The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

FINANCE COMMITTEE

Wednesday 19 September 2012

Session 4

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FINANCE COMMITTEE
23rd Meeting 2012, Session 4

CONVENER

*Kenneth Gibson (Cunninghame North) (SNP)

DEPUTY CONVENER

*John Mason (Glasgow Shettleston) (SNP)

COMMITTEE MEMBERS

*Gavin Brown (Lothian) (Con)
*Bruce Crawford (Stirling) (SNP)
*Michael McMahon (Uddingston and Bellshill) (Lab)
*Elaine Murray (Dumfriesshire) (Lab)
*Jean Urquhart (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Simon Fevre (British Dietetic Association)
Professor Elspeth Graham (ESRC Centre for Population Change)
Delia Henry (Action on Hearing Loss Scotland)
Barbara Hurst (Audit Scotland)
Professor Robert Logie (Centre for Cognitive Ageing and Cognitive Epidemiology)
Colin Mair (Improvement Service)
Robert Parry (NHS Education for Scotland)
Anne Simpson (National Osteoporosis Society)
Alan Sinclair (Centre for Confidence and Well-being)
Lord Sutherland of Houndwood (Royal Society of Edinburgh)

CLERK TO THE COMMITTEE

James Johnston

LOCATION

Committee Room 1

Scottish Parliament

Finance Committee

Wednesday 19 September 2012

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

Interests

The Convener (Kenneth Gibson): Good morning and welcome to the Finance Committee's 23rd meeting in 2012. I remind everyone present to please turn off mobile phones, tablets and other electronic devices, including BlackBerrys.

I welcome to the committee our two new members, Jean Urquhart and Bruce Crawford, who replace Mark McDonald and Paul Wheelhouse. I put on record my thanks to Paul and Mark for all their excellent work and their commitment to the committee. They will be sadly missed, but I am sure that their replacements will prove effective in their new roles.

Agenda item 1 is a declaration of interests by both new members. I invite Jean Urquhart to declare any interests that are relevant to the committee's remit.

Jean Urquhart (Highlands and Islands) (SNP): I have nothing to declare.

The Convener: I invite Bruce Crawford to declare any interests that are relevant to the committee's remit.

Bruce Crawford (Stirling) (SNP): Likewise, I have nothing to declare.

Demographic Change and Ageing Population Inquiry

10:01

The Convener: Our main item of business is item 2, which begins the oral evidence sessions in our inquiry into demographic change and the ageing population. We will hold two sessions today.

I welcome to the meeting and say good morning to Alan Sinclair from the Centre for Confidence and Well-being; Barbara Hurst from Audit Scotland; Colin Mair from the Improvement Service; and Professor Elspeth Graham from the Economic and Social Research Council Centre for Population Change.

The purpose of our inquiry is

"To identify the impacts which demographic change and an ageing population will have primarily on the public finances in respect of the provision of health and social care, housing, and pensions and the labour force, and the planning being undertaken by the Scottish Government and key public bodies to mitigate such impacts."

Identification and planning are the key aspects. We are talking about identifying the budgetary impacts on each of those policy areas and ensuring that the Scottish Government and key public agencies such as local authorities and national health service boards have in place appropriate and active plans to tackle the impacts.

The inquiry will focus on three policy areas: health and social care, housing, and pensions and the labour force. I will allow up to 90 minutes for the session and I would like the discussion to address issues in all three subject areas. If any participant would like to respond to a question or make a point, please indicate that to me or the clerks.

In these sessions, we usually take opening statements but, as we have four panellists, we will not do so today. I will start by asking the panellists questions. Three of the four panellists have made submissions. I will ask each of them questions, and then I will ask Professor Graham to comment.

Alan Sinclair says in his submission that long-term thinking is needed and asks whether we want to continue spending in the same way on health and social care for older people. You talk about the importance of directing public services to people's individual needs and about the need for

"greater efficiency in health, care and housing services".

You say that some parts of the country have responded to the ageing population and you say that in

"Nairn, North Lanarkshire and the Borders ... the nature of services is being rethought and delivered in a different way. In Holland a big problem has been broken down to a human scale, with a human touch through the Buurtzorg."

Will you give us examples to elaborate on what is happening in some of the areas that you mentioned?

Alan Sinclair (Centre for Confidence and Well-being): The traditional format for public services involves saying, "Here is a need—now what can the public service do to meet that need?" Given the scale and duration of what is coming our way in relation to health and care services, we need to think of a different model of public service. I cited examples from Scotland and Holland of public services that have reconfigured themselves. They are trying to support individuals to look after themselves better—to anticipate the things that could go wrong and help families and neighbourhoods to deal with the issues—rather than trying to meet all of people's needs. It is quite a different take on the nature of a public service.

The Convener: You are talking about independent living primarily, or people working together to provide mutual support.

Alan Sinclair: It is different in different places. In Nairn, for example, there is a risk register for every elderly person, so that services know what might happen as opposed to waiting for people to come to them. They also have a statement of intent from each person. In other words, if I have a severe cancer, do you revive me? That would be on doctors' records locally and in a container in each person's front room so that, if an ambulance has to be called suddenly, the crew will know what they are meant to do. In other words, they do not have to go through the process of deciding whether to revive.

Another example is Buurtzorg in Holland, which is the most significant reconfiguration of community nursing that I have ever seen. There, community nurses have gone back to the basics of what community nursing is for. If you talk to community nurses here, they will say that they are frequently caught up in lots of procedures and that they have almost stopped being nurses. Community nurses in Holland get a remit from the doctor for what they are meant to do. However, they get to know the individual patient over a few weeks, and they get to know who is coming in and out of the house and what else the person can do, which may vary over days and weeks because that person is elderly and frail or ill or has mental health problems. The community nurses then redesign the package of care, which often ends up being reduced because the community nurses, rather than providing endless support, are trying to help people to look after themselves. It is a different mindset.

The Convener: And you believe that we could emulate that philosophy in Scotland. What would be the cost implications of such a change?

Alan Sinclair: I see two sides to that. Given the increasing costs of ageing and the number of people who are ageing, the most likely outcome is that we will have a vast amount of unmet need because we will just not be able to respond adequately. Buurtzorg in Holland finds that its approach makes a lot of economic sense as well as care sense because it means that fewer people go through to the more expensive, more intensive forms of care. It is keeping people in their natural communities for longer, and they are doing better. It is winning on two dimensions: it is meeting a need and it is making economic sense.

The Convener: Thank you.

Barbara Hurst, you talk in your submission about

"the lack of good performance information across the public sector"

and you say that the issue is whether the current system for allocating funding to councils and NHS boards allows them to properly plan for the long-term provision and funding of services for an ageing population. Will you elaborate on that?

Barbara Hurst (Audit Scotland): We have done quite a lot of work on health and social care services over the years, starting from the very early days of Audit Scotland when we looked at home care services and aids and adaptations, right through to our more recent work on community health partnerships and commissioning social care. Without fail, what we have found through our work is that there are a lot of assumptions about what should be happening without the clear evidence that that is what works in the context.

For example, some quite interesting research has recently been done at the University of Bristol about what helps public bodies working together—councils and health boards—to reduce emergency admissions. The research is interesting, because it is not the things that you would expect. It found that things such as telehealth and improved rehabilitation services reduced unplanned admissions. However, things such as hospital-at-home services, home visits and care management for individuals did not have a direct correlation with reduced emergency admissions.

The interesting point is that there is a separation, because there are issues about the performance that is needed to drive the financial metrics. Emergency admissions are clearly very expensive to manage and unpredictable, so we would want to drive those down, particularly in the case of the demographics that we are looking at.

At the same time, we want to improve people's quality of life and make them partners in their own care. The beauty of telehealth services—which are probably underdeveloped in Scotland, although there are some really good projects—is that if people who have long-term conditions engage with telehealth, they are much more willing to manage their condition themselves and to identify the triggers that might require an intervention.

There are things that the health service could do more of now. A lot is going on around improving the quality of life not only of older people but of people with disabilities and the like. Self-directed support will really help and the move towards a much more joined-up approach between health and social care is obviously a big win. However, housing is not yet a key player at the table on such issues. We have done less work on this, but the emerging findings from, for example, our early work on aids and adaptations and work that other people have done, show that the housing sector has to be engaged, because housing has such a crucial part to play in helping people live independent lives.

The Convener: You obviously have concerns about the cost of activity and the quality of services and the fact that, although good work is undoubtedly going on in some parts of the country, the information is not being shared and effectively audited so that other local authorities and health boards, for example, can assess whether they want to adopt the same approach in their areas.

Barbara Hurst: Every local authority will know its local circumstances better than anyone else. It is interesting that the range of submissions that the committee has received reveals the different levels of planning that are taking place. I note that the City of Edinburgh Council has a long-term financial plan, which one would think is pretty good practice given the circumstances, whereas some other councils still work on a three-year budgeting cycle in their planning. Given the demographics, which Elspeth Graham knows better than any of us, one would think that three years is not long enough for such planning.

The Convener: We need to look at things in a much more long-term way.

We were all amused by the opening line of Colin Mair's submission. It states:

"'In the long run, we are all dead'".

Colin Mair (Improvement Service): Some of us are closer than others.

The Convener: That was a cheery start and it went downhill from there.

A quote in paragraph 28 of your submission states:

"'The uncertainty associated with projecting future costs of long-term care and other factors of uncertainty described in our report, means demand and costs must be reviewed and remodelled regularly.'"

That touches on a lot of what Barbara Hurst has just said. Your submission also says that

"if costs could be reduced over time ... the volume of demand a given level of budget could support would increase."

Could you elaborate on that?

10:15

Colin Mair: I sense that a lot of good long-term work is being done on profiling. We can model scenarios in some depth for 2030 and 2060 at United Kingdom and Scottish level. However, if you ask how we get through the next five years, that is altogether less clear to me. I agree with Barbara Hurst that it is important to have a long-term focus, but if we do not have a short-term focus on making services sustainable as we move into a period of substantial downward pressure—probably in cash terms—in Scottish public services expenditure, we will bounce our way through the genuine issues rather than planning our way through them. We almost have to remodel our assumptions on a two to three-year cycle, because they change quite dramatically over time.

The point that I will make on the cost question is almost tautological. If we reduce costs through more effective organisation and procurement and how we manage the workforce and the wage bill, the volume of care that we can deliver at any given cost level will go up. That said, the care workforce is overwhelmingly made up of fairly low-paid public service workers, so the cost reduction that can arise purely from cutting their wages and conditions seems to be minimal, and such savings would probably be counterproductive in some cases as that expenditure feeds into other outcomes that those workers experience.

In some of our procurement initiatives, there is an effort to increase the hours of care that can be achieved for a given cost through the procurement vehicles that we use. However, Barbara Hurst's question about how we measure the quality and outcomes from that is critical, because it is possible to cheapen things and not make them better, in which case the impact of care in sustaining people's lives will be diminished.

As I state in my submission, we are still experimenting with what works in the area of preventative spending and what patterns of investment have the best long-term pay-off against the demographic trends that we are facing. A huge amount of effort is going in throughout Scotland around reablement. How do we get the right resources in, intensively, at the right time to

restore people's capacity rather than maintaining them as dependent for the rest of their lives? There is significant merit in doing that.

There is also quite a lot of effort on enablement. How can we support families and communities better in their caring roles? Whatever we say about public services, the vast majority of caring for older people is done by their families and by other older people. It is not done by the state in its local government or health service guise. The enablement of families and communities must be a key part of the performance strategy as well.

The Convener: Previously, the committee has discussed the important issue of universal services. In paragraph 29 of your submission, you state:

> "There are powerful simplicity and solidarity arguments for universal entitlements but the arguments for reconsidering these entitlements are also substantial: non-means tested entitlements are less progressive than tested means entitlements and preserve rather than reduce inequality".

Will that issue come more to the fore in the future? I imagine that your answer will be yes, but might a possible alternative to reducing universal benefits be to look at other models, such as the Buurtzorg model, which Alan Sinclair talked about, to see whether we could get the best of all worlds in that regard?

Colin Mair: At the election, all political parties in Scotland were committed to quite a wide range of universal entitlements for older people. The crux of the evidence that we have provided is that, if we analyse the next five to 10 years in some depth, we will either have to make much more substantial cuts in other areas of public service—I find it hard to see where they would happen—or be tax willing as a country to support what we want to do, and have the fiscal tools to do that.

I do not see what Alan Sinclair described as an alternative to what I have said. We might need to look at both approaches and ask how we can use whatever volume of resources we have more efficiently and effectively, and how sustainable some of our universal entitlements will be over time, as well as whether the public is willing to pay through fiscal mechanisms, say post-2016, to have a level of entitlement that is not enjoyed in other parts of the UK or indeed in most parts of Europe.

That is a straight political choice, and I think that the parties offered that choice at the election. They went out committed to the universal entitlements. To some extent, post-2016, when we formally set tax rates for Scotland, we will have to raise money if we want to sustain that under demographic pressure. Are people willing to pay a bit more in tax to sustain the solidarity? I absolutely accept the genuine arguments for solidarity, but are we willing to pay for it in the longer term?

The Convener: Professor Graham, you will have heard the comments of other members. Although you have not made a written submission, you clearly have a lot of expertise in the area. Would you like to comment and give your views to the committee?

Professor Elspeth Graham (ESRC Centre for Population Change): Yes. Colin Mair mentioned demographic pressure, and we need to be realistic about what demographic pressure we might be facing and, in particular, how that pressure will vary across Scotland. It will be much higher in some areas than in others.

At the moment, the population in Scotland is more or less balanced between the under-16s and the over-65s. About 17 per cent are under 16, about 17 per cent are over 65, and about 66 per cent are of working age. As everyone knows, those figures are projected to change, although within a growing population. The headline figure that we should think about particularly is the growth in the number of people aged 75 and over. That is likely to grow more rapidly as a percentage of the total population. Having said that, I note that we have about 0.4 million over-75s at the moment and that will probably rise to around 0.7 million by 2035.

One of the big problems with forecasting or projecting an ageing population is getting it right. Scotland is very much influenced by migration into the country and, indeed, migration within the country. That will change the balance of population ageing in different local authorities.

I can go into some of the assumptions that have been made, but what happens to mortality and life expectancy in Scotland is going to be important. Life expectancy has been rising steadily but, as is well known, it is lower than in most European countries. A push towards better care and longer life expectancy would impact on the number of people who are over 75.

The migration factor is also quite important to the workforce, although a lot of migration into and from Scotland appears to be student migration. When we are looking at numbers in the 16-to-64 age group—or the 16-to-68 age group in the future—we must think about taking those students out of our calculations. An estimated 20,000 migrants, or perhaps a few more, came into Scotland last year, although it is difficult to measure that figure precisely. Most of them come at the age of around 19 and leave around age 24, and that indicates that they are probably students.

The rest of the migrants are spread throughout the working age groups but they tend to be under the age of 30. It is quite important to understand

how that dynamic might affect Scotland in future, and it requires us to make certain difficult assumptions. Basically, we can make a reasonably good guess about what might happen in the next five years, but the further we get towards the 25-year projections, the more doubtful those assumptions are.

The Convener: Of course, migration depends on a number of factors such as the economy. If the economy is growing, people are attracted to the country, but if it is not growing, they are not. That is a factor in the projections, even from year to year.

The committee has previously received evidence that although, 25 years from now, people will be expected to live an average of seven years longer, four of those years will be spent in ill health, which will give us resource issues. How important is it that, as our population ages, the health of older people continues to improve faster than life expectancy? Is it possible through changing lifestyles to ensure that the quality of life improves and not just the length of it?

Professor Graham: It is very important to focus on healthy life expectancy as well as life expectancy. Others might be able to comment on this, but evidence suggests that the last two years of someone's life entail the highest expenditure. If we could promote healthy life expectancy to ensure that, on average, only the last two years of everyone's life were the most expensive, we would obviously be in a better fiscal position. However, we have a long way to go; indeed, in some areas of Scotland, there is a particularly long way to go. I was involved in the Royal Society of Edinburgh's submission, which cites evidence on the impact of obesity on healthy life expectancy in Scotland. We need to think about all that in a joined-up way because those of working age who are obese are going to be elderly at some point in the future.

The Convener: As I have talked for long enough, I will now open the session up to committee colleagues. Michael McMahon will ask the first question.

Michael McMahon (Uddingston and Bellshill) (Lab): The witnesses have covered a lot of what I wanted to ask about but, as a starting point, I think that it has been established as a principle that if we do not invest in free personal care for the elderly and what have you, we will face even greater longer-term consequences and costs. Do you agree that the question is not whether but how we remodel and focus on preventative spend?

Colin Mair: Absolutely. It is worth drawing out the link between the cost of one type of universal entitlement and the shift and remodelling that you have just mentioned. Looking at Scotland's councils, I sense that the pressures from and the cost of providing free and universal personal care to those who need it because we have not prevented certain things from happening in their lives are squeezing the resources that are available for prevention. In a sense, then, there is a tension between the cost of reactive services—the model that we now have—and how we get resources into preventative services.

I absolutely take the point about extending healthy life expectancy. We are evolving in Scotland a very good strategy that targets factors that shorten healthy life expectancy and lead to a bigger gap between life expectancy and healthy life expectancy. As one can demonstrate quite systematically, that gap seems to be very closely linked to deprivation and community characteristics. If we want to put investment into that, we need to work out how to balance such a move against a growing pressure on the universal element of the care budget that, over the next five to 10 years, will pull us quite sharply away from some of our investments in prevention. I absolutely take Michael McMahon's point, but there is a tension that we are not resolving and which will be hard for us to plan our way through. I guess that that is why we plan on a three-year rather than a 10-year basis; frankly, it makes it easier to handle the contradictions of costs.

Alan Sinclair: Given that this is a very sensitive and difficult issue, perhaps I can help by making a point that might bring together the convener's last question and Michael McMahon's point. Two years ago, as I was undertaking a piece of work to help the third sector look at the implications of ageing, I became acutely aware of the fact that deep in the heart of the health service and the training of clinicians is the mentality that the primary aim is to keep people alive—full stop. However, the more I spoke to and looked at research on old people, the more I found that all old people want is a decent life and a life worth living, and we have not yet found a way of reconciling something that is in the hearts and minds of the population and something that is institutionalised in our systems.

10:30

Barbara Hurst: I would like to follow on from what Colin Mair said about what is happening. We have recently done some work on commissioning social care and it is very clear that Colin is absolutely right. Increasingly, the resources are going into the intensive end. It is being done with the right will, in trying to keep people in their homes for longer, but it is squeezing out the preventative end. We would argue that that spending at the more intensive end, if it involves very short periods of home care visits—there has been a move to that over a long period—is not where the best benefit is to be gained, in terms of

quality of life and maintaining community engagement.

We need to find a way through and make a genuine move to starting with people earlier. I take Colin Mair's point that the current financial pressures make things very difficult. It was even difficult 10 years ago, when there were not the same pressures. In a sense, unless that cycle is broken out of, it will be very hard to cope with increasing demand on services. The social care budget should not be looked at in isolation from the health and housing budgets. There must be some way of breaking through that.

Michael McMahon: I am glad that you mentioned that, because that is where I want to go with my next point. I have spoken to a number of people who work in healthcare for people who are towards the end of their lives. Something that those specialists and professionals are saying is that we spend too much money on acute services. We count the number of operations and interventions that take place, but those things do not necessarily improve people's lives. Some cancers may be operable, but going through an operation could shorten an elderly person's life because overcoming an operation is difficult in itself. However, the pressure to do an operation can outweigh concern about moving from acute services to preventative spend. We can plan all we want for beyond 2016, 2030 and 2060, but unless we get out of that short-termism and get the spending right now, we will never achieve those longer-term plans. We have to make the changes now, rather than put them off.

Colin Mair: I agree; the question is how we create the cultural space for that. To take the point that you eloquently made, in Scotland we are not good at dying or talking about dying. Fifty-eight per cent of us will die in hospital—I think that is a horrible statistic—rather than in our homes, with our families. There is a question about how protracted we wish to make people's dying, and how protracted they wish it to be. Often, it takes a powerful older person to say, "I don't want this, so do not do this to me." Often, there is significant family pressure, which is understandable because the family may be committed to doing anything that they can to protract a person's life. In Scotland we genuinely have not got a narrative about dying and what a death service could look like that would be slightly better than what we have now. I take your point that unless we can shift money from the acute and reactive side of things into prevention we will struggle in the next period, because there will be an overall pressure on the budget. The budget for reactive services is already under stress. Most councils this year are tending towards overspend on their adult social care and older persons care budgets because of demand pressures.

Michael McMahon: I will finish by making an observation, which you can comment on or not and disagree with or otherwise. Is it not easier for people from local newspapers and organisations and even local politicians to stand outside hospitals and facilities with placards that say, "Don't shut our acute service," rather than stand in an empty field and ask for the building of a local health centre to prevent death?

Colin Mair: Absolutely. The truth is that politics oscillates around big facilities. They attract public support, political support and so on, and so our discussions are narrowed down to being about keeping this or that facility open. Interestingly, someone speaking to me about the new bill on community governance that is coming before the Parliament remarked that the quickest way to get a community together is not to give it an asset, but to take an asset off it, as that will galvanise it instantaneously—that may be a new way of community capacity building.

Bruce Crawford: I am concerned that we get the starting point right. What I mean by that is the modelling information that we have available. We all accept that, inevitably, the population is getting older, but what does that really mean? I was struck by the point in Colin Mair's paper—and in some of the other contributions—about the modelling often being crude and needing greater precision. If those are the facts of the modelling that is available to us in Scotland, we need to think about whether that modelling is acknowledging things such as the no smoking policy, the impact of minimum pricing of alcohol, the changes in welfare policy that are going on in the UK and, not least—as Barbara Hurst and Elspeth Graham described—the lack of statistical data and the lack of any real grip on what has happened with regard to migration.

I am concerned that if we do not get some of that right and improve the modelling, we will start making decisions now that are irrevocable. We could be locked into decisions that are not good for the future and not good for Scotland because we did not have the right information base to start with.

That is a wide question, I know.

The Convener: Is it directed at anyone in particular?

Bruce Crawford: It is directed at anyone who feels best equipped to take it on, because if we cannot get this right at the very beginning, we will have a hell of a task later on.

Alan Sinclair: If I were trying to bottom this out, I would add to the model one other large dimension that we do not have just now—the state of the Scottish, UK and European economies over the next two to three decades. There is an implicit

assumption that, if we hold our breath, in five years' time things will get better. However, we have modelling evidence on other economies with this level of debt overhang of 90 per cent for five years or more—there are 26 instances of that over the past 200 years—and the recession that that sets in place is, on average, 21 years long, with a decrease in the rate of growth of, on average, 1.2 per cent. The cumulative effect of that 1.2 per cent decrease over 23 years, for example, is significant. We need to think much more about building that into our model instead of wishing that we were in a different position.

Barbara Hurst: My response is at a more basic level than Alan Sinclair's. I agree that the modelling is key to some of this, but the data to underpin that modelling is not really good enough. If we are not even sure of the costs of delivering particular things it is quite difficult to see, longer term, what those changes might entail. However, there is enough intelligence and knowledge in Scotland to be able to start looking at quite radical changes.

I was very taken by Mr McMahon's point about attachment to buildings as ways of delivering services, because it is quite clear in the case of the health service that some services are much better delivered in larger regional centres, in terms of quality of care and outcomes. We are not really having that debate on a national scale. However, once we start opening it up, we could start looking at what doing that would release in terms of funding for services that we know, from evaluative evidence, work in the longer term.

My argument is that we need to improve the quality of the information that we have to do some of that modelling, which could bring real benefits to the longer term planning.

Professor Graham: I will say a few things about modelling, especially modelling the future population of Scotland. National Records of Scotland provides population models that are based on assumptions that are best guesses at the time. It is interesting to see how the assumptions change from year to year. However, NRS also provides a range of projections so that we have an idea of what might happen under different scenarios. I know that people who have to plan services and so on like to have firm figures, but it is probably a good idea to think more flexibly about the projections as the range of things that might happen in the future. I am not a great fan of projecting further than 25 years down the line because we just do not know what is going to happen.

Migration is the big thing and we do not have good migration data, so we are making guesses about what might happen in future. As an example, one of the migration streams into Scotland has been from accession countries that have newly joined the European Union, but we do not have much information about that. We know that it is happening but we do not know how many people are going back, or how many are living partly in Poland, for example, and partly in Scotland. We do not pick that information up in the migration data so it is difficult to project the future.

That said, we have had a recent increase in population through not only migration, but increased fertility. I have heard it said that one way in which Scotland might cope in future is through saving by closing schools and putting that money into the older population. However, the best guess is that we will still need the schools. The number of under-16s will rise slowly before falling off slightly in about 10 years' time. That is the best guess, so I do not think that we should think about saving at the school end or the young people end in order to invest for the increasing numbers of elderly people.

Colin Mair: Everyone has made important contributions and I will not duplicate them. There is a question of modelling how and why particular demographic patterns, however they emerge, convert into demand for public services. The majority of older people do not use public services that are associated with their age. A distinct deprivation effect runs through all the data and we need to take that seriously when we are targeting prevention with respect to older age.

My concern is the five to 10-year projections, rather than the 50 years that Bruce Crawford mentioned. What conversion factors are going on? Why are they going on? If we wanted to alter things, how could we challenge and intervene on those conversion factors? In my submission, I suggested that some are about entitlements—what converts demography into demand is about someone who falls into a certain age category having the right to get something. My organisation manages the distribution of concessionary travel scheme cards for older and younger people across Scotland—2.4 million at the moment. Anyone who is over 60 is entitled to a travel concession so there is clearly an almost automatic conversion there. We know that care is much more complicated. The majority of older people do not make any significant demands on health or care services until the very last period of their lives, which typically lasts around 18 months to two years.

We need to get a much better hook in modelling and in planning public services and public spending on the patterns of conversion, whether we can change some of them positively by challenging deprivation in old age and so on, and how much of what happens in Scotland is subject to decisions that in the short term will be made by

UK Governments, whatever the outcome of the constitutional question. There is a distinct issue about how welfare reform will impact on all this in terms of the insecurity that it will generate for people.

We are struggling to model long-term economic trends accurately, and, as Elspeth Graham said, we are struggling to model long-term demographic trends, as well as with working out how the one converts to the other and into demand for public services.

Bruce Crawford: If migration is one of the big issues that we need to deal with by getting raw data, what will give us access to that information and make that modelling better?

Professor Graham: The problem is that the information is not collected at the moment. There is no border between Scotland and England that allows us to monitor movement.

Migration is monitored through re-registration with the health services and the international passenger duty; however, as that provides only a very small sample—and the sample of people coming into Scotland is even smaller—the data that we have is very inaccurate. We have reasonable data on students, simply because the universities provide it. I do not know what you can do about that situation.

10:45

Bruce Crawford: I will put it another way: how good is the data on people coming into the UK? Does it tell us what is happening and can we extrapolate from it?

Professor Graham: Yes, we can. However, as I said, all we get are small sample surveys.

If I may, I will pick up a point about the connection between the demographics and demand for care. Professor David Bell in Stirling is trying to set up the kind of data collection survey on the ageing population—it has the unfortunate acronym HAGIS, which stands for healthy ageing in Scotland—that has already been set up in other countries. England has the English longitudinal study of ageing or ELSA and Ireland, too, has established a longitudinal study, both of which bring together data on the ageing population in a survey that monitors demand for different types of service. Scotland does not have such an exercise, and I think that it would be very helpful in future.

The Convener: I should inform new members of the committee and witnesses that we—and, indeed, Professor Bell—have raised the issue of data on a number of occasions and have taken evidence on it from Scottish Government officials. I am sure that we will continue to return to what is a very important matter.

Gavin Brown (Lothian) (Con): My first question is for Alan Sinclair. In response to the convener's opening question about what was going on in Nairn, North Lanarkshire, the Borders and Holland, you talked about the reconfiguration of services and specifically mentioned the use of a risk register covering every elderly person in Nairn. Can you expand on that and tell us whether you have any evidence of the success of or results from those projects?

Alan Sinclair: I know that in Nairn figures are collected as part of the subset for the Raigmore hospital area around Inverness. The group of doctors in Nairn, who have gone through some of their figures with me, are convinced that there have been improvements in trends of people dying at home, being looked after in the community and so on instead of being admitted to hospital. Those figures exist and the committee might be interested in getting, say, the head of the practice in Nairn to go through them with you.

The North Lanarkshire example is not as far down the line, so the evidence is not available, and the project in Holland is a different kettle of fish.

Gavin Brown: That was helpful. My second question is open to everyone but is perhaps directed initially at Barbara Hurst. As a number of members have pointed out, your submission refers to

"the lack of good performance information across the public sector"

particularly with regard to "cost, activity and quality" and, indeed, in your last verbal submission you referred to the need to improve the quality of information. Obviously we will have to write a report at the end of the inquiry and I am fairly sure that we will conclude that, as Mr Crawford touched on, there is a lack of good performance information. Can we be any more specific about that at this stage? With your director of performance audit hat on, can you tell us the priorities for getting better data? What suggestions could the committee make as a matter of urgency in its report to ensure that something happens and that we do not find ourselves five years down the line saying, "Och, there's a lack of good performance data." There are perhaps dozens of areas where things could be better, but what in your view—and, indeed, the view of other panel members—are the absolute priorities that we should be focusing on?

Barbara Hurst: With my director of performance audit hat on, I think that although the current focus on improving outcomes for people in Scotland is legitimate—after all, that is why we do these jobs—it cannot be the sole focus. For any outcome, you need to understand both what you

have to spend and what you have to do to achieve it and it is not enough to focus only on one end of that equation.

You would not think it would be so hard but, in all our work, we struggle to get really robust data on how much people are spending to deliver a service and how they know whether it represents the best use of that money. It sounds like a very basic and pure value-for-money question but the fact is that we need better data if we are to understand what is being spent, what is being done, whether there is evidence that what is being done works better than something else and whether, in the longer term, it is leading to better outcomes. It is not easy to single out one of those elements but, given the current financial situation, it might well be that without that information we will not know whether there are other ways in which services can be provided. We can find ourselves getting locked into doom and gloom, but if we start to get much better evidence of what works for a given price we might be able to unlock some of that. However, we will need radical thinking about different ways of providing services. We will not be able to break the cycle if people continue to provide services in their individual silos without bringing the costs of that activity together.

I apologise—that answer might not be very helpful to the committee, but the issue permeates all our work at the moment.

Colin Mair: I have two points to make in response to what is a very good question. The fact is that we sometimes struggle with what success means with regard to outcomes. We seem to have two levels of evaluation in Scotland, the first of which is very detailed, relates to individual projects or services and can be undertaken at a local level. Often with that kind of local-level evaluation it is easier to attribute costs because the service is delivered in a given place and all the input costs, the outputs and the outcomes can be examined. Many of those evaluation reports suggest success—in other words, they say that the outcomes sought are being achieved in a reasonably cost-effective manner.

However, if you go beyond that level, say, "Okay, we'd expect spatial trends in this area to be different than they were and different from other areas with the same characteristics," and carry out that kind of analysis using, say, Scottish neighbourhood statistics across the whole of Scotland, you almost always find that there has been no impact whatever on trend. The question is: what is working here? If people are reporting success when they evaluate individual services but, after things have been mapped over time we find that the outcomes are not different—which is the uniform outcome of such studies—we are faced with a real dilemma. It is not that anyone is being dishonest in the first type of evaluation; it is just that it appears to yield a totally different result from the second type.

The question for members of the Parliament is: what are you asking for? Do you want fundamental trends in Scotland to shift to ensure more equal and more positive outcomes across the board, to set a timescale for that and say to people, "Go do"—in which case, we will report back on the latter basis—or do you want people to keep testing things project by project? I take Barbara Hurst's point that we are running out of time for piloting things and that we are now getting to the point at which we should be making fundamental decisions on how we move forward. There is, as I said, a dilemma in that respect.

It is also difficult to attribute costs. One of the best studies on reducing emergency admissions to hospital, which was undertaken by the King's Fund in respect of the Midlands strategic health authorities down south, showed that that can happen quite quickly. Elspeth Graham talked about a 40 per cent reduction in emergency admissions of older people to hospitals in a three-year period. However, achieving those reductions in emergency admissions costs more than admitting the people to hospital. It depends what we are trying to do—are we trying to save money or to improve outcomes? Barbara Hurst's point is that we need to bring those two things together. We need to look at how we can get the best possible outcomes from the resources that we are likely to have.

Barbara Hurst: We often try to develop case studies of good practice to demonstrate particular things, and we have found that two things are going on. One is the not-invented-here syndrome. I appreciate that local areas vary, but in some cases there is overwhelming evidence that particularly good ways of doing things have not been picked up because they were not developed in the local area.

The second thing reinforces something that Colin Mair said. We have a lot of pilots. An organisation might get an injection of money and set up a pilot, but there is little mainstreaming. There needs to be much better evaluation and, if something works, people should mainstream it if they can. For example, we are doing some work on health inequalities, and some really good work is being done in Glasgow to address health inequalities through particular general practitioner practices, but at present that is happening only in Glasgow. If something is working there, surely it can be replicated elsewhere.

Professor Graham: The 2011 census will give us lots of opportunities to look at the macro outcomes on long-term illness and premature mortality, so we will be able to do that. When we

look at health inequalities at the macro level, deprivation comes out as the main factor in just about every outcome that we consider.

The 2011 census will also give us an opportunity to see much more detail on how much unpaid care is being provided in Scotland, by whom and to whom. We will be able to have a more detailed look, albeit a cross-sectional one, at what is going on with health inequalities and unpaid care.

John Mason (Glasgow Shettleston) (SNP): In paragraph 9 of his submission, Alan Sinclair discusses some of the things that older people want, which include

"to have control over their lives, to be independent, to stay in their own homes, to be respected, to be treated fairly, to have decent neighbours"

and so on. Are people realistic about what they expect in their old age?

Alan Sinclair: I was trying to show that it is mundane, everyday things that people want as they grow older, and most of those things are non-clinical. We think that old people are a clinical issue, but that is not the case. Getting older and dying are just everyday parts of life. We need to start thinking in that context rather than thinking like the joiner who only has one tool—a hammer—and everything is a nail. We keep on thinking that ageing is a clinical issue.

John Mason: Colin Mair made the point that we are not good at dying. Are we also not good at thinking realistically about what our lives will be like between the ages of 65 and 80 or whatever?

Alan Sinclair: I think that we have a clash between the types of service that we provide and what people actually want. It is interesting that there are few studies on the subject. The one that I could find showed that services were measuring the number of visits that were made according to what had been commissioned, whereas what the older people wanted was somebody to talk to them. That was how they judged the services.

We have a clash of cultures in the area. If we are going back to basics and looking to get the fundamentals of our model right, we need to make services for older people a human issue and understand them as services to help people to have a decent life, rather than just thinking of them as part of the public services that we deliver year in, year out.

11:00

Colin Mair: To reinforce the point that Alan Sinclair has just made, if you look at the large-scale statistical data sets, which is quite easy to do, you will see that the people who are most likely to make high demands on health and social care services in their old age are the people who will not enjoy the things on the list that you read out. The people who will make the least demand on health and social care services in their old age are the people who will enjoy those things.

I will probably retire in three or four years' time, and I expect all the things that you mentioned and will make sure that I get them. That is because I will start my old age in a very advantageous position, with a decent pension, savings and so on, and I will orchestrate those things in order to get the life that I want. It is also unlikely that I will make the same pattern of demand on health and care services as someone who lives in an area of deprivation on an extremely low income. When we think about prevention, we are not talking about a preventative health service or care service; we are talking about the kind of prevention that comes from people living better and less stressful lives in better housing and so on. If all that is in place, people will make less demand on expensive public services.

John Mason: You have touched on the word that I was coming to next: pensions. That issue has not been mentioned so far. I see a whole load of tensions in that area. The public sector provides a reasonable pension, if not a great one, and the private sector generally provides a pretty awful pension. It seems to me that we have to pull up the private sector pension for employees and employers.

We can say that saving is a good thing and a preventative measure for the long term, but interest rates at the moment do not really encourage saving, which is a disadvantage. The chancellor wants people to spend, not to save. If services are not going to be universal when people are older, that discourages them from saving. Many people say to me, "Why should I bother saving if that means I'll have to pay for a service?" If people think that they will have to pay for their bus pass, will that discourage them from saving? I am struggling to get my head round that area. Can anyone help me?

Colin Mair: A lot of public attitude surveys raise the issue of people saying, "Why should I save all my life when someone else will get free of charge what I will be paying for?" On the other hand, that attitude seems to correlate to levels of income. Someone who is just above a deprivation level of income is more likely to have that attitude than someone who is earning £50,000 or more a year. People at those higher levels will be saving and, frankly, the issue of a bus pass is almost irrelevant to them. We have to determine the point at which the disincentive kicks in. Having evidence to measure that is important.

On pensions, it is true that, as part of a general movement at UK level, pension arrangements in

the public sector in Scotland will almost certainly be altered. People will pay more across their working life and get lower average pensions in their older age, because the schemes will be based on pay across their working life rather than on their final salary.

One of the issues for parliamentarians is that, if a generation appears to have hit it seriously lucky throughout their lives—we never paid tuition fees or anything like them, we got grants, we got good state earnings-related pensions and good occupational pensions—there might be some resentment among younger people about paying so that those people can have free services in their older age even though their incomes are actually higher than those of the younger people who are paying the tax to pay for the services. There is a question of intergenerational equity, whichever way you go, that will lead political thoughts with regard to maintaining the solidarity to which Michael McMahon alluded earlier. We are in danger of having an intergenerational breakdown of solidarity, because some people appear to be doing very well.

If economic growth happens, the data that we have just commissioned from the private sector is very bad news indeed, because it shows that the moment that growth happens and interest rates go up, about 20 per cent of households in Scotland will be in real trouble. The only thing that is holding their household finances together at the moment is the fact that interest rates are at a staggeringly low level, by historical standards. If there is an increase of 1 or 2 per cent in interest rates, they will be gone.

We have a vulnerable younger population, as growth kicks in, and growing demand from the older population for services. That is what parliamentarians will be balancing. The policy challenge will be how you can make fair intergenerational judgments.

Alan Sinclair: I will pick up on a practical consequence of that. On intergenerational equity, as well as health equity and deprivation, we must seriously consider what Dilnot has proposed for care in England. The proposal was for some form of insurance system into which people who have a net worth of more than a certain threshold will contribute, and that money will pay for their later care if it is required. That is the only practical measure that is in any sense realistic. Initially, the chancellor kicked the idea into the long grass because he did not want to think about something like that, but he has begun to reconsider it more recently. We should be thinking about such a proposal in Scotland and, although I am not quite sure how the legislation would work, it would have an awful lot of equity.

John Mason: I want to press you on that point. As I understand it, someone who is in a care home in Scotland has to keep using up their savings until they reach a minimum level, and they are allowed to keep that. Under Dilnot, a person would pay up to £35,000 and would not pay after that. Is that right?

Alan Sinclair: My understanding is that the situation varies across Scotland. Some families are meeting the costs from their own purse and in other local authority areas, the costs are being met for them.

John Mason: But under Dilnot, after a ceiling is reached it would not matter whether a person was medium rich or very rich—they would not pay any more.

Alan Sinclair: That is right. There would be a cap on what people were required to pay, but there would be insurance up to a certain point for those who could afford it.

Colin Mair: There is a distinction between personal care and social care. The Scottish Parliament has legislated that personal care is free irrespective of income, but the social care element and accommodation have to be paid for out of savings or the family has to pay on the person's behalf. Down south, the personal care element is charged in the same way as the social care element. Our current personal care policy is therefore distinct in the UK and, I think, in Europe.

John Mason: So, the Scottish charging for social care is currently more aggressive than what Dilnot is proposing.

Colin Mair: It is, but the English charging for social care is also more aggressive than what Dilnot is proposing. One of the issues for the chancellor is to decide, if that charging is capped, whether income will be taken out of the system as demand grows and how all that will be balanced.

John Mason: Have I time for one more question, convener?

The Convener: One more.

John Mason: I return to Mr Sinclair's point about countries taking 23 years historically to get out of heavy debt. You suggested that that was without the levels of personal debt that we have. Are you suggesting that it could be worse than 23 years?

Alan Sinclair: Reinhart and Rogoff are the big economists in the area. We have talked about modelling quite a lot this morning, and Reinhart and Rogoff's health warning at the bottom of the article that they wrote about this modelling showed three things that are different from the level of indebtedness that goes beyond the five year debt overhang that is shared across many of the

advanced economies. Normally, state debt is with the state's own inhabitants—the creditors live in the country—but now a lot of state debt is internationalised, which means that it is harder to shift the debt because the country cannot turn to the tool of inflation to punish the creditors. That is the first difference.

The second difference is what we have just been talking about—pensions and demography are against us at this moment in time.

The third difference is that, in the 23 to 26 other recorded instances in which there has been a debt overhang for five years or more, there has not been the same level of personal debt, just state debt. Reinhart and Rogoff have put out a real health warning.

Elaine Murray (Dumfriesshire) (Lab): My question follows on a bit from what we have been talking about. Universal services such as free personal care are only really a financial problem when they are being claimed. A lot of people are not claiming them. Colin Mair referred to families and communities being able to assist, but people are having children later in life and being required to work until they are 66 or 68. My parents will be 95 and 91 by the time that I receive my state pension so I am not going to be a lot of use to them really.

I wonder about an alternative model in which older people are involved in the design and delivery of services. The Food Train in my constituency is a good example of that. To an extent, personal care is too late. If somebody lives in a house but cannot do the heavy housework or gardening any longer, they might endanger themselves by trying to do things of which they are not capable. There will be a significant effect on their mental health if they live in a way that they feel is inappropriate. Are there examples, from this country or internationally, from which we can learn of how, through social enterprises, older people and communities can become involved in the design of the services that are needed to prevent people from requiring higher-level services later on?

Colin Mair: There are great examples of that from throughout the voluntary and social enterprise sector. There is a range of instant neighbour schemes—although sometimes they are not branded in that way—through which people do something for an older person that any neighbour would do, but the help can be summoned up. Some imaginative schemes have involved social enterprises creating jobs for offenders as they come out of prison and get back into society.

As Elaine Murray said, it is a blow to someone's pride and esteem if they have kept a garden in pristine condition for most of their life but it starts to deteriorate, become overgrown and look disgusting. That really bothers people and affects their mental wellbeing. It almost visually expresses their decline to them and their neighbours.

There is a host of examples. The interesting thing is that they take the low-cost, light-touch approach. To pick up on Alan Sinclair's point, much of the value is in the contact that such schemes generate. I have mentioned to Kenny Gibson before that, when I was involved in evaluating joint future schemes in which a single assessment was carried out, rather than multiple assessments of older people by public agencies, one old lady up a glen in Perthshire said that the new system was much slicker and all that, but she really missed all the young people coming to her house to assess her. She did not mind multiple assessment, because it provided contact, although that is quite an expensive way of getting contact for older people.

There is also the practical aspect of doing fairly simple things such as changing light bulbs and putting up curtains or taking them down to be washed. Communities can organise such schemes for themselves. We can show that, over time, when such schemes have been in place, demand for the more intensive public services and clinical services is reduced.

Community capacity and willingness have to go alongside public service effort to get to the better balance that Elaine Murray talks about. There is a lot of evidence on social enterprises. If you would like me to, I can send that to the committee.

Elaine Murray: Obviously, social or community enterprises come from the community and are not really a matter for central Government clonking in and telling people how to do things or that they should do things. However, are there ways in which local and national Government can facilitate the growth of such enterprises?

Colin Mair: Absolutely. Local and national Government can be involved, because much of what is needed for such schemes is about co-ordination. A full-time person is needed who can get everything together, take in what people need and match it up with what other people are willing to offer. That enablement function is important. We should not make small cuts that save little money but which remove that function so that, as a consequence, we lose whole voluntary services. In the coming period, we need to take a lot of care that that aspect is protected.

Jean Urquhart: My observations follow on from Elaine Murray's and Colin Mair's comments, because they are on the point that we need to think about things in a completely different way. People are doing that, and the committee needs to

hear from some of them. There are extraordinarily good examples and pieces of research by universities. I would like to know where those end up. Are they just gathering dust on a shelf? Every community probably has examples of something that worked.

I think that Colin Mair said that taking a service away unites a community. In my community, when a lunch club was taken away from folk in their 70s and 80s, they were united, but the outcome was that, rather than about 17 people getting their dinner twice a week, we suddenly had 87 people getting their dinner. That was because they did it themselves. They were not the local authority, so they were not assessing one another; they just knew that people wanted to come out and talk.

11:15

There are ways of doing that. We need to concentrate on the positives. We try to keep people at home at all costs, because that is what we have said should happen, and that is what people want—probably no one wants to be institutionalised or hospitalised in their old age. However, as I think Barbara Hurst said, because of that, preventative spend is being reduced or is not available. There is a question about who decides about that.

Nobody has talked about how preventative spend is working, or not working. The preventative stuff has to come to the fore. I have to admit that the statistics on how many old people we will have do not excite me and I often do not believe the figures. We are doing things such as introducing a culture in which people drink and smoke less. People are getting healthier, and younger people are seeing things differently.

I will finish with a couple of wee examples. The first is about an eight-year-old boy who arrived late for school. When the teacher asked why, he said, "I was teaching my great granny to work her iPhone." That sparked a number of groups in rural communities up and down north-west Sutherland involving eight-year-olds teaching 80-year-olds how to work their iPhones. The fact is that we do not all want to talk to 80-year-olds.

I come to my second example. About 15 or 20 years ago, I had a group of folk from Burkina Faso visiting the Highlands. We went on a wee tour in a minibus with about 12 people. They were asking what everything was as we went along the road. They asked about a building in Gairloch and I told them that it was an old folks home—I still think of them in that way—or care home. They went into a great babble in their language, which I could not understand, but the translator told me that they did not understand me. I explained what it was and then there was a great babble again. Then they said, "That is extraordinary. If the old people are there, how do the young people learn?"

The iPhone teaching example is just an anecdote, but we can do this. We can look at alternatives and at the positives in getting older. We talk about older people as a resource, but we do not actually give people that sense. There are young people doing old folks' gardens. There are allotments where people grow vegetables and give them to old people. Can we hear about some of those examples from across Scotland?

The Convener: Jean, we have to let the witnesses comment. The questions should be much more succinct than that, because we have to allow witnesses to answer and keep within the time that we have available.

Does anybody want to respond to Jean Urquhart's comments?

Barbara Hurst: I absolutely agree with Jean Urquhart and with Colin Mair that there are loads of examples of great community initiatives. However, the issue about preventative measures losing out because of the financial pressures that arise from the more intense needs means that some of those services are at risk. I do not know whether any voluntary sector people will come to talk to the committee, but we hear relentlessly that the voluntary sector is being squeezed in the current climate. Nevertheless, I absolutely agree that there are great initiatives going on. An example is the circles of care approach, in which people, with a bit of support, do different things from what we might expect, such as get together to visit art galleries, because that is what they want to do.

In terms of the positives and thinking about the future, we must remember that all those technological advances can be put to good use. People—of our generation and those who are younger—will be used to and comfortable with using apps for different things, so if you want to engage them in their own healthcare, that is a brilliant way to do that. There are some great examples, including people who have emphysema or asthma being phoned up to be told that the weather is changing and that they need to be careful with the heating. I agree that it is important to get out of the mindset that using technology is a problem; it is also important to get into the mindset that we must make use of everything that we can.

One area that we have not touched on—I am about to bring us back to the doom and gloom—is dementia, which is inevitable with a growing older population. However, telecare services can keep people at home safely for longer than was the case in the past, and it is services such as that through which we can perhaps be more creative.

Colin Mair: I am sympathetic to much of what Jean Urquhart said. The economic role of older people is not unimportant with regard to childcare and a variety of other things, so it is quite right to say that a balance sheet is involved and not just one dimension. Looking at how older people can and do contribute is an important part of the preventative strategy—if they contribute, they remain active and engaged and they are rewarded by contact with a much broader range of people.

A parallel anecdote is that I took a group of senior Indian civil servants around Scotland. One of the things that we looked at was a brilliant and beautifully designed place that was run by the Church of Scotland for dementia sufferers. Afterwards, the group asked me, "Why do you hate your older people?" I asked them what they meant, because I thought that they would be impressed with the place. They responded, "What sort of society dumps all its older people into places designed for older people? Why are they not living with you? Why are they not out there?" A lot could be said in response to that about our family and work patterns and how they have changed over time, but it is true that some of our most expensive ways of addressing the needs of older people are also the ones that, to older people themselves and to anyone looking from outside, seem the oddest ways in which to deal with people whom we care about and value. We need to think about that valuation principle, and how we build that through our strategies.

Professor Graham: Intergenerational exchanges are important in any society. As we heard, older people tend to provide different care for grandchildren, for example. It is therefore important to tackle issues of intergenerational justice, but also misperceptions between the generations. It would be damaging to set up a distinction that younger people are suffering because older people have been so successful; they are suffering because the economy is not doing so well. That is one of the things that must be recognised. Certain parts of the press talk about intergenerational wars, and that is a damaging notion.

The Convener: That has exhausted all the committee's questions. Does each of the witnesses have a final point that they want to put to the committee before we wind up the session?

Colin Mair: I would welcome a view on the short to medium term, as well as the long term, in the committee's deliberations. In Scotland, we are focused largely on the longer term—often politicians are accused of being totally short term and unwilling to think about the long term—and the question is how we get through the next five to 10 years. We must honestly address that or it will become a guddle and a shambles as we bounce off difficulties as we encounter them. I very much welcome the fact that the committee is undertaking the inquiry and, although I welcome a long-term view, too, to be frank, is critical how we transact the short to medium term in moving forward.

Professor Graham: Obviously, there are challenges ahead from ageing but I re-emphasise that the challenges after the next five to 10 years are unclear—the picture could change quickly—and that they vary greatly across Scotland.

Alan Sinclair: I would ask for a more realistic economic model as we go forward. When I talk to people on this subject, I find that there is a divide—their professional brain is in one place and their personal brain is in another. In considering the ageing process, I recommend that the committee takes a human approach—not just a political one—to what makes a life worth living in a difficult economic context.

Barbara Hurst: I welcome the committee's timely inquiry. If there is anything that the committee can do to encourage and support the breakdown of some of the silos in the provision of services, that would be the biggest prize, in terms of both the budgets and how services are delivered.

The Convener: Thank you very much. That was helpful, as were all the contributions from the witnesses; I am sure that they will help to inform the round-table session that will follow.

11:26

Meeting suspended.

11:38

On resuming—

The Convener: We turn to our second group of witnesses. Given the number of witnesses that we have, we will take evidence in a round-table format.

I welcome to the meeting Anne Simpson from the National Osteoporosis Society, Delia Henry from Action on Hearing Loss Scotland, Lord Sutherland of Houndwood from the Royal Society of Edinburgh, Professor Robert Logie from the centre for cognitive ageing and cognitive epidemiology at the University of Edinburgh, Robert Parry from NHS Education for Scotland, and Simon Fevre—I hope that I pronounced that correctly.

Simon Fevre (British Dietetic Association): It is pronounced "fever".

The Convener: Simon Fevre from the British Diabetic Association.

Simon Fevre: It is the British Dietetic Association. [*Laughter*.]

The Convener: My apologies—I did know that. The problem is that I cannot read with my glasses on.

We discussed with the previous panel the impact of demography and the ageing population across the three subject areas that we are considering in our inquiry. I would like this session to focus on health and social care.

I will again allow up to 90 minutes for the discussion. As we are taking evidence in a round-table format, the session will be less formal. With the previous panel, I opened the questioning and then invited committee members to ask questions, and the witnesses answered in turn, but in this session I will make a comment or two and then I will ask Lord Sutherland to kick off. After that, anyone who wishes to ask a question or make a point will be able to do so.

There is no restriction on the number of questions that people can ask or the number of interventions that they can make. It is simply a question of catching my eye. The clerk Jim Johnston will write down people's names, and people will be allowed to contribute in sequence. However, if you want to comment on something specific immediately after someone has spoken, you might be able to come in with a supplementary. It is a case of suck it and see.

To start us off, set the tone and allow people's cognitive juices to start flowing, I will quote paragraph 8 from Lord Sutherland's submission:

"Fiscal sustainability is influenced by the extent to which, as a country, we embed healthy ageing and preventative interventions into our current and future priorities ... It is important that preventative measures are aimed not merely at avoiding death but also at reducing morbidity, enhancing quality of life, increasing people's contribution to society and reducing their demand on services. The economy as a whole will benefit from the adoption of this approach."

I invite Lord Sutherland to expand on those comments.

Lord Sutherland of Houndwood (Royal Society of Edinburgh): Thank you, convener. Just to be clear, it is the Royal Society of Edinburgh's submission. I am very happy to speak to it because I have great admiration for it, but many people were involved in putting it together. A lot of work was involved.

I am glad that you picked out that paragraph. It is easy to see doom and gloom in the fact that demography is changing in every advanced country, and even in those countries that are still developing their economies. It is not just a UK thing or even a western thing. It is happening across the board, so it is a common issue.

One aspect that we certainly have to focus on—I do not know how far your committee can push other people in this direction, but it would be great if you could—is value for money and effectiveness of spend. That relates to the extent to which, in spending money, people look beyond an immediate, real problem to ask, "If we spend money in another way, will the community be healthier in five or 10 years' time?" If we want to make it financial, we can ask whether we will be spending our money in the best way.

We all know that it is at the end of life—I do not mean in the last few days, but in the last few years, as pensioners—that people make greater claims on the health service and on social care. The situation is not the same for everybody, but if there is any way in which to reduce that, let us focus on it. That is the point of the paragraph that the convener quoted.

Healthy ageing is to do with everything from the biomolecular onwards. Are you taking your statins, for example? That is a real issue. There is a big debate about whether everybody over 50 should take statins. I am not a scientist and I do not know what the outcome will be, but that is an important question to ask and to answer. Investment in that could be money well spent, and statins are much cheaper than some of the drugs that people might need later in life.

I am not going to mount a defence of free bus passes, although I benefit from that policy occasionally. I will make a suggestion. Let us suppose that the committee said that it is important for folks to get out of the house. Many older people find that difficult and, without the option of taking the bus into town or to the supermarket to get their shopping, life would be much harder for them. People could be given a bus pass that is limited to 20 journeys a week, 20 journeys a month or whatever. It does not have to be all or nothing, and it could be means tested, although I am not raising that issue. That use of money might have a positive effect on healthy ageing. The health is of the mind as well as of the body. We need to ask what quality of life people have access to.

I could begin to drift towards the subjects of transport, housing and a range of other things. The committee heard from the previous panel about the stimulus that people can get as they master the web. That is a generational thing. The generations after some of us will be used to getting a stimulus, in their own house, from the little screen in the corner, or indeed the big screen, as it might be.

How do we focus spend appropriately? We can only do that through decent evaluation of value for money—Audit Scotland has had quite a lot to say about those things.

I will stop at that point, but it is important to focus on the effective use of money and on getting value for money in the medium to long term, as well as on the need that is in front of us now.

11:45

Michael McMahon: Lord Sutherland has neatly connected us to the earlier evidence session in which Colin Mair asked us to look into the short to medium term as well as projecting as far into the future as we can. He gave us a few ideas, and we heard some of those ideas when we held our sustainable spending inquiry. We are not reinventing the wheel. A lot of the ideas we are hearing are already out there, and we already know a lot of what people expect, what has to be decided on in the near future and where some of the ideas are.

Colin Mair asked us to consider looking in the short to medium term at how we deliver health and social care, which reminded me that the Kerr report has already looked at that very issue. Are we just going to return to the questions that the Kerr report looked at, or do we take the Kerr report and use it as a blueprint and start implementing its recommendations? It seems to me that, although they have been implemented in some areas, the Kerr report recommendations are lying in tatters on the floor in my area of Lanarkshire.

The work has already been done on how to deal with health and social care in the short and longer term, by moving from acute services to preventative spending and prioritising primary care services, but the real challenge is in implementing those plans. The ideas are already there so how do we implement those blueprints? It takes political will and expertise to argue the case.

Lord Sutherland: I have just come from a conference in Our Dynamic Earth at which some of these issues were discussed. That was why I could not be in the earlier witness panel. One of the fundamental issues is the integration of budgets. I have no doubt about that. If we can, we need to find a way to integrate health and social care budgets, which depends on the pilot studies that the current Government has sponsored.

The Convener: I have many talents but telepathy is not one of them, so if people want to come in, please let me know.

Robert Parry (NHS Education for Scotland): NHS Education for Scotland is the national education in workforce service and it provides a service to all professionals within the health service. We work in partnership with many public sector organisations, and I can see the future of sustainability.

The Christie commission identified public reform and organisations coming together, and a number of workstreams are already in place between ourselves and the Scottish Social Services Council, for instance, to look at the health and social care issue for professionals. Our biggest resource is the staff whom we employ. The SSSC has a register of around 198,000 and the NHS has a head count of around 160,000. That is a substantial number of people whom we need to engage in the debate, and partnership work across the public sector is one way forward to help to support the agenda.

Elaine Murray: Lord Sutherland talked about the integration of health and social care, but we should not lose sight of the role of housing.

Lord Sutherland: Absolutely.

Elaine Murray: A lot of the housing associations will say that people who live in inappropriate housing are much more likely to have accidents, which could lead to them being much less able to do things for themselves, or to suffer from mental health problems. Barbara Hurst made the same point in the earlier evidence session. Are there issues around the inclusion of housing that will have to be addressed when we look at the bill for integrating health and social care?

Delia Henry (Action on Hearing Loss Scotland): The committee will not be surprised to hear that I work in the voluntary sector. During the earlier evidence session, we heard about relatively low-level interventions that can help people to sustain their independence. We work in collaboration and partnership with the statutory sector. For example, we have just done a whole series of work with NHS Education for Scotland and pharmacists in the community to highlight issues around people's hearing loss and the implications of their lack of ability to take on health promotion messages. That did not cost a massive amount of money but it represents a different way of thinking. If we can do what we are suggesting today, it will be particularly helpful.

To go back to the earlier point, when we talk to older people and people in general we hear that they want to maintain their independence and stay in their own homes, so it is critical that we take all the points that have been made together. However, I do not want to minimise the challenge of changing cultures and ways of thinking. We have to do that or we will not be economically able to deliver services in the future.

The Convener: Professor Logie, you have raised some concerns about cognitive health. Can you elaborate on that point?

Professor Robert Logie (Centre for Cognitive Ageing and Cognitive Epidemiology): Yes. My

background is in looking at cognition across the lifespan. I am a researcher rather than a practitioner and one of the issues that comes out of that type of research is that different people age at different rates and different aspects of people's abilities change at different rates, including physical abilities as well as cognitive abilities. Some cognitive abilities deteriorate much faster than others, for example in the early twenties, whereas other abilities are maintained quite well into old age. People who develop various neurodegenerative disorders including Parkinson's disease, Alzheimer's disease and the various other types of dementias have particular needs.

One message is that not every old person is the same. Different services are needed for different people, and some of those services are indirect. A lot of the care for people with dementia, for example, is provided by relatives and friends—essentially for free to the state except in so far as those people are not contributing to the economy. Removing respite care support for those people, for example, could have a major impact because the carers might need NHS treatment and the people whom they care for would have to go into residential care, which is a major cost.

It is important to consider the differential needs that people with different challenges have as they get older. Alzheimer's dementia is not an inevitable aspect of ageing. According to the Alzheimer's Society, it affects about one in four people over the age of 80. That means that three out of four people are much less affected. However, not everybody can be active and cognitive in their old age. They may need help with their finances, with organising their grocery shopping and so on. It is important to consider that there are subsections of society that might not benefit from provision for people who are generally active.

Gavin Brown: As Delia Henry was speaking, I looked at the submission from Action on Hearing Loss Scotland and RNIB Scotland. The submission gave statistics, including the prediction that we would go from 850,000 people with a degree of hearing loss in Scotland today to 1.2 million people in 2031 and that the number of people with sight loss would go from about 180,000 today to 400,000 in 2031.

The submission gave two reasons for why that could happen—the ageing process and Scotland's more general health record. On those specific points, to what extent are those figures inevitable and to what extent can we look at things that might be done to alter them?

Delia Henry: There is an inevitability and there is a correlation between an ageing population and sensory deterioration. Action on Hearing Loss Scotland works closely with RNIB Scotland—which is why I am giving evidence on behalf of both organisations. We would both argue that we should pick up on those losses as early as possible.

For example, Action on Hearing Loss Scotland would argue that we should screen people earlier to pick up their hearing loss because we know that people wait for up to 10 years to have their hearing loss diagnosed. People need to make a change to their lifestyle to become used to things such as hearing aids or to be aware of other equipment that would help them in their home setting. It can be fairly inexpensive to do that, but the earlier we pick people up the more comfortable they are with the intervention and the more comfortable they are in dealing with it.

There are correlations with other things—Robert Logie and I were talking about that earlier. If people are more comfortable with their hearing loss or their visual impairment, ironically they say things like, "Well, I can't hear what you're saying because I haven't got my glasses on" as they cannot see to lip-read. We would argue that getting those interventions happening as early as possible could particularly help people's independence in the longer term.

Professor Logie: To follow up that comment about early assessment, it is also important to inform people who are caring for individuals. For example, there was a discussion towards the end of the previous panel about science and research and so on gathering dust. I think that Jean Urquhart made that point. It is important that we get some of that science out there and inform carers.

Understanding the nature of the cognitive problems from which a person suffers can be helpful to someone who is caring for that person. Whether they are caring for them in their home, in a residential setting or in hospital, it is important for a carer to know what a person can and cannot do rather than assume that they cannot do anything.

Some functions are affected more than others in the case of dementia, for example, and in the case of healthy ageing. Research can therefore inform carers. A practical example is that people who have Alzheimer's disease have trouble doing two things at once, so you should not try to get them to walk and talk at the same time. They can either walk or talk, but not both at once. That is a simple example of practical advice that can be given to carers that comes from a scientific base.

Bruce Crawford: I found the earlier evidence session to be absolutely fascinating, and I am glad to be coming to the committee at the beginning of the process because we have a chance to make a significant difference.

I was particularly taken by Lord Sutherland's comment that it is not all doom and gloom; a lot of positive things are happening out there. Paragraph 24 of the Royal Society of Edinburgh's submission says that we need to consider

"healthy ageing and preventative actions or care."

We should think about what we have done in the recent past, and the budget contains a greater emphasis on preventative care than there has ever been before. We introduced the smoking ban a few years ago and we now have a policy on alcohol. We are still waiting to see the implications and positive benefits of these actions, and I do not doubt that there is much more to do on smoking and alcohol.

One thing that I would like to know that would help the committee to form an approach is where the next early gains are going to come from. We might have a long-term problem but we also have a significant short-term problem. Where can we get early gains? Will they come in dealing with obesity? Is that where we should go? Perhaps Simon Fevre can help us with that.

What impact will welfare reform have on some of the gains that we have made through preventative spend? If we do not get some of those gains now, the long-term picture will be much more difficult for us. Can any of the panellists help with the more positive aspects and where we can get early gains, as well as giving us longer-term solutions?

As I said earlier, convener, I will be glad when we can get some modelling done that will tell us what positive impact some of the changes that we have already made will have.

Simon Fevre: Inevitably, at these meetings, we look for our wee niche and I thank Bruce Crawford for giving me the opportunity.

Early gains in obesity are very difficult. At the moment, we are firefighting and dealing with the consequences of obesity rather than looking at the root causes. Some of the root causes related to activity, food production and appropriate labelling are longer-term challenges but we need to deal with them. There are many current initiatives and strategies on healthy child weights and preventing obesity, but it will just take time for them to roll out. I am not sure that there are any quick gains to be made from them but we have to start them. With some initiatives, such as the smoking ban, we might see some immediate gains but there are also longer-term gains, and we need to think as strategically and in the long term about food as we did about smoking and are doing about alcohol.

One issue that we featured in our evidence is malnutrition in older people. The number of undernourished older people in our communities has been a hidden problem. The squeeze on social care and community meals budgets is a significant issue for us, and a relatively quick win might come from nutritional screening of the older people who live in our communities. We know that 93 per cent of our older people who are malnourished live in our communities but we do not have detailed screening programmes for those individuals. If they come into hospital they are screened, but they are not necessarily screened if they live out in the community. If we are to manage that and deal with that situation, we need to identify those individuals quickly.

12:00

Equally, we need to look at social care. I often see patients who have somebody who comes in to sort out their tea, but they have only 15 minutes to do that. It is not practical or possible, certainly in my household, to make something nutritional in that time. In addition, although meals-on-wheels services offer an important service, the number of community meals that are delivered to older people is reducing. What many older people want is social contact. They want somebody to spend some time with them. In the previous session, somebody—I think it was Jean Urquhart—mentioned lunch clubs and people's ability to get together.

I think that there are some quick wins in relation to malnutrition. On obesity, we can do some firefighting, and we are doing that across Scotland at present, but there are also some longer-term gains in obesity management and we need to look at those carefully.

Professor Logie: I entirely agree that firefighting is important, but in relation to healthy cognition in old age, which is a major factor in independent living, it seems that lifespan is important. One of the major activities in the research centre where I work involves looking at longitudinal change in individuals. The centre has data on people at the age of 11, and we can follow up those people now, at 70 to 80-plus. It seems that lifestyle factors throughout life are important for healthy cognition in old age. Education, active involvement and physical activity throughout life are long-term preventative strategies. Firefighting is important, but it will not solve the problem.

The Convener: Anne, in your written submission, you state:

"each year, Scotland spends £192 million treating and caring for people with hip fractures."

You state that it is estimated that, by 2036, there will be a 43 per cent increase in the number of fractures, given current trends. You go on to state:

"The first-line bone protecting treatment is generic alendronate; it is cheap and effective and is currently available for £14 per patient per year."

That treatment and the fracture liaison service appear to be reasonably low-cost ways in which to prevent fractures. Could you address that in your comments?

Anne Simpson (National Osteoporosis Society): As Bruce Crawford said, some positive things are happening. The fracture liaison service, which has been rolled out to about 80 per cent of the Scottish community, having originated in Glasgow, has led to a reduction in fractures.

The point of the comment in our submission was to emphasise the impact and cost of hip fractures in particular. It is costly to the NHS and social care services if people do not return to full independence after a hip fracture. A significant proportion of people do not do that and will need continuing care in all sorts of ways. It is preferable for that care to be provided at home, but a proportion of the most elderly will end up in care homes. In addition, a proportion of older people who have hip fractures will have dementia and hearing and sight problems, so there can be a significant all-round problem with their quality of life in later years.

We are pleased that smoking and excessive consumption of alcohol are being addressed, because they are bad for bones. However, in relation to bone health, there is also an issue around nutrition, both in the elderly and in younger people. There is evidence that most people in Scotland have low vitamin D levels, but that is a particular issue for the elderly, many of whom do not get out and about and do not get the few rays of sunshine that we get in Scotland, and therefore vitamin D.

The National Osteoporosis Society would like bone health to be addressed as well as obesity, because maximising bone health in all age groups will reduce the risk of fractures in the very elderly population. There is a positive story in Scotland. Fracture liaison services are being delivered, albeit not particularly equitably in some parts of the country. We are working well with NHS Scotland's falls and bone health activity, which comes under the rehabilitation framework. The picture is positive, but we would like the picture on the management of bone health, the prevention of falls and fragility fractures and looking after the most elderly to be equitable throughout all health board areas.

Robert Parry: We have heard about physical disability, but one of the most important things is people's psychological wellbeing. If someone feels much better in themselves, their outcomes will greatly improve. In relation to comorbidity, the report "The Challenge of Delivering Psychological Therapies for Older People in Scotland" identified an important interrelationship between physical health and psychological wellbeing. One underpinning factor is to do with the psychosocial elements of living in poverty and being in isolation. Evidence tells us that, on average, about 14 per cent of older people suffer from depression. There are also issues to do with anxiety and other major mental health issues in older age that relate to dementia.

We could deal with those three major issues if psychological services were developed further. Certainly, we would have better outcomes for people living in their own home, perhaps resulting in fewer hospital admissions. The basic fundamentals are about educating our professional and volunteer staff. The committee has already heard two examples of NHS Education for Scotland working in partnership with two organisations to support people in delivering psychological underpinnings to support people and keep them at home.

John Mason: To follow on from what has been said in a previous discussion as well as in this one, I point out that we have heard about the importance of community, of having people dropping in and of friendships. In practice, can the Finance Committee do anything about that? Robert Parry talks about paying more for psychological services to do that kind of thing, but the approach also involves things such as lunch clubs that are run by volunteers. Respite, which has been mentioned, directly supports volunteers, but are there other things that we should do or things that we should say about the budget that would really give a boost to communities and to families and friends?

Robert Parry: We work in partnership with the voluntary and independent sectors, with organisations coming together. Through the change fund in Scotland, we have been able to test and build up community capacity, co-production and assets in local communities. We are getting a body of evidence on what is being provided. There are examples of what can be done from up and down the country, and we are sharing them. There are things that professionals, the third sector and the independent sector can do to support initiatives.

John Mason: I would like to come back in, although I am not sure what I am going to ask. It is hard to pin down the issue. For example, why is it that people used to care for their neighbours but do not any more? Is that just the way society has gone? Do we have to accept that, or can we do something about it?

Robert Parry: We can do lots of things about it. The situation varies up and down the country. Some communities are stronger than others. We

have had the advent of the nuclear family and people have moved away from rural communities to more urban settings for work. However, techniques are available, such as telehealth and telecare, which we have heard about, and there are other ways for people to stay in contact with the local community. We take an asset-building approach. We need to carry on building assets by considering the examples and initiatives that have been pump primed through the change fund, which have worked in certain areas.

Lord Sutherland: I was very taken with Bruce Crawford's challenge to us, which is a fair one, and also with the point that was just raised.

One of the things that the Finance Committee could do is watch what is happening at local level. The worry is that when times are tight, and they are going to get tighter, the voluntary organisations are the first thing to be cut from local authority expenditure. By and large, that is bad value for money.

I am delighted to be associated with Alzheimer Scotland. It is not a fair comparison, but you probably get more bang for your buck from such organisations than you do from formal public services, because you have the community. In the case of Alzheimer Scotland, it is a community that is built by its experience of the depredations of various forms of dementia. What it gets in terms of the local support that it elicits from volunteers—because they need a bit of help, they need a bit of organising—is good value.

Nobody else could do this, but the Finance Committee could say to each local authority, "How has your budget for voluntary collaboration changed?" It might be a higher percentage of the total reduced budget, but what tends to happen is that it is lower.

I admire what your committee is doing to raise the issue as a matter for public discussion—that is exactly what we would expect of our politicians. Here is an example of what can be done in the short term. We know how much smoking is safe—zero. However, we have numbers that guide us on alcohol—14 units, 21 units or whatever it is. We do not have similar numbers that we can happily and easily put out to people on obesity and diet. Can you tell me what your body mass index is? I have asked various practitioners to give me a formula so that I can work it out, because then at least I would have a stick to beat myself with, which would be quite useful. If every GP, as well as having signs up about units of alcohol, has a BMI card up so that people think, "Oh, yes, I need to be a bit tougher on myself," that would help. We know about blood pressure now—we are getting better at dealing with that. These little things affect behaviour.

I have some other examples of what can be done. One example is related to what happened on smoking—that required legislation, but it is really going to pay off, I have no doubt about that, and all credit to the Scottish Parliament and the Scottish Government for being willing to push through with what might have seemed to some a very unpopular policy. We just have to think similar thoughts about food. I have been involved in some of the discussions about that with the Food Standards Agency and with the food industry. I understand that the food industry is in it to make money but, on the other hand, there are certain ways that it can be either shamed or constrained and that ought to be thought about—it is a matter for Parliament.

Another example is on the issue of strokes. I chair the Science and Technology Committee in the House of Lords, and the committee produced a report on ageing and research. One frightening number that we came up with was that in this country the aim was to give somebody who had a stroke a scan within three days. In Canada—a big, sprawling country—the aim was to do that in three hours. London has cracked it—London now has a system and it is willing to pretty well guarantee that people will get a scan within three hours of having a stroke. That has required restructuring, reorganisation and channelling of budgets. It is well within the range of Scotland's capabilities to do that. It would be difficult if it is somebody in the Hebrides, but not everybody lives in the Hebrides—what are we doing about the other people?

My last example is to do with a figure in the RSE paper that jumped out and hit me when I first read it. We spend roughly £4.5 billion per annum on health and social care for the elderly, of which £1.5 billion is spent on unplanned hospital admissions. Where is the survey? Where is the check on where this is happening most so that we can ask why? When we get the answer to that, perhaps we could change it.

The Convener: That last point was first raised by the committee in August last year at our away day and it is something that we have drawn to the attention of ministers. I believe that there is a focus on trying to reduce that.

Michael McMahon has asked me to convey his apologies as he has had to leave the meeting.

12:15

Delia Henry: While people were speaking this morning, it occurred to me that diagnosis is critical, to allow earlier interventions. We need to get better at that. For economic reasons, people need to have early intervention and to be given the right information and support. I argue for people who

have a hearing loss, but what I say goes across the piece.

We must give people the tools and information to manage their conditions but, as a society, perhaps we have not been good at that. It is important to think about giving people information and support. I argue that we can do that across all sectors. From my experience of working in the statutory and voluntary sectors, I think that the voluntary sector is particularly good at that work, which is not an expensive intervention.

Mental health is an important aspect that we must consider seriously, particularly as people get older. One in four of Scotland's population has some sort of mental health issue. Among people with a sensory impairment, the rate jumps to 40 per cent—it is significantly higher. We need to have earlier interventions and to give people the tools and information to manage their conditions and to support themselves and—equally important—their families. Understanding the impact is really important.

A slightly different but equally important point concerns keeping people economically active for longer. In Scotland, about 135,000 people who wear hearing aids work, but many issues relate to their employers and what they know. If information and support are provided, people can be economically active for longer. For many reasons—such as the fact that working gives people a sense of self-worth and has an impact on mental health—the committee should think about that subject. I am sure that the situation is not unique to the condition that I support and that it goes across the piece.

Just last week, I spoke to people from the Society of Occupational Medicine who are keen to get information across about sensory impairment, but I am sure that the point applies across the piece. There are inexpensive ways of doing that. For example—I know that I am being anecdotal, for which I apologise—a nurse felt that she could do only night shifts because she was deaf. She also worried that she could not get up early enough in the morning to phone in, and she did not have a phone that worked for her. We told her about a piece of equipment that costs £40—it is basically an alarm that can be put under a pillow—that could wake her by shaking her, which would allow her to do an earlier shift. She was able to buy that herself and she was keen and motivated. Having such simple information can keep people economically active for a lot longer. That issue is worth consideration by the committee.

Jean Urquhart: In the previous evidence session, the point was made that poverty does not help any of the situations that we are talking about. How do we create good habits? Where does that start? Is that all about school, cookery lessons and teaching people about dietetics when they are really young? What advice do you all have on preventative spend? How do we target the people who smoke most, drink most and eat the poorest food, which tends to be full of additives and to create obesity?

The Convener: While Simon Fevre has the floor, I have a question. Your submission refers to

"a key role in empowering people and supporting self-care for the people in Scotland through delivery of structured patient education programmes"

and to

"working in partnership with multi-professional teams across all organisational boundaries".

Once you have responded to Jean Urquhart, will you move on to that?

Simon Fevre: I will pick that up first—otherwise, I will probably forget it.

The Convener: That is okay; I can just read out the quote again.

Simon Fevre: The structured education work in diabetes care is well evidenced. Significant structured education programmes have been put in place for people with diabetes in Scotland. In the past two weeks, eight or nine of my colleagues have been away at a course in Fife to look at the X-PERT programme for diabetics, on which sessions will be run in Fife. Conversation maps are also used in diabetes care. Those well-evidenced programmes are being rolled out across the UK and within Scotland, and such programmes could be further supported.

One of the difficulties in engaging with patients and getting them to see education as something that will be useful for them is the significant time commitment. It is not just about having people in positions to be able to deliver that education; it is about working with patients so that they see their condition as theirs to self-manage as opposed to something that is for other people to manage for them. With obesity management and diabetes, we are trying to drive that approach at the local level and put the emphasis back on the individual and how they can see their life changing. I hope that we can direct them to the appropriate activity or healthier-eating paths.

In Fife, there is the really good community kitchen idea. I think that there are several community kitchens around Scotland. We can engage with areas of the community and people in it who have very limited cooking skills. They can be taken into a kitchen and food workers can be used to work with them so that they can learn basic skills.

That was about structured education; I now want to pick up on hospital admissions. In 2010,

the British Association for Parenteral and Enteral Nutrition surveyed hospital admissions and found that a third of patients admitted to hospital in the United Kingdom were malnourished. That clearly comes from the community, and the figures stack up.

The NHS's reluctance to spend to save is an issue. My background is in the NHS. Looking at short-term goals to achieve financial balance year on year is all well and good, but some of the longer-term spend-to-save initiatives are much harder to get health boards to agree to. The funding for some projects—the child healthy weight programmes and some work for pregnant women, for example—is for one year or two or three years. That creates uncertainty about how the project can be sustained after year 1 or year 2, for example. We are often told, "It's okay. You'll soak it into the system." We have set up clinics to look at child healthy weight, and the system must manage them afterwards, which is very difficult, as the system is stretched at the best of times.

On self-care, John Mason asked how the Finance Committee can help. Care needs to come from a variety of places, including the patient. Carers and families want to care, but they sometimes need just an extra bit of support. That extra bit of support not being there is sometimes a barrier. It can be difficult to get an extra half hour or the ability for somebody to be taken to a lunch club or a day care facility or to have lunch with friends in another house. It is sometimes small amounts of money that are important.

The change fund has been used differently in different places. In many cases, because of the money that is involved, there are large projects to deliver services in a very different way. That is probably appropriate, but the smaller projects could sometimes benefit from small amounts of money. Again, the difficulty with the change fund is that there is four-year funding, and it is difficult to sustain some of the initiatives. In our submission, we used the example of Ayrshire and Arran for dietetics. There, some of the change fund has been spent on training home carers on good and appropriate nutrition for the people for whom they care. The difficulty is in being able to reproduce that approach in a couple of years' time, when there will be a totally different number of home carers.

We need to see those things as fundamental and core. Nutrition is a core part of care but it is not necessarily seen that way in some of our local authorities. In the community meals service, it is seen as a way of potentially saving money, as it is in hospital catering services. We are changing that, but it is taking time.

Robert Parry: Our biggest asset is our workforce and the staff who are engaged in delivering and supporting health and social care. Research undertaken in the south-east of Scotland for NHS Fife and NHS Lothian recognised that one of the issues that we all face is the number of people in those professional groupings who will retire in the next five to 10 years. It looked at what support services need to be developed. For instance, 31 per cent of NHS Fife's workforce is eligible to retire in that period.

That is a big issue for the NHS boards and the workforce planners. By undertaking that research, NES and the south-east NHS education forum were able to identify things that we could do now to value the workforce and get them to work differently. Because of their years of experience they can take a mentorship role. There are alternative models of employment that enable people to retire but come back into employment after a period of time. It is about working with the workforce, in the current economic climate, to address the shortage that we will all face of professionals to deliver services. The issue is multifaceted, and all of those facets need to come together.

Anne Simpson: I emphasise the positives from the point of view of the National Osteoporosis Society. There is the NHS falls activity in Scotland, as well as our network of osteoporosis specialist nurses, who are in post in most health boards in Scotland. We are rolling out support for people newly diagnosed with osteoporosis. Last year, well over 1,000 people from throughout Scotland attended our sessions. Lifestyle issues are an important part of complementing the clinical management of osteoporosis and the prevention of fractures. The sessions, which usually last about half a day, are well received. People are often extremely surprised and devastated at receiving a diagnosis of osteoporosis. They have had a fracture and had no idea that it was due to osteoporosis. They can feel very depressed about the future. We have been working in partnership to provide information that makes people feel that they can take charge of their condition and informs them about the services that they can access locally.

I endorse Simon Fevre's comment. There are issues at the local level, for example in relation to falls posts and osteoporosis specialist nurse posts, which are vital to delivering the fracture liaison model. Such posts are under threat, perhaps because of the short-term approach to funding. It is not fair to expect a specialist practitioner to be able to deliver good services when they are on year-on-year contracts. It seems like such a waste of money for falls co-ordinators to be put in post and then, within two to three years, just when the effect of that intervention and the joint working required in each area is beginning to be felt, for that post suddenly to be gone. In some ways, the

change fund has perhaps not been used to best advantage. It is about sustainability. We simply cannot deliver services based on year-on-year funding.

The Convener: Gavin Brown has the spotlight.

Gavin Brown: I was struck by something Lord Sutherland said about nutrition, comparing it to what are perhaps simpler messages about cigarettes and alcohol. I pose a question to Simon Fevre. How do we get round the difficulty of the conflicting messages about nutrition that come across the airwaves?

I am convinced that many people just switch off because they hear one week that coffee is good for them and has big health benefits but, literally a week later, there is another study that says that coffee is bad for them. They hear that eggs are really good for them because they are a good source of protein but also that they are really bad for them because they are high in cholesterol.

The nutrition message is more complex than the other two messages to start with but, because there is a constant conflict, people simply ignore nutritional advice. Does Simon Fevre have thoughts on how we tackle that?

12:30

Simon Fevre: You are right that nutrition is complex. It is not as simple as telling people to stop smoking; the message is more complicated than that. I have been qualified for 26 years now, and the core message has not changed over those 26 years. Unfortunately, it gets lost in the mass media's search for a story about the latest food and, perhaps, in people's desire for a quick fix from a secret food that simply does not exist.

We need a combination of approaches. The key element is the consistent message that NHS staff, the Scottish Government and the boards give. However, that message just does not get out. I suppose that some of the other stories are much more exciting than that message, which is not exciting.

Consistency is really important. We should probably tap into the significant number of potential ambassadors that we have in our staff. If we can channel staff in local authorities and the NHS—the two biggest employers in Scotland—into a role in health promotion and give them the resources and tools to be able to carry out that role, we might be able to tap into that consistent message on a one-to-one basis.

We also need to take some hard, firm decisions on food, and we need to be brave. I am not certain what that brave step should be, but we have been brave in relation to other things and perhaps we should be brave on food as well.

Bruce Crawford: I do not want to be controversial, but I cannot help it on this matter. I understand that there is a consistent message about eating less fat, sugar and salt and that we should have our five a day, but is the message deeper than that or is that it? If it is more than that, I am not sure that I have heard it—it has not been as loud as it should be. It may be consistent, but how are we getting it across? If I have got the message wrong, please tell me. How on earth do we embed it? I think that that is where Gavin Brown was coming from.

Simon Fevre: The message is right. The issue is how we put it across and engage with the people who need to hear it. You have heard the message, and how you implement it is key. Many people are able to do that—they are able to rationalise and consider strategies for implementing the message themselves—but there is a significant number of people who struggle to incorporate it into their lives for a range of reasons. Those may be economic reasons or educational reasons or they may be to do with the information itself.

We need to look for, identify and promote good projects rather than concentrating on the projects that are not working. I mentioned community kitchens. A couple of weeks ago, I received a report about the impact of the community kitchens project in Fife. We need to make such information available.

It may be possible to engage with young people on projects of that type. Most young people probably know the five-a-day message but the key to the issue is how they incorporate it into their lifestyles. We need to be better—and, probably, more creative—at addressing that.

Elaine Murray: Many people do not know what one unit of their five a day is. There is advice that half a tin of kidney beans is one unit. Who wants to eat two and a half tins of kidney beans, and would they have any friends left afterwards? [*Laughter*.]

Mental and psychological wellbeing have been touched on, but I wonder whether we concentrate enough on mental health issues, which are often tied into self-destructive behaviour such as smoking, drinking too much and so on. Depression is one of the major illnesses of old age. Rather than sending an old person to a doctor who might give them a pill to try to make them less depressed, are there other actions that we can take?

That takes us back to Lord Sutherland's comments on the voluntary sector and what I said in the previous session about Food Train in Dumfries and Galloway, which uses the resource of newly retired people to drive and provide

support. Initially, the project was about buying food in for people who cannot shop for themselves, but it has been extended to cover gardening, heavy housework, things such as changing light bulbs and just going in to talk to people. That type of social or third sector enterprise helps to improve the physical and mental wellbeing of both the newly retired and the people whom they support. We need to concentrate on such activities.

The Convener: I will let Robert Parry respond to that. He has touched on the issue already today, but he states in his submission that there needs to be a

"Greater emphasis on prevention of mental health problems and long-term physical conditions in later life".

That point is coming through loud and clear.

Robert Parry: Yes. The report that I mentioned earlier identifies the comorbidities around physical and psychological care. Part of the role through the matrix within that report would be to prepare the general public through a health education campaign about simple psychological interventions to promote people's wellbeing in older age, and also to work with professionals, such as the district nurse who goes in to dress a leg ulcer. How can we upskill that person on psychological interventions around cognitive behaviour? We could focus on how they speak to people and how they promote wellbeing to individuals to keep them healthy, both mentally and physically. All those things are important. Education is required to underpin the work of those groups of professionals, because we need to develop values in them that help to support people in their own homes.

Lord Sutherland: These matters are complicated, and sometimes there is a slow burn. It took us 50 years to take on board Richard Doll's research on smoking. We could not have got the legislation on smoking through in 1960 or 1970, and probably not in 1980, because the minds of the public were not prepared. I am not suggesting that it will take 50 years on the question of obesity, but it will take a while. It will be hard work and a lot of effort will be required. There will need to be prodding and provoking.

On the point about five a day, I might be a simple person, but I like to have a number such as that, because then I can at least begin to track what I am up to in terms of eating. However, contradictory advice is coming through. I used to keep a little file of things that were meant either to be good for preventing dementia or to encourage it. At one stage, one thing that was supposed to prevent it was reading the Dundee *Courier*. [*Laughter*.] How did its public relations man get that out? I could tell you the story, but it is a long one. Anyway, the range of things was just crazy.

Scientists have to be careful. I am looking across the table at Robert Parry and Robert Logie. We heard the news today that some of the big drugs companies are pulling out of fundamental research into and trialling of cures for dementia. I suspect that one reason for that is that they were given overoptimistic pictures early on. Every scientist likes to be in the papers. The papers have a responsibility, too, but there has to be responsible behaviour about what can be achieved and how many years it will take. It is important to work at it and get the numbers out.

Now that alcohol is being dealt with seriously, let us do the same for food and nutrition.

The Convener: Tacrine, which came out in the 1980s, was supposed to be the drug to change the picture for dementia and Alzheimer's. Earlier this year, I read a report in the *New Scientist* from the University of Ulm, which stated that drinking three cups of green tea a day prevents the formation of the plaques that cause Alzheimer's. That is a potential preventative measure.

We have an expert professor here today and he will speak next.

Professor Logie: My comments are consistent with Lord Sutherland's. The message is very complex with regard to food and also with regard to cognition. It is possible to have a very simple message. In the case of smoking, there are vested interests and conflicts of interest and there are companies that make their living and their profits from selling these products. That is no less true of a wide range of foods. The public, therefore, is confronted by a wide range of very mixed and conflicting messages and it is unclear what source they should take as the basis for the advice they are given.

I think that that is one of the reasons why it is so difficult to communicate messages. The scientists themselves disagree because science is about debate and about moving knowledge forward, and arriving at a consensus view is often quite difficult. One of the major problems in explaining scientific views is the difference between causal links as opposed to associations. In the green tea example, we do not know whether people who are less prone to dementia are likely to choose a healthy lifestyle or whether a healthy lifestyle lowers the propensity for dementia. The difficulty with interpreting evidence is at the nub of much of the difficulty of communicating clear messages.

I agree entirely with Lord Sutherland about scientists being very careful in what they say to the media. Not all scientists want to talk to the media, and we do not know whether those who do are the best ones to do so. However, it is important that we are able to evaluate evidence that emerges and to question whether it is really

causal or correlational and whether it is evidence that one wants to promote to the general public. There may be some findings in the laboratory that are not appropriate for the general public. I have done such work on human cognition. It is important for the practitioners, the politicians and the policy makers to have a dialogue—a triologue—and to discuss in detail the scientific evidence, its practical relevance and its importance for policy.

Last week, I gave an update lecture to the Irish Gerontological Society in Cork to an audience that comprised scientists, practitioners and politicians. It was very much a case of the science trying to influence policy in a rather positive way. I think that such forums are really important—it would be nice to see that happening in Scotland, too.

The Convener: People should let me know if they wish to comment.

You will have noticed that during the meeting I have seamlessly managed to quote from each of the six papers that were submitted in evidence, except for Delia Henry's paper. I wish to raise a point with her with regard to blindness and sight loss. She states in her submission that

"Early diagnosis and treatment can prevent up to 98 per cent of severe sight loss."

Perhaps she might like to speak about that.

Delia Henry: It reinforces my earlier point that it is critical to pick up sensory impairment—both hearing loss and visual impairment—as early as possible. There are relatively low-cost interventions to address most of these issues.

Hearing loss is not curable. We funded a project whose scientists spoke to the press about opportunities for regrowing hair cells in one type of hearing loss, but that research is in its early stages. Although there are no significant cures, early interventions exist that can help people to address issues and give them the tools to manage their own condition. We would argue that early intervention and giving people the tools to manage their condition—such as those described by Simon Fevre with regard to the management of diabetes—are critical steps. It is important to keep people economically active for as long as possible. That is what people tell us they want, and it would also suit the purposes of the Finance Committee.

I want to mention technology, which our statutory services use in a rather ad hoc fashion. Consistency is important, because it helps people to be independent for longer. I do not go to my general practitioner that often but, when I did so a couple of weeks ago, I got a text to remind me about my appointment, which I thought was a really good development. After all, 62 per cent of our fairly elderly membership—the average age is 64—use a mobile phone. Accessibility of statutory services is important and I think that we need to start thinking about such relatively inexpensive interventions to support people.

The Convener: Does anyone else wish to make a comment? It is a bit of a going, going, gone scenario. Going once, going twice—okay.

I thank all the witnesses for their contributions. According to my calculations, we had 35 contributions from the floor. I also thank you for your very interesting submissions, which will certainly give committee members food for thought.

Meeting closed at 12:46.

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