways, in different parts of the country. There are issues concerning the Borders pilot, where the situation is very different. I am grateful for those points having been made.

Are there any further questions on any further issues?

Ian McKee: You mentioned the two threads of the discussion, convener. As far as health inequalities are concerned, is there not also evidence of inadequate take-up of treatment? I refer to the number of cardiovascular bypass operations, for instance. Is that not also a factor in inequalities in the cardiovascular area?

Ben McKendrick: It is, absolutely, and not just in terms of socioeconomic deprivation. There is evidence to suggest that in remote and rural communities the uptake of elective interventions is lower than we might expect. It would be very welcome if interest was taken in, and inquiries were made into, that area.

Ian McKee: We must maintain that as part of our inquiry. It is not good having procedures available if they are not taken up by people in rural or deprived areas. We should find out why that is.

The Convener: I agree.

Amanda Smith: I will comment on the situation in rural areas. It might be necessary to go to a hospital in a different area sometimes. In NHS Highland, we do not currently provide a lot of the things that are required for cardiac services. We do angiograms, but we do not do the angioplasties, the stenting and so on. That is coming—next year, hopefully—but a patient in Skye might currently have to travel all the way to Aberdeen, Glasgow or Edinburgh for cardiac surgery. That is a long way. When they are there, either the patient will have no support from their family, or their family will have to seek accommodation in order to support them. That is another outlay for them. Although we provide for the patient, we do not provide for the family. It is a big thing to undergo cardiac surgery, and the patient needs somebody there. Many surgery treatments do not get taken up in rural areas because patients have to travel for their actual procedure.

The Convener: Ian McKee was making the separate point that, in deprived urban areas, people are not taking up services.

Ian McKee: I totally understand the problems in rural areas, although I am not certain how to deal with them. It is strange to consider a community in an urban area with a higher-than-average incidence of cardiovascular disease, where people are getting fewer angioplasties, stents and bypass operations. That is not so easy to understand as something as obvious as the nearest hospital being many miles away and difficult to reach. I am talking about people living in Edinburgh, Glasgow or elsewhere in the central belt, where there is a high incidence of cardiovascular disease, who are not getting the attention that they need. Do any of the witnesses know of any reasons why that should be the case, and what could be done to overcome that?

Dr Fitzsimons: From the acute point of view, people living in Bearsden and Possil Park who present acutely will get reasonably equal care immediately. The Golden Jubilee national hospital now has a specialist cardiac centre. Indeed, some elective cardiac surgery has had to be put on hold. There are so many acute admissions that there are not enough beds for all the elective cardiac surgery. That is not so much of an issue from the acute point of view.

From the elective point of view, however, it comes down to expectation. I suspect that people living in Bearsden are more likely to be badgering the health service and asking when their operation is coming, whereas people in Possil Park are more likely simply to wait their turn—which, sadly, they assume will be a few months, or maybe a year. I do know if that is how long it is in reality, but it comes down to expectation.

Ian McKee: Not just expectation, but the ability to use the system better, would you not say?

Dr Fitzsimons: Yes.

Ian McKee: Expectation is one thing, but some patients, albeit with a certain expectation, might not know how to use the system. Might that be a factor, too?

Dr Fitzsimons: Yes, I think so.

The Convener: What is your view on how to remedy that deficit of knowledge about how to use the system?

Dr Fitzsimons: It goes back to general practice, the grassroots and knowing the patients—who has been in before, who has been waiting and so on. We need to ensure that, after their admission, they are brought back to the practice nurse for rehabilitation or whatever. We need to ensure that all the dots are joined up and that everyone is working in the same direction so that the patient is dealt with as swiftly as possible.

11:45

The Convener: That brings us to the practice nurse.

Elaine Harrower: In the area where we work, many people have low self-esteem. Although they are only between the ages of 50 and 60, they consider themselves old and they do not expect a lot. We need to try to educate them as well. Whereas someone from Bearsden who suffers chest pains will go straight to their doctor or to the hospital, someone in our area might put up with such pain for weeks or months. The problem might be discovered incidentally, while the patient is in for something else. Through keep well, we are finding that people need to be referred for fast-track chest-pain clinics. We have picked up a few heart problems.

Dr Simpson: As Dr McKee pointed out in a debate on the new ways waiting times system, one factor that needs to be considered is whether people take up appointments appropriately. Under the new system, any patient who has declined an appointment twice is removed from the list and sent back to the GP. Both Dr McKee and I have been concerned about the effect of that on people with literacy or mental health problems and on people who are confused. We now have a very bureaucratic system—that is not the Government's fault, by the way—following the abolition of the availability status codes, which everybody agreed should happen. Some of us have concerns that deprived patient groups who already suffer from health inequalities will not be able to manage the bureaucracy of the new system. Will Dr Fitzsimons or any of the other witness comment on that?

Dr Fitzsimons: Some patients will ask us to check with the hospital because they have not yet received their appointment. When we then phone the hospital, we find that the appointment has been sent out but the patient has not received it. Many patients do not appear to get their mail. I am not sure whether that is because they live in high-rise flats or whatever. I do not know how the hospitals should follow up appointments. Some patients can hardly remember what they are to do next week. If I am seeing a patient today who has a keep well appointment only two days from now, we will still phone the patient tomorrow to remind them to come. If some patients are given an appointment four weeks from now, they do not remember. There must be a way of chasing them up.

Dr Simpson: In my most recent incarnation as a practitioner, we used a texting system to deal with that. Most patients now carry a mobile phone, so using a texting system seemed to help a bit. We need sophisticated systems like that if such groups are not to be disadvantaged.

Rhoda Grant: A texting system might be good, but the patient who cannot read the original letter may not be able to read the text. I would imagine that there really needs to be a phone call.

Dr Fitzsimons: It is important to have reliable phone numbers. In our practice, we find that people's numbers tend to change. Most people have mobiles now instead of a land line, but their number might change if they lose their mobile. Many patients are hard to contact. Again, the issue comes down to the fact that we are a family practice. We know our patients, so we know who so-and-so's mother or sister is if we cannot get hold of her. You need to be careful about confidentiality issues, but you can usually track down who you are trying to find if you know your patients. That is why I think that it works when we do things in the practice.

The Convener: You have a long-established practice and you know your patch. I know that Ian McKee and Richard Simpson also knew their patches. Other than experience on the job, what training do GPs and other practitioners receive on all the issues that you have uncovered so that they recognise those problems?

Elaine Harrower: The longer you are there, the more people accept you. It takes a while to get to know who is related to whom. That comes with the experience of being in the practice for X amount of years.

The Convener: I was thinking how, when I sat through a GP's surgery once—with the leave of the patient—I watched one gentleman who was in for six or seven minutes and we never got to what was wrong with him until the last minute. Everything else was camouflage. Is that your experience? That patient had a pain in his foot, but he had not really come about that problem. However, he had to get settled first.

Dr Fitzsimons: The rectal bleeding is usually thrown in during the last minute. Nobody ever comes with one problem anymore; they come with lots of different problems. Some of the problems need to be investigated and others are trivial, but the person still needs to be reassured about them.

Consultations are taking longer, and you need time to do a good consultation. Time is a problem in the deprived areas. The keep well programme has given us time and I would like that to continue in some form.

The Convener: A GP told me that, often, patients come in after they have self-diagnosed themselves using the internet.

Dr Fitzsimons: Thankfully, we do not have many of that sort.

The Convener: No, I would not have thought that that was an issue for you.

Are there any issues that we have not raised that you think we should bear in mind when addressing health inequalities?

Anne Wotherspoon: On the recommendations around general wellbeing and mental health, heart attacks and strokes are fairly life-changing events—I am sure that the staff around the table will echo that view—but there is a distinct lack of clinical psychology support in that regard. The vast majority of my patients will, at some point, develop a degree of anxiety and depression following their stroke. That might not happen while the person is in hospital, so it will not be picked up and will, instead, fester when they go home, particularly if it happens after the rehabilitation phase has stopped.

In Lanarkshire, we have little rapid access to psychology services. I am pretty sure that that problem is replicated across Scotland.

Helen McIntyre: It is a huge issue in the Highlands as well.

The Convener: I think that the MSPs around this table are aware of the huge issues around access to psychologists, as opposed to psychiatrists. Sometimes, people are on waiting lists for years. We have all told this Government and the previous one about the problems, so I am glad that you raised the issue.

Ben McKendrick: I agree with that point. It is important to make sure that the focus is on what happens after people's clinical assessments. Clinical psychology is crucial in relation to heart disease, as people with heart disease are more likely to have a further event or die prematurely if they have mental health issues.

Another important issue is continuing funding for smoking cessation. The funding has been set at the same rate for the next three years, and I would like to flag up that that should be kept under review. Our view is that smoking cessation work needs to be targeted at deprived communities, and funds must be made available if that is to happen.

The Convener: Thank you all very much for your evidence. You have given us a great deal to think about from the perspective of the front line, which is the perspective from which we like to hear evidence.

We will now move into private session.

11:53

Meeting continued in private until 12:16.

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