HEALTH AND SPORT COMMITTEE

Wednesday 17 September 2008

Session 3

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21st 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:

Mary Allison (NHS Health Scotland)
Dr Eric Baijal (NHS Highland)
Cath Denholm (NHS Health Scotland)
Pip Farman (NHS Highland)
John Howie (NHS Health Scotland)
Sue Laughlin (NHS Greater Glasgow and Clyde)
Alex Mackenzie (North Glasgow Community Health and Care Partnership)
Ian Murray (Highland Council)
Susan Russel (Mid-Highland Community Health Partnership)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 5

Scottish Parliament

Health and Sport Committee

Wednesday 17 September 2008

[THE CONVENER *opened the meeting at 10:01*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Welcome to the 21st meeting in 2008 of the Health and Sport Committee. Apologies have been received from Ross Finnie; Jamie Stone is here as a substitute for him.

I ask the committee to agree to take item 3 in private, in line with our usual practice of considering potential witnesses in private. Do we agree so to do?

Members *indicated agreement.*

Health Inequalities Inquiry

10:02

The Convener: Under agenda item 2, we continue our health inequalities inquiry. With us on the first of two witness panels we have Ian Murray, the head of community learning and leisure in Highland Council; Susan Russel, a public health practitioner in the mid-Highland community health partnership; Sue Laughlin, the head of inequalities and health improvement in NHS Greater Glasgow and Clyde; Dr Eric Baijal, the director of public health and health policy in NHS Highland; Pip Farman, a public health specialist in NHS Highland; and Alex Mackenzie, the director of north Glasgow community health and care partnership. I thank you all for submitting your written evidence.

We are looking into health inequalities in dealing with cardiovascular disease, including issues such as screening for the condition. I advise members as well as witnesses that we should try to maintain our focus on that area. The written submissions that we received quite rightly covered a wide spread of issues, but we want to keep our focus narrow in this session.

Mary Scanlon (Highlands and Islands) (Con): I do not know about other people, but I am having difficulty in coming to terms with the new single outcome agreements, which are quite complicated. NHS Highland's submission says:

> "Single Outcome Agreements should provide the vehicle for implementation through developing a shared agenda"

and that

> "More 'joined up' working … should be developed".

For the past 10 years, I have been reading that more joined-up working should be developed. Will the single outcome agreements help in that process? How can parliamentarians scrutinise the single outcome agreements to ensure that they are addressing inequalities, given that the documents are so weighty?

Dr Eric Baijal (NHS Highland): I think that we are on a journey; it is not about starting partnership working afresh. We have a good partnership working arrangement with both the local authorities in our area. The work that we do with education in schools lays a foundation for good cardiovascular health—I am thinking about the promotion of healthy meals and snacks in schools and our work on the physical education agenda. There is a basis from which further work can be developed.

A number of the issues that you are concerned about are dealt with in the single outcome agreement. We are developing robust performance monitoring and management at the local level, which will feed back to central Government.

Ian Murray (Highland Council): The single outcome agreement gives an opportunity for a variety of single-sector plans to be monitored and brought together in one place. For example, the children's plan, which has traditionally been mostly to do with council services with some input from health, is being pulled together in a much better way.

The Convener: Can you say something more about the children's plan? Members of the committee might be fully aware of it, but I am not.

Ian Murray: Each local authority is required to produce a children's plan. Ours is called "For Highland's Children", and we are on the third version of it. The plan brings together the action plans and other elements of work that are targeted at children and young families. For example, the sure start programme, which gives individual families additional assistance with child care, helping people get back into work or claiming benefits, is being brought into an action plan with other programmes rather than being controlled by different services and agencies.

Mary Scanlon: Highland Council's submission says that, under the current system,

> "only 16% of income deprived people are identified".

Why does the current system work in that way with regard to poverty in the Highlands?

Ian Murray: I confess that I do not know the absolute detail of how the Scottish index of multiple deprivation areas are worked out, but the effect is that people who live in more rural areas are less likely to be identified as having the multiple deprivation factors than people who live in urban situations. Unfortunately, people in rural areas also have transport issues, as well as income issues and issues relating to access to basic services.

Mary Scanlon: I am looking for clues that will help me to understand why such a low percentage of people living in poverty is identified—obviously, the issue is important in relation to the national resource allocation committee, which makes decisions that are not beneficial to the Highlands. Is the problem something to do with car ownership in the Highlands?

Ian Murray: I am sorry, but I am unable to answer.

Dr Baijal: The main issue with the SIMD is that it does not pick up on issues around remoteness. For the SIMD, car ownership, for example, would be a marker of affluence even though, for many of our more remote residents, it is a necessity that is prioritised above other needs.

I emphasise the super-sparsity that we deal with. Access is a major challenge to us, as most people around the table know. Highland Council's area is about the size of Wales; if we include Argyll and Bute as well, we are talking about an area the size of Belgium with a population a little over that of Belfast. In population terms, we are talking about two people per square kilometre compared with the average for Scotland of 66 people per square kilometre. Remoteness and access are crucial issues that have not as yet been picked up on.

Susan Russel (Mid-Highland Community Health Partnership): My point is on the SIMD. Given that the data zones are conglomerates of about 200 to 500 people, communities in the Highland area may not trigger any indicators despite the fact that individuals in the area come under a deprivation indicator. That makes it very difficult to identify where deprivation is to be found and to find ways in which to address it at such small population levels.

Mary Scanlon: That is helpful.

NHS Highland says in its submission:

> "Many of the recommendations relate to 'doing things differently', however we will need to be clear what it is that we need to 'disinvest' in to shift resource to the more targeted approach … particularly in relation to support for … early years".

What do you mean by that? I am unclear how disinvesting will achieve a more targeted approach.

Dr Baijal: It is about the big issue of investment prioritisation. The NHS invests a significant amount in cure and care. We welcome the current guidance and drive towards the health-improving agenda in the national health service. That said, we need to think more about shifting resource into more health-improving activities outwith the NHS. We are saying that perhaps we should look not only at what is going on in the NHS, but at overall public sector investment.

Mary Scanlon: I understand the need for prioritisation, but I am still unclear on the other comment. Can you give us an example of where you will disinvest resources and take a more targeted, prioritised approach to meet the recommendations in "Equally Well" and so forth?

Dr Baijal: One good example is child and adolescent mental health services, in which the balance needs to be shifted. We need to shift resource from a hospital-focused approach to one that is community based. For example, we need to develop the integration of the service with social work services.

The Convener: I have a question on a point that I thought Mary Scanlon would raise in her questioning on rural remoteness and the SIMD. I am thinking of ways in which to redress the balance in the south of Scotland and other rural parts of the country. Have you engaged with Government on the matter?

Dr Baijal: Absolutely. We have a good engagement with our colleagues in Government and NHS Health Scotland. The committee can take it as read that everyone has a good appreciation of the issues.

We know the other measures and indices that are coming into play. We also know that they are not the complete answer. We would like to see those measures being used more routinely in data analysis. That is happening, but we are still left with the problem that my colleague described of identifying the disadvantaged and hard to reach in small communities. In our geographic area, postcode areas are very large, therefore there is a lot of heterogeneity and identification is a challenge. Identification is easier in our urban areas, because the SIMD is more appropriate to places such as Inverness. In urban settlements, such measures make it clear where the areas that we need to target are. Doing that in the more remote areas is more challenging; examining the communities that are of interest is more challenging, too.

10:15

The Convener: But discussions are being held on how to remedy the situation and identify those pockets of deprivation.

Dr Baijal: Absolutely. We are working well together, as Pip Farman can ably explain. As far as research is concerned, the well north projects are moving us towards some of the answers.

The Convener: Is that the case, Ms Farman? You have been passed the ball.

Pip Farman (NHS Highland): The well north projects are funded projects that are allied to the keep well programme, but which recognise that, on anticipatory care, we might need to do things differently in remote and rural areas. Those programmes are still in progress, so we cannot report on the outcomes yet. Part of the process is about understanding how to identify vulnerable individuals and families. Once we know who they are and where they are, the secondary issue is how to target them and ensure that we reach them with services and appropriate interventions.

The Convener: Other members have been waiting, so I will let Mary Scanlon back in later.

Mary Scanlon: I just have a brief point to make.

The Convener: Okay. Richard Simpson has been extremely patient.

Mary Scanlon: If Governments recognise the issues around remote and rural funding, why is it that we did well under the Arbuthnott formula, but the new formula has resulted in a cut in NHS Highland's funding of £22 million a year?

Dr Baijal: I hesitate to comment in detail, because we know that the NRAC formula is extremely complicated. In fairness, Government has sought to implement the formula in a phased way so that there will be no disadvantage to the boards who appear to be losers under it. That was an attempt at objective description rather than a political statement. Alongside the NHS funding, we must set the funding that is being provided to local authorities and for the development of the third sector.

The Convener: Those are good questions, but it might be better to put them to the minister when we ask her about policy and political priorities.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am sure that we will return to the issue when we consider the budget. If only 16 per cent of income-deprived people in rural communities are being identified, whereas 35 per cent of income-deprived people in urban communities are being identified, it is clear that there is a disparity that the 2006 edition of the SIMD does not address.

My question is not that dissimilar; it is about targeting. Targets are set in almost all the screening programmes that have traditionally been run. Primary care has the target of an 80 per cent rate for screening for cervical cancer. The target for breast cancer screening is 80 per cent, and I am sure that it is the same for screening for colorectal cancer. That always leaves 20 per cent, who are clearly hard to reach, however we define that. My question for all of you is how do we identify those people? How do we target them and develop innovative services that can reach them? Have we done enough to identify such people?

Dr Baijal: A good specific example is measles, mumps and rubella, on which we in Highland have done detailed work with local primary care teams to identify specific families whose children have not been immunised. Through community nursing, those families have been encouraged to take up immunisation. Such work, which is very much about working with local primary care teams, must be done at a detailed micro level.

The advantage of that work, and of similar work that we have done on cervical screening, is that we have relatively good information systems. However, with some of the other interventions that we wish to pursue, the information systems are not as good. We know that practices have disease registers and we know what interventions have been done, but we cannot always marry up the interventions with the individuals or families on the disease register. At the moment, targeting such people often comes down to local knowledge.

The Convener: I know that this is difficult for members and witnesses, and I know that general funding issues arise, but I want us to keep our focus on cardiovascular issues—whether we talk about early interventions at school or about later interventions at age 40. It is difficult for me, too.

Alex Mackenzie (North Glasgow Community Health and Care Partnership): In north Glasgow, where I manage services, we are one of the first-phase keep well projects and we focus on cardiovascular disease. Our experience in a number of sites in Glasgow is that, over a period of three or four years, 95 per cent of our population engages with primary care. The hard-to-reach population is not as large as some may think. People attend primary care, so our task is to use that episodic engagement to do more than we do at present—although there are a number of time and resource constraints. Furthermore, even if people are not in contact with primary care services, they may well be in contact with social care services or with our community addiction teams. We make contact with people who are difficult to contact, and our task is to use the opportunity to do more.

The Convener: How?

Alex Mackenzie: There would be a number of strands in a response to that question. We have to create space and time within our engagement to deal with more than what individuals present with. In our keep well experience, we have invested in additional capacity in primary care practice—be that additional general practitioner time or additional nursing capacity assisting in the practice. For example, we can have an initial half-hour engagement with the individual when they come in the door, and we can use that time to explore their health and wellbeing, their circumstances, their level of literacy, any addictions, smoking cessation, and a raft of other issues. Obviously, that has time and resource implications.

There are cultural implications, too. In our experience, our workforce deals with the presenting issue, but we have to be broader than that. We must realise that we have an opportunity, when people engage, to address wider health determinants. The answer to your question, convener, includes training, culture and resources.

The Convener: Thank you—that was very helpful.

Ian Murray: Mr Mackenzie has covered an angle that I was going to cover. Local authorities can back up NHS colleagues in building up the confidence of communities and in building capacity. Many people who do not take up services do not do so because they have low ability in literacy. Councils' work in adult basic education, and their work in English language issues with immigrants, are beginning to have an effect.

Dr Baijal: I am probably reiterating what is in all our minds. General interventions to do with inequalities will pay off and have an impact on cardiovascular disease. As has been suggested, improving people's literacy will help them to access services.

A specific example that we are pursuing is the five-minute MOT among disadvantaged populations. As most of you know, that involves a series of quick checks with individuals—on cardiovascular disease, cholesterol, blood pressure, physical fitness and body mass index. From those checks, people can be signposted to appropriate services. We are doing such checks with people who are engaged with community mental health services, with prisoners, and with other disadvantaged and hard-to-reach communities.

Susan Russel: We work towards targets, and local knowledge is required to reach the hard-to-reach people. I do not think that the current targets incentivise anyone to try to find those people. We may need to consider how that can be done. It has to be the primary care teams that identify the hard-to-reach individuals.

Sue Laughlin (NHS Greater Glasgow and Clyde): The committee has tapped into a very important issue, on which we have all chosen to comment. I want to emphasise what my colleague Alex Mackenzie said about the need to improve engagement between clients and health service and local authority professionals. We sometimes completely underestimate the importance of the quality of that engagement to involving people in taking additional responsibility for their own health. If they do not understand about physiology or how their bodies work; if we do not present them with information and advice in a way that they can use; if English is not their first language; if we do not empathise, acknowledge and validate their experiences of poverty; or if we make assumptions about them—that is as important for heart disease as it is for any other issue—we are not going to be able to involve people in the sorts of activities that you are asking of us as efficiently and effectively as we might do. Sometimes we neglect those things and have to continue to remind ourselves of them, and be monitored on the extent to which we are striving to improve the transaction between the professional and the client.

Pip Farman: I support those feelings. We are moving towards more inequality-sensitive practice, which means redesigning services so that they meet the needs of communities and individuals. It is not just about identifying those varying needs, but about making sure also that the services that we provide meet them. Benefits advice might be as important for meeting people's needs as an exercise programme in the community, and we need to understand the matter from the perspective of individuals and households.

Dr Simpson: As I have indicated to the committee before, Professor Barber, a professor of general practice in Glasgow, and I did a study on blood pressure in the late 70s across six different practices in different settings, from rural to urban. We checked 70 per cent of the population over three years and the results were even across all the practices. However, we were only screening for blood pressure; it was not the validation that Sue Laughlin is talking about.

You have focused on primary care and the fact that people come into primary care and trust their primary care centres on the whole, but you are bringing in something called "Health for All Children 4". There has been a lot of criticism of that, and I know that it has been temporarily suspended. Does that apply in the areas that you cover? The press reports show that Hall 4 appears to be breaking the link between the primary care unit and health visiting and replacing it with a more geographically based link that is closer to social work. There is a lot of anxiety about that. I know that that is a separate issue from the review of nursing in the community, but in terms of identifying individuals and forming the network links that you have emphasised are important, I have some serious concerns about RNIC and Hall 4.

Alex Mackenzie: There are two or three issues there to respond to. Work is being done around the implementation of Hall 4 and its philosophy of focusing resources on the children of families that are in the greatest need. We would all support that.

Work is also being done in the area of Glasgow in which I work to develop a better network of services within which health visitors can operate. That flows two ways. First, they need to be seen and to continue to be integral to the primary care team. Secondly, when they are dealing with children—I emphasise that I am talking about the area in which I work—who live in chaotic households where there are addiction or mental health problems, it is important that our response is for the family and the child within the family, so, the relationship between the health visitor and social worker or community mental health team is equally important.

The task for us in the work that we are doing in Glasgow to implement our health visiting review, in Hall 4, and in our relationship with our social work colleagues, is to create that network so that we strengthen the primary care team at the same time as we reinforce the need for a multi-agency and multidisciplinary response to families in need, and focus our resource on families in the greatest need. It is a difficult balancing act, but we are trying to reconcile those different pressures in a solution to our health visiting review.

10:30

The Convener: On sharing information, are there data-protection issues for professionals, and do they inhibit the process?

Alex Mackenzie: We need to be sensitive to data protection. In the past, we have used it as an excuse not to share information, but it is a matter of working through the detail. There are examples of data being shared among joint teams. There are joint addiction teams in Glasgow, among which information is shared. We have a process and we have experience. We need to build on and use that experience when we create wider networks of teams—while using information sensitively.

The Convener: On cross-partnership working, how do people react if they approach social work and somebody tries to refer them or suggests that they should be doing something about their health? Do you have any examples of that? Do people react badly, or are they pleased when other things are picked up on? Does that situation arise?

Sue Laughlin: We have done some work on what has been described as inequality-sensitive practice. We have tried to use the engagement of the client with the professional to explore the contexts of some of the health problems that are presenting, so that we can get underneath them and work out some of the causes, rather than just deal with the symptoms, and so that we can ascertain how they might affect management of the health problem. We have evaluated that in some specific settings. In all of them, we found that clients or patients welcome the opportunity to have issues explored with them.

The Convener: I just wanted to hear that said.

Susan Russel: The issue of sharing information is addressed fairly well in local authority and NHS circles. We have information-sharing protocols and, in relation to health visiting, all clients are advised that their information can be shared, although they are asked for permission for that.

The Convener: I just wanted to get those two issues discussed on the record. I call Jamie Stone, to be followed by Rhoda Grant.

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): Thank you very much, convener. It is nice to join you today, albeit briefly, in Ross Finnie's absence.

The Convener: The delight is shared.

Jamie Stone: I thank you for that. My question is on a rather different tack, and arises from the first main paragraph of Highland Council's submission, which refers to

> "play, physical activity and healthy eating".

This is perhaps for my old friend and former colleague, Ian Murray, although others may wish to comment. Headteachers from my constituency are telling me that home economics is financially tight. The training involved and the preparation of healthy food is crucial when it comes to early intervention in respect of cardiovascular disease. I should pay tribute at this point to farmers in Caithness, who have given some food gratis to Wick high school. Not a day goes by when I do not mention Wick high school here.

The Convener: That was your press release, Jamie; move on.

Jamie Stone: No, my press release is this—

The Convener: No it is not.

Jamie Stone: What discussions have Highland Council and—possibly—the Convention of Scottish Local Authorities had with the Scottish Government about funding of home economics? Ring fencing might apply to that revenue stream, or it might not. I would be interested to hear about it.

Ian Murray: We have not had discussions specifically on that. We are conscious of the provisions of the Schools (Health Promotion and Nutrition) (Scotland) Act 2007, and we are well on the way to meeting those provisions. That mostly relates to our school meals service, and we have been making big strides forward with it. The good thing about the curriculum for excellence, which is currently being rolled out, is that it makes some great links between subjects. It will not just be the home economics sections that will deal with the need for good nutrition; it will be dealt with across the board. The answer to the question is that we have not had specific discussions on the matter, but we are very much aware of it, and it is always in the balance as we juggle our finances.

Jamie Stone: I pay tribute to what is being done with school meals in the Highlands. All Highland members have noticed it. In particular, the provision of fruit and vegetables is very good. Do I take it that you or the Convention of Scottish Local Authorities might in the future consider developing discussions on that front with the Scottish Government?

Ian Murray: We can certainly explore that, although we have not had specific plans to do so. The matter is in the balance with all our other financial difficulties.

Jamie Stone: That will do me. Thank you.

Rhoda Grant (Highlands and Islands) (Lab): My question is about getting services to people in remote rural areas. We have talked about the difficulty in identifying people who are at risk in those areas, but most people in remote rural areas will have difficulty in accessing services. We spoke last week about the importance of access to gyms and other facilities to promote healthy living. We also spoke about the need for specialist nurses. It is clear that, although there is a willingness to get out to the more remote rural areas and provide a service there, it would be difficult to do so if there was only one specialist nurse for, say, the Highland area. It would be easier for that nurse to be based in Inverness and see a throughput of people than for the nurse to go to Skye to see one person, which would take a whole day. Although there is willingness to take services out to remote rural areas, in practice the inequalities are pronounced because it is not possible with current resources to reach the people who need the services in those areas.

Dr Baijal: Without wishing in any way to disagree with my learned professional colleague, Dr Simpson, I think that the review of nursing in the community is one of the interventions that will help with that. I understand that learning from specialist nurses will be cascaded to teams with generic skills, so that they will have a skill set that is appropriate to the population that they are dealing with. They should be able to provide practical services—certainly, in terms of cardiovascular disease, which we are discussing this morning—in remote communities. They will ensure that people have their blood pressure checked or even check it themselves. There is also an issue about how much the voluntary sector can play into that kind of work. It is about teams having the skills that are appropriate to the population that is being served. You have, rightly, identified the challenges in the efficiency of centralisation and the overheads that are associated with provision of an easily accessible service in remote areas.

Susan Russel: Mid-Highland is a fairly large area to cover and, in a lot of services, we are trying to ensure that the generic primary care teams in local areas develop the skills that they require to deliver specialist services and are able to refer back to a specialist nurse if they come across a particular issue. We have been working with the Lothian NHS Board heart manual and have facilitators who run a programme whereby people who have had a cardiac incident can go through a set of assessments and post-incident rehabilitation. We have trained nurses throughout our area to take that forward. One of the issues with the heart-failure nurses is that we need to embed the skills that they have within our generic teams. That is something that we will be working on.

Rhoda Grant: That sounds really good. I am glad that that is happening. How practical is it, though? There could be one nurse in a given area who is expected to be an expert on everything from early-years care to geriatrics, with a specialism in cardiovascular issues and probably diabetes. You are talking about a range of things. I guess what I am saying is that I like the theory, but is it practical or possible to have all that information crammed into one head?

Susan Russel: Perhaps it could not be crammed into one head. Our staff are in teams, and although they may cover large geographical areas, they work as a team. Within the team, specialist skills are identified that they may want to develop to meet the needs of the population—for example, palliative care skills, expertise in children and families or parenting skills. Some of our staff are developing interests in cardiac nursing.

I am not saying that the system is perfect. One of the problems is that the specialist skills are sometimes seen as an add-on to the core work and, when staffing is short or when other incidents occur, that is the work that falls off. We need to embed it completely within the team. Even when our local staff have those skills, we need to ensure that they are delivering the service in a way that addresses the inequalities agenda. They must identify those who are most at risk and those who would perhaps not come to the surgery for a service but who may go to another area or be seen at home.

Rhoda Grant: I see how the arrangement works, but a great deal of travelling is involved. Even if you take in people from a large physical area, you will not have the same throughput or see the same number of patients as staff in an urban area would. You will still struggle with the rurality issue.

Susan Russel: Our team struggles because of rurality anyway. The majority of our staff in more remote areas, such as Wester Ross, Skye and south Lochaber, must travel to visit patients—that is just a way of life. It may not be as cost effective as having people come to a centre, but it delivers the service. Staff may see fewer people, but we hope that they have the required skills.

Dr Baijal: The committee will be aware that the Highland NHS Board area is a pilot site for the review of nursing in the community. The action research that is linked to the pilot will provide insights and guide our approach to the issues that Susan Russel has described. Remoteness has driven our development of the use of telehealth and telecare, which is still in its infancy but will provide a way into monitoring and assessment of cardiovascular risk factors.

The Convener: Borders NHS Board is also a pilot area for the review. I have been told that one reason for the review is the change in demographics in some rural areas, where a staffing shift towards the elderly population is required. Is that an issue up north?

Susan Russel: I am involved with one pilot site in Highland. The shift in emphasis is not from one end of the age spectrum to the other but towards considering the health needs of the population as a whole and taking the public health agenda forward as an entire team, so that public health is not limited to health visitors but is seen as part of everyone's role.

Helen Eadie (Dunfermline East) (Lab): Can you share with us some examples of successful anticipatory care programmes? Are there barriers to rolling out such initiatives nationally?

Dr Baijal: We have a project in Nairn to identify patients who are at risk of multiple readmission factors. It is not focused specifically on cardiovascular disease, but heart failure is a large component of it. The project has demonstrated that such identification can significantly reduce patients' length of stay in hospital, at the very least.

Pip Farman: We are not in a position to give members evidence on the outcomes of the well north projects, which are anticipatory care programmes. Six projects are operating in the north of Scotland. We hope that they will generate evidence that will allow shared learning and understanding of how to implement anticipatory care effectively. Issues such as economies of scale, on which we have already touched, are likely to be a barrier to implementation. We have spoken about the priority that people attach to anticipatory care and the equally well agenda, as against other targets.

Another issue is how we join up with existing schemes. As we have heard, there are many schemes that target relatively small communities. It is important that services understand how to bring those together for the benefit of the whole community, instead of looking at issues in isolation.

Ian Murray: Dr Simpson asked how we can reach people who do not normally engage with services. There are a number of health initiatives rooted in and run by the community that tend to reach parts and people whom statutory agencies may not reach. For example, three healthy living centres are running in the Highland Council area and I think that there are 36 or 40 such centres in Scotland, all of which bring benefits. It is unfortunate that the funding stream for the centres will come to an end in April. All 36 centres are scrabbling around to try to find sustainable funding.

10:45

Dr Simpson: I think that the Government put in extra money for six months, to give them the opportunity to consider their sustainability. Some of that funding will come to an end at the end of October, and funding for 18 centres will end at the end of March. It is a big issue.

The Convener: Ms Farman, when will you carry out an assessment of the well north programme? Will that happen two years down the line?

Pip Farman: Yes. The implementation period is 2008 to 2010.

Helen Eadie: The committee issued a call for evidence and our questions have steered witnesses in a particular direction, but are there other issues that we should be asking about?

The Convener: I hope that witnesses will stick to our remit and talk about cardiovascular disease.

Dr Baijal: The current target on coronary heart disease is a sentinel marker for a range of underlying issues. We know that the high-impact interventions for health in general are to do with management of blood lipids, hypertension and body weight. Such interventions have a spin-off in the context of an holistic view of health and people's health experience, so it is difficult to disentangle the holism of health and the specific subset of cardiovascular disease.

However, I acknowledge the importance of treating cardiovascular disease as a separate entity. Perhaps an unrelated concern is that we should not have yet another raft of targets around cardiovascular disease that are difficult to measure.

Michael Matheson (Falkirk West) (SNP): In its submission, NHS Greater Glasgow and Clyde said:

> "work is good for your health".

That is a bold statement—I suspect that it depends what work a person does. However, I take the point.

I am interested in the attempt to anticipate which individuals will present with health problems in future, given their current lifestyle, in particular through the workforce plus initiative. I noted that, in the two years since the programme was established, there has been a 15 per cent reduction in the number of people claiming incapacity benefit. There have also been reductions in the number of people in receipt of jobseekers allowance and in the number of lone parents in receipt of income support. Given that the scheme is predicated on the notion that work is good for us and that its purpose is to try to get people into employment, I presume that the figures represent individuals who have taken up employment, rather than people who have moved on to claim other benefits. Is that correct?

Sue Laughlin: I do not know whether that applies to all the people who are represented in the 15 per cent reduction. The paragraph in our submission tries to summarise an approach whereby we acknowledge the barriers to working that poor health puts in place and we work more actively to help people to find appropriate work and to prepare people for work, if their applying without support might militate against their getting the job.

Michael Matheson: Can you say for sure that all the reduction in the number of benefit claimants is directly attributable to people entering employment?

Sue Laughlin: A number of the people in that 15 per cent have gone directly into employment. I cannot tell you exactly how many, but I know from my colleagues that a good proportion of the people with whom they have been working in that field have been able to acquire employment because of the support that they have received.

Alex Mackenzie: Sue Laughlin is right about the numbers, but a significant part of our agenda is the maximisation of income for individuals and there is another side to that—for example, there is a reference to income support in the NHS Greater Glasgow and Clyde submission. Part of our work on anticipatory care, for example, has been to maximise income and there are other strands of activity to ensure that people maximise their benefits.

Dr Baijal: In the north of Scotland, we are running a similar programme to the one in Glasgow: the condition management programme, which is a partnership arrangement with Jobcentre Plus and others. I cannot give you the exact figures, but we have had considerable success in moving people who are on incapacity benefit, who might therefore be regarded as the most challenging cases, back to work.

That is underpinned by the strong body of research evidence to suggest that work—organised work, to be more specific—is good for you. Once people are in work, we seek to sustain them in work, in part by ensuring that they are healthy through the healthy working lives initiative and OHSxtra—occupational health and safety extra.

The Convener: Perhaps you could provide that data to the committee as supplementary written evidence.

Michael Matheson: How long is the workforce plus programme in Glasgow intended to go on for? At what point will it report on its outcomes?

Alex Mackenzie: I cannot answer that.

Sue Laughlin: I cannot answer that either.

Michael Matheson: I would be grateful if you could get that information to us, given that you have referred to it in your evidence.

I will move on to your evidence about protective factors, and the parenting strategy, which sounds positive. Can you give us a bit more detail on what the parenting strategy involves? What was the catalyst for that? I confess that I was surprised to see that such a strategy had not been in place before, but it appears from your evidence to be a fairly recent development.

Alex Mackenzie: The parenting strategy brings together for the first time a raft of activities that were supporting vulnerable families, and particularly mothers, in Glasgow. The new single strategy focuses on supporting those families in relation to healthy eating and diet, general welfare and income maximisation. It is not an NHS strategy but one that we deliver through our community partnerships. It sits behind the single outcome agreement as a joint strand of activity to support vulnerable families in Glasgow, and it acknowledges the priority that the community planning partnership has given to focusing resources on activities that are targeted towards children and the early years.

Michael Matheson: How do you target individuals who might benefit from those services?

Alex Mackenzie: Based on our analysis of the needs of Glasgow's population, we have identified—going back to the Hall 4 analysis—children who need additional support. We also have an analysis of children and families who are known to our social work colleagues and we have intelligence from our health visitors. We have a number of sources of documentation and analysis that identify vulnerable families in Glasgow, hence the focus of our attention and resources on that analysis.

The Convener: Ian McKee has been very patient.

Ian McKee (Lothians) (SNP): Thank you. I will ask one question on rural areas and one on urban areas. With regard to rural areas, the NHS Highland submission mentions access to services. Dr Baijal talked about telemedicine being in its infancy, but I was involved in a telehealth project more than 30 years ago, which is almost a professional lifetime. Given that there is a very good chance of telehealth services vastly improving the quality of advice and care that can be given to people in remote communities, I wonder why it is still regarded as being in its infancy.

There are some people in rural areas who need to go to hospital, sometimes reasonably urgently. However, I know from evidence that I have seen before that the co-ordination between hospital out-patient departments and patient transport systems is fairly appalling, resulting sometimes in patients not being able to keep their appointments. Sometimes, in remote areas, helicopter access is required. However, I know of an impoverished rural community that is having to raise the money—between £6,000 and £8,000—for helicopter landing lights, so that a helicopter can land in the hours of darkness, which there are a lot of in the winter.

My point is that, in practical terms, there are simple things that could be done before the more abstruse things, but they are not being done. Do you agree? Once you have answered that, I will ask my urban question.

Dr Baijal: For some time, we have been taking steps to address the practical issues. We understand that there is no sense in having an out-patient appointment at Raigmore hospital first thing in the morning for someone who has to travel a long way to get there. There is an increasing drive to deal with those practical issues because of the referral-to-treatment target of 18 weeks; we cannot afford to have people not managing to make out-patient appointments.

It is fair to say that we have made considerable progress in collaboration with the Scottish Ambulance Service, and we will continue to do so. We recognise the issues that you are raising. It is good that those issues are recognised at a political level, so that they can be given some priority. The issue relates to the wider agenda of transport infrastructure across the north, and I am sure that members of the committee are aware of the strategies that are in place to deal with that. Again, that will help to resolve the challenges.

On telemedicine, perhaps "infancy" was an unfortunate choice of word. However, I perceive there to be a considerable need for development of that type of service delivery. A number of good-quality pilot projects are in place across the north of Scotland, but the very formation of the Scottish Centre for Telehealth indicates the need for further work to be done to take those initiatives forward. We have not transformed what we know into a widespread service that will provide coverage to all remote areas. Again, there are issues outwith the health service that impact on our ability to deliver. I am sure that members of the committee are well aware of simple issues such as the bandwidth that British Telecom is able to provide us with and the cost of upgrading that.

Ian McKee: On the issue of getting patients to hospital, I think that ensuring that there is liaison between the hospital and the hospital's car service would be a simple matter that would be much more useful than requiring the patient to contact the car service.

Moving on to my urban question, we know that the incidence of cardiovascular disease is higher in poorer communities but that the take-up of treatment in those communities is lower. The submission from NHS Greater Glasgow and Clyde talks about establishing

> "Public Patient Forums … which facilitate involvement from and dialogue with people from deprived areas".

I wonder how that would help. My experience is that no one knows who is on their public patient forum, which means that they do not have any dialogue with them.

The submission also says:

> "Direct access hubs being planned to ensure that people in disadvantaged areas can access health and social care service more easily".

Are those the plans for helping people in deprived areas to get the services that they need, or could more be done to ensure that people who are ill receive the necessary treatments, in addition to providing anticipatory care and encouraging the lifestyle changes that we know will help in the long run?

11:00

Alex Mackenzie: Access and transport issues exist in urban areas as well; they are just different. In north Glasgow, where I manage, we have 12 data zones, and there can be 10 times as much deprivation in our most deprived areas as there is in our most affluent areas. People will not travel in some of those areas because of gang culture and other barriers, so access is a significant issue. Part of the solution to the difficult task that you have set for us is to make services accessible and close to individuals.

We have identified that we need at least three major access points to respond to the needs of the population in north Glasgow. Even with those, we will need to develop outreach arrangements. Our anticipatory care model is about encouraging people to come in through a number of mechanisms—by phone, by writing to people and by using opportunistic engagement. It is also about going and chapping on people's doors, engaging with people. It is about being proactive in delivering care to individuals by going to their houses to do that.

There is no simple answer to your difficult question. There is a raft of activities that need to be laid on top of one another. It is about access and focusing our resource. Our work on health visiting in Glasgow, to which we referred earlier, is about focusing our health visiting resource on our most deprived areas. Our resource allocation model does that. It is about getting resource into deprived areas and promoting access for individuals and a raft of other strands of activity that we hope will add up to an improvement in access—[*Interruption.*]

The Convener: I am the only one who could not find their mobile phone. I thought that I had left it at home. I apologise for the depths of a woman's handbag, which know no end. Sorry, Mr Mackenzie.

Alex Mackenzie: I have covered everything that I wanted to say. I will hand over to Sue Laughlin.

Sue Laughlin: Issues of access are significant. Physical access is obviously important—the proximity of services to people is vital, especially if people feel uncertain and reluctant about using those services. I agree that the issues in urban areas are completely different from those in rural areas.

People will access services if they feel comfortable about accessing them and if they feel that they will get a good service when they get there. Their judgment is based on the experiences that they have when they access services. As Alex Mackenzie pointed out earlier, 95 per cent of the population will access primary care services over a relatively short time. When they get there, how we communicate with them is part of that access. How we help them to understand their health problems is part of that access, and how we then support them to move on into acute services is also part of that access. So, it is not just about getting people to services; it is about the quality of the interaction that we have with them when they get there.

Although we must consider how we can provide more resources in poor areas—that is part of the equity challenge—we must also ensure that, when we provide those services, we do not just provide services that were not previously fit for purpose. The services must take into account people's lives and experiences, and they must engage with them in a more meaningful way. The access issue is vital, but we must extend it beyond a simple understanding of physical access.

Ian McKee: Do you have evidence that you are making progress in the field? I am thinking of services for people who have physical signs and symptoms of cardiovascular disorder taking up the interventions that are available. Do you have evidence that more interventions are now being taken up, following the efforts that you are making, or are we standing still or even getting worse?

Alex Mackenzie: Our experience of the anticipatory care model is similar to that of NHS Highland. We can demonstrate that we are engaging with people, because people are coming through the door as a result of our efforts, but the outcome of that engagement is unknown as yet. Our projects have been going on for two or three years and evaluation will take time. Only seven or eight years down the line will we have evidence on whether we made an impact on people's lives and wellbeing. However, we are seeing more people.

Ian McKee: Do you mean that you are seeing more people with signs and symptoms of physical illness or more people who have raised cholesterol levels, raised blood pressure and so on? Are you doing more cardiovascular procedures such as heart bypass and angioplasty? I am talking about the physical interventions that make people better, which can be measured fairly quickly.

Alex Mackenzie: I have no evidence on that. We have not found unseen disease through the anticipatory care model; the approach enables us to see people earlier and to address issues to do with smoking cessation and alcohol use, as part of a preventive agenda. The focus of our activity has been to move that agenda upstream, to try to prevent disease.

Ian McKee: I was asking about treatment of people who have a disease.

Alex Mackenzie: I understand that. I am sorry; I cannot answer your question.

Dr Simpson: We have been discussing primary prevention and identification of lifestyle issues, but Dr McKee was talking about people who have been identified as needing treatment. The committee has learned that there is strong evidence that fewer procedures are done for, with or to people from deprived communities. Dr McKee was making the point that the incidence of such procedures is an outcome measure that could be provided quickly. How are you addressing the issue?

No one has mentioned ethnicity—

The Convener: I was going to ask about that.

Dr Simpson: I will let you do so.

The Convener: I noticed that, in its submission, NHS Greater Glasgow and Clyde mentioned its recent work on

> "our Communication Support and Language plan and its implication for people … for whom English is not their first spoken language."

Language is only part of the issue; culture is another part. Perhaps after Mr Mackenzie has dealt with the question about interventions Ms Laughlin will talk about how the board engages with hard-to-reach cultural groups. I understand that there is a high prevalence of cardiovascular disease and diabetes in some groups.

Sue Laughlin: I am not sure what the question was. Were you asking about the communication support and language plan?

The Convener: Does the plan come into operation only when people access a service?

Sue Laughlin: The purpose of the communication support and language plan is specifically to improve the quality of engagement after people have accessed our services.

The Convener: Right, so my question is about something different. Do you have a plan to reach other cultural groups? How do you get in touch with hard-to-reach groups?

Alex Mackenzie: I will give a couple of examples that might help. Members will be aware that there are 4,500 to 5,000 asylum seekers in Glasgow at any given time. Across the city we have a network of asylum-seeker assisting practices, which are resourced to respond to the needs of asylum seekers in the locality. In doing that, we are supported by an interpreting service, which is delivered jointly with Glasgow City Council and assists with language and access issues. As part of the asylum process, we deliver a comprehensive health assessment, so we have a raft of responses to meet the needs of the asylum-seeker population. That is an example of a strand of activity.

In south-east Glasgow, where there is a significant Roma population, we have put additional resource into primary care and social work, to respond to need in that patch. Of course, the response depends on the issue, but those two examples perhaps show how we resource specific services to respond to the needs of populations.

Sue Laughlin: The collection of routine data on ethnicity is an on-going problem for all health boards. We have to admit that we have not yet met the challenge—nor has there been the impetus nationally for us to do so. However, from the data that we have, it appears that uptake of services by people from black and ethnic minority communities is not necessarily lower than uptake by other communities. If people are using our services, we must ask whether they are getting what they need, taking into account issues of language and culture. As I said, it is about the nature of the practice and how we communicate with people.

We are fairly confident that by improving our ability to communicate with people, by developing and implementing our communication support and language plan and by bringing in additional resources for translation and interpretation, for example—last year, we increased the resource for such services by 30 per cent to £1.5 million—we will be able to secure better outcomes for those communities. The problem is less about those people being hard to reach and more about our not engaging satisfactorily with them when we reach them.

The Convener: Will you explain what you meant by

“nor has there been the impetus nationally”?

Sue Laughlin: There has been an expectation that we should improve our ability to collect disaggregated data for different inequality groups, but we do not routinely do that, in particular in relation to black and ethnic minorities and disabled people. The collection of disaggregated data requires considerable additional resource, planning and staff training, and we have not found it easy to implement the approach.

The Convener: It might be useful to put that point to the minister.

Ian McKee: We did not get an answer to the question about measuring interventions.

The Convener: I was coming back to that.

Dr Simpson: If witnesses want to add anything on that—I do not want to ask you to write to us—

The Convener: We got to the issue late in the day. I think that Ian McKee’s point was about uptake after people have been diagnosed—

Dr Simpson: The question was about uptake of secondary procedures and interventions.

Alex Mackenzie: I can provide information on that, if that is okay with the committee.

The Convener: Thank you. We have had a good session and I thank the witnesses. We will have a short break before we question the next panel of witnesses.

11:12

Meeting suspended.

11:20

On resuming—

The Convener: Our second panel of witnesses represents NHS Health Scotland. I welcome Mary Allison, head of the better health team; Cath Denholm, director of equalities and planning; and John Howie, health improvement programme manager. I noticed that you sat through the previous evidence-taking session. I hope that you found it useful. I see that there are some new people in the public gallery. I remind them to ensure that their mobile phones and BlackBerrys are switched off, as some people—naming no names—can be caught unawares. I invite members to question the witnesses.

Mary Scanlon: In the previous evidence-taking session, the point was made that, according to the SIMD, in remote and rural areas, especially Highland, 16 per cent of income-deprived individuals are identified, whereas the figure for Scotland is 36 per cent. Is the index, which is only about two years old, being reviewed? Are you aware of the issue that has been highlighted? Are you addressing it, given that the index is at the heart of funding to address inequalities?

Mary Allison (NHS Health Scotland): We are aware of the issue, which is concerning. In our written evidence, we acknowledge that in some areas there is no substitute for local intelligence and knowledge. To develop better national systems, we are actively engaged with Government in examining alternatives that can be applied to health improvement, in particular. In the keep well pilots that we are working on, there has been discussion of the poor sophistication of the SIMD when it comes to targeting in rural areas. John Howie can say more about that.

John Howie (NHS Health Scotland): The national criteria for keep well used SIMD data, focusing on the most deprived 15 per cent of communities. The index works well in densely populated urban settings, but it does not lend itself so well to rural settings. As my colleague Mary Allison mentioned, we are examining alternative means, especially local intelligence, to inform the targeting of communities in rural and suburban areas. In Fife, SIMD data were used to identify keep well target populations. In some practices, only one or two individuals were identified, but local intelligence suggested that other families could be targeted, based on their levels of need.

Mary Scanlon: What do you mean by local intelligence? I may be exaggerating, but are you expecting others in the population to report that a family living in the area needs help?

John Howie: When local intelligence is used, it is important to have a degree of standardisation. We cannot operate under a free arrangement that allows people to apply their own markers of need; we must develop a standardised methodology. There is a need to use local intelligence, but we must agree on the markers that will be used to identify families who should be targeted. Colleagues who are involved in the programme will advise us on the best method of applying local intelligence.

Mary Scanlon: Who would be doing the identifying?

Mary Allison: By "local intelligence" we mean a lot of information and data that are held locally by different bits of the public sector. It is not the local population per se but local professionals working in front-line services who will have regular contact with a range of families for a range of reasons. It is important to feed their data and intelligence into the process, while bearing in mind the challenges that that brings, including issues around confidentiality and the transfer of data. It is local, front-line intelligence about the distribution of resources that is being shared.

Mary Scanlon: So we have a national index that identifies 16 per cent of people who are in poverty, and the funding follows that. However, if it identifies only 16 per cent of people, it is unlikely that the funding will be sufficient to address the inequalities. Against that background, various organisations with local intelligence know perfectly well about, say, 90 per cent of the people who are in need, yet their information is not being used, and it is being superseded by a national index that does not do the job. Why has that been allowed to happen?

John Howie: The national index is among a whole range of things that have been tested under the keep well programme and the wider anticipatory care agenda. The question has been asked whether the SIMD works as an effective targeting mechanism. The mechanism that we have employed has identified about 120,000 people across all the keep well programme areas. That is a significantly large population for testing a range of interventions, from identifying the target population through to delivering local services that meet people's needs. There are early lessons to learn with respect to identification, and we are actively considering other means of targeting. Reviewing the use of the SIMD is part of that.

Mary Scanlon: Would it be better to scrap the SIMD and use intelligent, empirical and factual poverty and deprivation figures? Why not scrap the index and use the information that you have, which has been substantiated to a greater degree?

John Howie: At this stage, we cannot make judgments based on empirical evidence. We suggest that the SIMD is currently the best mechanism for identifying target populations. However, active consideration is being given to alternatives and to identifying other people who are not caught up in the SIMD. Such considerations form part of the learning that we have identified under the programme.

The Convener: I understand that to mean that you favour the SIMD, but with an add-on of supplementary, localised, pocketed information.

John Howie: We are required to consider that. As part of the programme, we must consider additional mechanisms to ensure that the people whose needs are greatest are effectively targeted at a strategic level.

Rhoda Grant: I take on board what you are saying about local knowledge and using people on the ground, which is preferable. However, how do you factor in the group of people about whom we have heard so much—the 20 to 30 per cent of hard-to-reach people? They will not be known to people on the ground, precisely because they are hard to reach. They do not walk in the door to seek help. In a way, they are the most difficult group, and they could have the most problems through not receiving resources and help. In rural areas, where the recognised equations govern whom to target, there will still be a big gap—even with the use of local knowledge—in relation to the factors that apply to urban populations.

Mary Allison: John Howie will be able to say something specifically about the work that is carried out under the keep well programme. As has already been mentioned, 95 per cent of the population will be in touch with primary care each year. As people come to primary care, we can use that as a gateway to provide other services that will be critical in supporting them to improve their health, although those services will not necessarily be delivered through a primary care route. We know that the patient record is one of the most important vehicles for identifying relevant groups, and it has been a vital part of the keep well process.

11:30

John Howie: In terms of wave 1 engagement figures, the target population is approximately 82,000 and about 40 per cent of those people have come through the door. If we asked any GP practice whether the people who attended for the health check matched up with the original list of those whom they thought would be the easiest to target, I suspect that the answer would be no. The project has thrown up a number of pleasant surprises. For example, individuals and families who do not normally engage have responded positively to the engagement mechanisms that keep well has employed. Our colleagues from Glasgow and well north have outlined those mechanisms, which include an encouraging letter, phone calls, home visits and the opportunistic health check, which is an invitation to people who are already in the primary care setting to come for a health check.

Rhoda Grant: My main question is about telemedicine and how we encourage people to use it. I was in Orkney recently, where all the GP surgeries are prepared to use telemedicine. Unfortunately, they use it to communicate only with the main hospital on Orkney, because the bigger hospitals on the mainland do not use telemedicine. Telemedicine saves some people a short ferry journey to the main island, but it does not save people big journeys, which might make them more fearful, because of the seriousness of their complaint. We need to get the people at the end of the line signed up, because the people who would benefit most are already signed up, but they cannot benefit without participation from everybody. How do we force—I was looking for a better word—them to take part?

John Howie: It is important that we work to a best-value and cost-efficient principle. Initially, the keep well areas will send a letter, because it is a cost-effective way of ensuring that people come along for their health check. Thereafter, there will be a phone call, and on top of that a home visit. The intensity of such engagement has cost implications, but there is a genuine desire to ensure that if somebody does not attend after the first attempt, a number of attempts will follow to ensure that they do engage. The process will take a considerable time for some people, but given that they are engaged with public services on an on-going basis, the real challenge is to ensure that we maximise that contact so that we can cross-refer between partner agencies to engage in other activities, such as the keep well health check.

The Convener: Are there no financial incentives for boards? Raigmore was mentioned.

Rhoda Grant: No, I do not think that there are. There are financial incentives for the boards with sparse populations, such as Orkney, to use telemedicine, because it means that they do not need to bring people from the islands to the main hospital. Those boards have a financial incentive, but the problem is that the other boards that they work with on more complex illnesses do not, because they do not pay for travel or see people's distress at having to travel long distances. The cost is not just financial; there is a big human cost. There is no financial incentive for the big boards to use telemedicine, because they are used to seeing people who do not have travel costs. We have to say to those boards, "You need to be able to do it."

Cath Denholm (NHS Health Scotland): What Rhoda Grant says touches on a broad and serious cultural issue for the health service, which is about entitling all patients to equal access to health services. It is clear that people in remote and rural areas are not getting the same access, but that is not universally understood by those who provide services. In providing their services, boards are not making the key principle of access a fundamental priority. Public sector duties are incumbent on health service organisations to ensure that people get equal access, but they have not been followed through or performance managed. One issue is that there are no targets, so people do not pay attention to the duties in the way that they do to some other issues. Rhoda Grant has identified a big cultural issue.

Rhoda Grant: So the answer would be to have a target.

Cath Denholm: There is considerable debate about whether a specific target on equality of access to services should be implemented in the health service or whether equality indicators should simply be built into other targets. However, without an equality of access target, it is unlikely that access will move up the agenda of health service providers.

The Convener: I am sorry, but I want to get back to telemedicine, which Dr McKee and others have often raised. Perhaps Dr McKee would like to come in on that. I think that telemedicine is still being treated as a fledgling or embryonic service, which surprises me. Given what you are saying, and what boards such as NHS Grampian have said, I presume that there are no financial incentives for boards to engage in telemedicine, other than the savings that Rhoda Grant mentioned. Is that correct? Is there no national way to develop telemedicine? Ian McKee was involved in such work 30 years ago. Do you want to ask about it, Ian?

Ian McKee: It would be inappropriate for me to give evidence on telemedicine, although I am tempted to do so.

The Convener: I am not asking you to give evidence. Perhaps you can ask better questions about it than I can.

Ian McKee: You have done very well.

I am continually frustrated by the lack of progress with telemedicine. To put things politely, a central impetus is needed to persuade people to take it on board, because people on either side of the telemedicine link need to co-operate, as Rhoda Grant rightly said. At the moment, people who work in larger institutions probably have so many other problems on their hands that telemedicine comes way down the pecking order, but it is vital to people at the far end. It is tragic that we have telemedicine facilities but are not using them. I am straining to ask the question—

The Convener: The question is embedded in what you said, Ian. Do the witnesses agree that there should be a central impetus to deliver telemedicine? We can also ask the minister about that. Telemedicine seems to have hit the buffers for a long time.

Mary Allison: It would be appropriate to make clear what our boundaries are. Treatment and care and deliveries for treating illnesses are not within our remit; NHS Health Scotland is the national health improvement agency. However, it is important to ask the minister that question, because we are still delivering health promotion through relatively traditional means. Information technology has huge potential to enhance what we do and to offer a wider range of services to a wider range of people, although we should bear in mind the fact that there will be pluses and minuses when it comes to inequalities. I certainly think that more impetus could be given to the modernisation of technology.

The Convener: We no doubt have a big underlined note to bring up that matter with the minister or cabinet secretary.

Dr Simpson: To be clear, are you saying that your focus is on primary prevention and not on secondary or tertiary prevention?

Mary Allison: The focus of our energies is largely on primary prevention, but a line cannot be drawn between those things.

John Howie: On our mechanism of targeting and following the patient pathway, we have identified a target population under the keep well logic model—I have mentioned the figure of 120,000 people. Individuals will come through the door and go down a primary prevention route. Those who have already been diagnosed will go down an optimal secondary prevention route. We will ensure that the whole range of needs is addressed through an enhanced health check process. However, as Mary Allison mentioned, the main focus is on a primary prevention model.

Dr Simpson: I asked a supplementary question; I will now ask the question that I wanted to ask.

On the second-last page of your submission, you state:

> "The reformation of primary care funding in recommendation 48 provides an opportunity to reward services who are sensitive in their targeting and witness a real shift in how we operate as public services."

You go on to talk about that approach being mainstreamed and suggest that an

> "SES is an effective starting point."

I presume that that is an enhanced service of some sort. Can you unpack that and say more about what enhanced services are working and about incentivising primary care as a whole? Can you also say what is not working and what should come in?

John Howie: I will focus my comments first on what the enhanced investment in primary care, through the keep well programme, has produced; then I will say where we are on mainstreaming.

Certainly, each community health partnership benefits from a significant investment in its keep well programme that means that it can set aside time for effective targeting and engagement, and invest in time to ensure that practice nurses spend between 30 and 50 minutes with an individual to go through a series of heart-health risk assessment checks and lifestyle and life circumstance checks. Each CHP also has investment that can be provided to other agencies in the NHS or outwith it to provide a number of services that will meet needs around healthy eating, physical activity and benefits checks. In turn, we get reports back from users about how highly they value the additional time and the quick access to services thereafter.

The next challenge, of course, is mainstreaming that within the current financial framework. The early discussions around mainstreaming have considered health improvement, efficiency, access and treatment—HEAT—targets as a possible mechanism. In addition, we have considered how local primary care services are rewarded for focusing on populations of greatest need. However, we are at an early stage in our discussions with the Scottish Government.

It is vital that we do not treat this as a one-off initiative or a small project, that we ensure a smooth transition from the programme, quickly learn the lessons that we have identified and translate that into an agreement between Government and local service delivery. We must not lose the skills and expertise that have been generated through the development of the keep well programme, well north and other anticipatory care programmes.

On timescales, we are working towards reporting a national evaluation for 2010. I would expect mainstreaming to be operating round about then.

Dr Simpson: What you say is fundamental. Dr McKee and I have lived through an era of pilot upon pilot. Individual GP practices have had good practice, but nobody has ever made it into a national scheme. Now there is a genuine attempt, started by the previous Government and continued by the current one, to introduce a national scheme.

Have you any indication at all of the global sums that will be required to deliver the scheme? Will you include in the forward budgeting what you importantly refer to on the last page of your submission, and to which Professor Watt referred in his evidence, which is

> "Redressing the balance of more GPs"

—I would say more primary care staff—in areas that you have identified as having a primary care population with high levels of deprivation? What work has been done on that and when can we expect to see the figures? They will impact on the

2011-12 budget, which I know is beyond the life of this Parliament, but we will have to discuss it in the prior year.

John Howie: The financial impact of mainstreaming a programme similar to keep well was identified early on. We are in the latter stages of a health economic study that the University of Glasgow has conducted. We hope to get a report on that later this calendar year. We must also consider the models that have been applied for the study. However, the study will help greatly and it will make judgments about mainstreaming costs.

We must be aware, though, that the costs of one health check compared with the costs of another and the cost of services that would follow on will vary greatly. For example, we can go from an individual with no signs and symptoms who will not need another check-up for five years, to one who has a range of different needs that require intensive investment.

11:45

Mary Allison: It is about not only the cost of the health check and its implications for primary care but the implications for a web of referral services in the community, where such services are ethically essential. To raise issues with people and not be able to refer them to support is a real challenge. We should not underestimate the amount of work that would need to be done to build capacity across the entire system, not only within primary care.

Dr Simpson: I presume that the health economic model will show at least some of the consequences of identifying early signs or issues that require secondary intervention or other approaches to lifestyle and behaviour, such as smoking cessation.

John Howie: Yes. It considers the entire impact of the intervention.

Dr Simpson: The holy grail will be Bevan's idea that health costs will ultimately reduce because everybody will be so healthy.

The Convener: Is that your prediction?

Dr Simpson: I doubt that it will happen. It is the one thing that he got wrong.

The Convener: Either it will happen or we will all live an awful lot longer and cause many more problems for the health service.

Ian McKee: NHS Health Scotland states in its submission that implementing recommendation 46 of "Equally Well"—the Government commitment to health checks for all at the age of 40—

"will require extremely sensitive targeting of resources to ensure that those 40 year olds at highest risk of CHD receive a range of 'protected' services".

That is obviously necessary if we are to reduce inequalities. If we introduce any new service globally, there is always a much greater take-up by the middle classes—for want of a better term—who benefit to a certain extent from it, while those most at risk do not take the service up so much. Consequently, health inequalities widen even though the total health of the population increases somewhat. If you are going to target resources, does that mean that you will not use so many on the other people you find who would benefit from the intervention? What exactly do you mean by targeting in this context?

Mary Allison: Part of what we are talking about is trying to have a conversation with all the parts of Government that would be involved in implementing that recommendation to illustrate the implications of introducing comprehensive health checks without adequate consideration of the consequences for inequality. Through that, we aim to showcase what we have achieved through the keep well pilots to ensure that it is maintained and enhanced and that the introduction of comprehensive health checking does not act to the financial detriment of the much deeper and wider work that is required to deliver good-quality health checks for the people who are hardest to reach.

In essence, we are trying to keep that evidence at the forefront of the decision making about allocations to ensure that the decision makers continue to understand that we need a range of models and that some people will require a greater level of service than others. Yes, we are considering a range of possible methods of engagement and possible levels of service in recognition of the fact that people with the greatest health need will require the greatest level of input. Others will be able to do a great deal of health improvement work with relatively little input, and many currently do.

That was the general point that we were making in our submission.

John Howie: It is an extremely important point. It is one of the high risks that were highlighted immediately when the commitment to carry out health checks for all individuals at the age of 40 was made. It was pointed out that there was a need to consider properly what that meant for inequalities. Hence the reason for the design of the intervention, which is built around the keep well programme and focuses on populations of greatest need. That is nothing new. It startled me when I first read Dr Julian Tudor Hart's papers about the need to focus on populations of greatest need, which go back to the late 1960s and early 1970s. That has been reflected in the policy design and the strategic delivery of the keep well programme, the well north projects and others.

How can we develop a screening tool? The development of a guideline by the Scottish intercollegiate guidelines network on a heart health risk assessment that builds deprivation and ethnicity into its score will be an important mechanism to ensure that we get further targeting of need that is based not only on people's physiological circumstance but on their social circumstance as well.

Ian McKee: As far as I can gather, Dr Julian Tudor Hart was successful because of his comprehensive knowledge of his practice area. He knew which doors to knock on and which cases to follow up. It is extremely difficult to do that on a more comprehensive basis. Even the keep well projects focus only on certain communities. Individual people who live in affluent communities might be at a higher risk. I would have thought that you will have to consider a range of factors in relation to much smaller primary care units.

You mentioned the things that you are going to do, but I am still not certain how you will achieve a focus on those who are at greatest risk. Do you intend to fund primary care teams to make more interventions in their areas, or what?

John Howie: On your point about the characteristics of Dr Julian Tudor Hart's success, the relationship with his practice population was crucial. Looking back at the records, it is probably the only example I have seen where more males attended. There was 100 per cent attendance by males compared with 98 per cent attendance by females.

Ian McKee: He went to them, in many cases.

John Howie: Yes.

On the point about how we can identify the populations, a suggestion is being developed that, instead of manually screening the records as Dr Tudor Hart did, the SIGN formula could be used to screen GP records. From that desktop exercise, we will be able to identify which individuals on a practice list are at greatest risk of coronary vascular disease. Deprivation is built into the score, which can be used as a starting point for proactively engaging with people to carry out health checks and, depending on the results, provide a range of services thereafter.

The Convener: I am probably drifting way off here—I do not mind if you say that I am—but say that the GP, having done the screening, decides that what should be prescribed is better housing. In an awful lot of cases that come across my desk, the health issues of cardiovascular disease, lifestyles, life expectancy and engagement go right back to the quality of people's housing. In my experience, given the demands that are associated with having to house the homeless, some people live in dreadful housing conditions—mums, children and grannies. What will happen if what is required is not medicine or counselling but simply rehousing? How can we deal with that issue in seeking to get rid of health inequalities?

Mary Allison: You are absolutely not going off on a tangent. Housing is central to what we are trying to achieve. It is part of the health improvement equation and is very much built into the web of referral services that we are talking about. When things are diagnosed and detected, primary care is used as the route to engagement, but the solution to many health issues lies way beyond the health service. That relates to what we are trying to achieve through the networks of primary prevention support.

John Howie can talk in detail about some of the keep well pilots, where we are already connecting people with services that would not commonly have been brought into what is essentially a primary prevention health check, such as debt counselling and services that help with domestic issues. John can probably give an illustration.

John Howie: In terms of the national criteria, it is certainly essential to work with community planning partners at a senior level and also at a practical level. Built into the health check are social circumstance questions about literacy, employment and benefit maximisation, but other things will also be raised during the 30 to 40-minute engagement. The quality of the person's accommodation is critical because of the impact that it can have on their health and wellbeing and that of their family.

To give an example, an extremely brave individual in her late 30s came to share her experience at a meeting of a practitioners network for the keep well programme, which was attended by 80 to 100 practitioners. She was a single mum with two young children and she had drug and alcohol issues and was a heavy smoker. Although she did not feel terribly unhealthy and was relatively young, through the health check she gained access to a range of services that were not related directly to the NHS. At the meeting, she shared her successes in dealing with money management problems and said that, when she had dealt with them, she could tackle some of the alcohol-related problems. That then spiralled into many successes.

That illustrates the need for health checks to involve skilled practitioners with an awareness of a broad range of services that can be provided and who can identify quickly, based on cues or direct questioning, other services from which the person would benefit. Those services can then be focused on, to get certain areas of an individual's life correct, after which issues such as smoking, healthy eating or increasing physical activity can be dealt with. So your point about the need to focus on social circumstances is extremely well made, convener.

The Convener: The trouble is that, in reality, GPs can write a pleading note to a housing association or local authority about a person in extreme circumstances, but they do not get rehoused. I am sure that my colleagues have experience of that.

Mary Allison: That is where some of the wider infrastructure for joint health improvement planning must come in. The keep well pilots would not have been as successful if we did not have joint teams working across services in planning the wraparound support. That is absolutely critical. If the solution involved a GP negotiating, we would have failed, because the programme is about the infrastructure of joint planning and joint service delivery, with a high level of sharing information and intelligence across systems so that people can give answers to patients and customers much more quickly than happened in the past.

Helen Eadie: Do you want to amplify the example in your paper about the Gloucestershire project for people of south Asian origin, who are up to six times more likely to develop type 2 diabetes and have a 50 per cent higher risk of heart disease? Do you know anything more about that project that would add value to our discussion?

Cath Denholm: It is a good example of a project that is designed to deliver services that are focused on a particular group. The khush dil project is run in Gloucestershire and Lothian, with similar projects in other places in Scotland, although I am not sure where. The approach recognises that, for groups such as the south Asian community, it is more effective to provide a culturally appropriate service. Khush dil provides health education advice in relation to the prevention of coronary heart disease. For example, it ensures that dietary advice is appropriate to people’s diet. That is the practical stuff that happens on the ground. Some of the work is about ensuring that people from various groups can access mainstream services, but it is also appropriate to design services differently for certain groups with a level of need. The khush dil project is a case in point, as it acknowledges that the incidence of diabetes and coronary heart disease is higher in south Asian communities.

The Convener: Before anyone adds anything, I will conclude the public part of the meeting. I thank the witnesses for their evidence.

11:59

Meeting continued in private until 12:21.

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