The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 30 January 2013

Session 4

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PUBLIC AUDIT COMMITTEE
2nd Meeting 2013, Session 4

CONVENER

*Iain Gray (East Lothian) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Bob Doris (Glasgow) (SNP)
*James Dornan (Glasgow Cathcart) (SNP)
*Mark Griffin (Central Scotland) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
Tavish Scott (Shetland Islands) (LD)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Peter Cawston (Drumchapel Health Centre)
Dr Linda de Caestecker (NHS Greater Glasgow and Clyde)
Elaine Egglestone (Govanhill Health Centre)
Caroline Gardner (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)
Dr Susan Langridge (Possilpark Health Centre)
Tricia Meldrum (Audit Scotland)
Dr Anne Scoular (NHS Greater Glasgow and Clyde)
Professor Graham Watt (University of Glasgow and General Practitioners at the Deep End)

CLERK TO THE COMMITTEE

Roz Thomson

LOCATION

Committee Room 5

Scottish Parliament

Public Audit Committee

Wednesday 30 January 2013

[The Convener *opened the meeting at 09:30*]

Decision on Taking Business in Private

The Convener (Iain Gray): I welcome everybody to the meeting and ask everybody to ensure that their phones are switched off.

We have apologies from Tavish Scott. Everyone else is here.

Agenda item 1 is to decide whether to take items 5, 6 and 7 in private. Do members agree to do so?

Members *indicated agreement.*

Section 23 Reports

"Prescribing in general practice in Scotland"

09:30

The Convener: From our first panel we will hear evidence on a just-laid section 23 report by the Auditor General for Scotland, entitled "Prescribing in general practice in Scotland". The Auditor General is with us to speak to the report and answer questions. She has with her Barbara Hurst, who is director of Audit Scotland's performance audit group, and Tricia Meldrum, who is also from the performance audit group.

I ask the Auditor General to introduce the report.

Caroline Gardner (Auditor General for Scotland): Thank you, convener.

The national health service in Scotland spends around £1 billion a year on prescribing in general practice, which is around 10 per cent of NHS boards' budgets. Last year, general practitioners issued 91 million prescriptions. In the report, which follows up reports that we published in 1999 and 2003, we have tried to assess how well the NHS is managing that spending.

Overall, we found that the NHS has done a good job in improving its management of GP prescribing. Spending fell by 11 per cent in real terms over the seven years from 2004 at the same time as the volume of prescriptions rose by a third. That is in contrast with what happened previously—in the seven years up to 2004, spending increased by 50 per cent in real terms. There has therefore been a genuine shift in the direction of travel for spend at a time when the volume of prescriptions is increasing.

One of the main reasons for that is the support and guidance that are now being provided to GPs to help them to manage their prescribing. That is provided in order both to keep the costs down and to meet the needs of patients who require drug treatment. The support includes support for GPs from prescribing advisers who are employed by health boards, agreed local joint formularies that give guidance to GPs in primary care and prescribers in hospitals on the sorts of drugs to prescribe, and published best-practice clinical guidelines to help GPs to ensure that they hit the clinical needs of their patients.

Overall, the NHS now has much better information on GP prescribing, and NHS boards and GPs are using that information to target the areas where they can improve. We are seeing that in the costs of prescribing as well as in the quality that is achieved.

In an area that accounts for more than £1 billion of spending, the NHS needs to continue to look for opportunities for improvements and savings. We have identified scope for further potential savings of around £26 million a year without patient care being affected. That could be achieved by two main measures: reducing unnecessary waste, for example as a result of patients getting repeat prescriptions for drugs that they no longer take; and reducing the use of drugs that are considered to be less suitable for prescribing, for example because better or more cost-effective drugs are available.

We looked at the impact of the abolition of prescription charges from 2011 to see whether that has had an impact on prescribing. Overall, we think that it is too early to tell whether there has been an impact, but we have certainly not so far found any evidence of a significant change. We will continue to keep the matter under review. We have also recommended that the Scottish Government monitor the impact annually.

In looking ahead at this important area of NHS spending, we know that demographic factors including the age of patients and deprivation are associated with higher levels of GP prescribing. Lifestyle factors, such as obesity, smoking and alcohol misuse, and associated illnesses, also have effects. That means that levels of prescribing are likely to continue to increase in the future, but some of the effects on spending will be offset by other factors, particularly falls in the prices of some drugs as they come off patent. We have estimated that in 2012-13 there will be savings of around £86 million in general practice from drugs that come off patent.

Finally, we looked at the quality and safety of prescribing from the patient's point of view, in particular in respect of the challenges facing patients who take a number of different drugs. Those people have a higher risk of either side-effects or interactions between the drugs that they take. We found that more than 900,000 people in Scotland are taking four or more different drugs at any one time. In October 2012, the Scottish Government issued guidance on reviewing and improving prescribing for patients taking multiple drugs. We have recommended that NHS boards work with GPs to implement those guidelines and ensure that those patients are being treated as safely as possible.

I will stop there. We are happy to answer the committee's questions.

The Convener: Thank you very much. As we are the Public Audit Committee, I feel that I should start by acknowledging what a good news story the report appears to be. The report states:

"The quantity of drugs prescribed increased by 33 per cent between 2004/05 and 2011/12. Spending on drugs fell by 11 per cent in real terms over the same period".

That is surely the kind of information that should gladden the heart of any Public Audit Committee member. It is a remarkable story.

I just want to tease out why that has happened. The report states that one reason for it has been an increase in prescribing of drugs that have come off patent; the report points to a drop of as much as 94 per cent in cost when a proprietary drug is replaced by a generic equivalent. I presume that drugs come off patent all the time, while new drugs are developed and come on to the market. Is the change that we are seeing in this respect because, for some reason, a lot of drugs came off patent and became cheaper, or are we seeing a real change in prescribing behaviour within the NHS?

Caroline Gardner: I think that it is the latter: we are seeing a real improvement in prescribing behaviour. You are right that it makes a difference when treatments become available as generic drugs rather than patented drugs, but that has always been the case. When we looked at GP prescribing back in 1999 and 2003, we found a much higher proportion of drugs being prescribed as branded drugs than as generics. The thing that has made a real difference is that NHS boards have been working with general practices to support them in targeting where they can improve their prescribing and to really change that behaviour. Tricia Meldrum can give a couple more examples of where that may have been the case.

Tricia Meldrum (Audit Scotland): We found that NHS boards now employ teams of staff who work with GP practices to target areas for improvement. For example, there are now good-quality data available on GP prescribing, so data analysts can analyse those data to find out what are the areas that can be targeted for improvement within a particular board, practice or community health partnership.

Boards also provide prescribing advisers, who may be pharmacists who have specialist knowledge of drugs and of best clinical practice and clinical guidelines. Again, they can work with GP practices to raise awareness of best practice. We also found examples of boards employing pharmacists to work with GP practices, where they would be based for some sessions each week to work either with the GPs or with patients directly on things such as medication reviews. That has really helped the GP practices to target where they can improve their prescribing. Such things are making a big difference.

There are also now joint local formularies, which set out the agreed drugs that are recommended for use locally. Those are now agreed between

general practices and hospitals. That provides continuity of care and is also making a difference.

Mary Scanlon (Highlands and Islands) (Con): This is not my prepared question, but your reference to data analysts brought me back to exhibit 5 in the report. A rough glance at that graph suggests that there is about £30 more spending per head on GP prescribing in NHS Fife than in the Greater Glasgow and Clyde NHS Board area. Given all those best-practice initiatives, clinical guidelines, data analysis and advice initiatives on prescribing, why do we see such a variation there?

Tricia Meldrum: We have made recommendations about certain areas that boards can continue to target in that respect and have recommended that boards with fewer prescribing support staff and higher prescribing quantities or costs might want to consider whether there is scope for a spend-to-save initiative to improve or increase the prescribing support that is available to general practices.

Mary Scanlon: There seems to be quite a variation.

I want to ask about pages 16, 17 and 20. I have to say that I was surprised by the recommendation on page 20 that

"The Scottish Government should ... remove the incentive for pharmacists to over-order repeat drugs as part of the changes to the community pharmacy contract".

It seems incredible that there is almost an in-built incentive to over-order drugs, given that we have been asking patients not to stockpile or waste medication.

Perhaps I can tie that in with information that is presented in paragraphs 39 to 42. I note, for example, that it was found that £110 million-worth of drugs were being kept in people's homes. What can the community pharmacy contract do about that?

My third question relates to a point that the Auditor General made. Anyone reading it would find it odd, but I see from the report that NHS Lanarkshire prescribes five times more

"drugs classed as less suitable for prescribing"

than NHS Lothian. Setting out a definition of that "less suitable", the report says:

"This does not mean they should not be prescribed at all but that the evidence of their benefit is uncertain, more effective drugs have superseded them, or they have significant side effects."

I know that this is not the Health and Sport Committee but, from a financial point of view, I am quite amazed to see such a disparity and that such a concern still exists after all these years.

Caroline Gardner: I will answer your first question on the community pharmacy contract. Tricia Meldrum and Barbara Hurst will pick up from there.

We have seen how much scope there can be in the GP contract to improve the effectiveness of primary care and to align it with the rest of what the health service and public services more generally are doing, and this seems to be a real opportunity to move the community pharmacy contract in the same direction. There are great initiatives, including the minor ailments initiative, which allows patients to register with a community pharmacy for management of their condition. We think that there is scope to take that further by shifting the incentives from a payment-per-item-prescribed system to a more effective and cost-effective prescribing system. The high-level recommendation is very much about negotiating the contract to improve prescribing as part of the wider management of patients' health.

Tricia Meldrum will tell the committee about specific things that could be improved.

Mary Scanlon: I am sorry—I should just say that on re-reading that paragraph I find that the £110 million figure applies to England. The figure might not be as much in Scotland. Do you have a comparable figure for Scotland?

Tricia Meldrum: One of the risks that have been identified with the repeat prescribing service is the potential for patients to get some of their drugs more frequently than they need them. For example, patients could be prescribed painkillers to take "as required"—in other words, when their pain is bad—and would therefore not be taking the drugs all the time. However, they might end up with a repeat prescription before they reached the end of their supply. We wanted to flag up those kinds of risks.

Mary Scanlon: Is the community pharmacy contract about to be renegotiated, changed or reviewed to address that issue?

Tricia Meldrum: Discussions are on-going. We know that significant changes have been made in the community pharmacy contract with regard to, for example, the minor ailments and chronic medication services, but we wanted to flag up certain issues about repeat prescribing.

Boards raised with us issues around public awareness campaigns that tell people to stock up on medicines before Christmas, for example, when practices are closed. Again, as with the repeat prescription service, we recognise the value to patients of their doing that, but people who were stocking up for Christmas were not necessarily cutting back on repeat prescriptions after that time, which meant that stockpiles developed.

09:45

Mary Scanlon: It is not just individuals who are stocking up; there seems to be poor practice in care homes as well.

Could you respond to the second part of my question, about drugs that are classed as "less suitable" or for which "evidence ... is uncertain" on their benefits and so on?

Tricia Meldrum: As new evidence comes on stream, new drugs are developed, new trials take place and new research takes place, there is a need to ensure that the formulary is keeping pace. For example, there is no clear evidence that co-codamol has any additional benefit over paracetamol for certain patients, so paracetamol might be the more cost-effective treatment. The same applies to certain migraine drugs, such as Migraleve. We are not saying that those drugs have no value, but it might be that they have been superseded by alternative drugs. We need to ensure that the formulary picks up on the most effective drugs and that the prescribing support team works with GPs to ensure that there is compliance with the local formulary.

Lanarkshire has quite low levels of prescribing support compared with some boards; there is disparity.

Mary Scanlon: You are saying that the low level of prescribing support and advice in Lanarkshire would explain why the prescription rate of unsuitable drugs by that health board is five times greater than, say, the rates in NHS Lothian and NHS Borders.

Tricia Meldrum: I cannot say that that is the only reason, but I think that that would be one of the issues. NHS Lanarkshire might want to consider whether there might locally be scope for spend-to-save initiatives.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I echo the convener's comment that this is a good report; it is probably one of the better ones that have come before us. However, as the convener said, we are the Public Audit Committee, so we have to look for something to pick on.

Paragraph 20 notes that spending on drugs is lower in the United Kingdom than it is in the rest of Europe. I am quite intrigued by that. It makes a comparison between the UK and states that have insurance-based healthcare systems. Does that imply that state and private health insurance systems tend to be more expensive, because they do not focus as much on generic drugs but focus instead on branded drugs?

Caroline Gardner: There is more prescribing of generic drugs in the UK than there is in the places in Europe with which we compared the UK. We have not fully investigated the reasons for that, but we think that the key is that we can use the purchasing power of the NHS through the price-regulation scheme. That is not to say that countries in which there are insurance-based schemes could not have such a national negotiation, although they tend not to. Their negotiations tend to involve the insurance provider at regional level.

Colin Beattie: I assume that, in the UK and Scottish contexts, there is no indication that the private system that we have, which operates alongside the NHS, is more expensive in terms of the drugs that it prescribes.

Caroline Gardner: We did not consider that in this audit. Tricia Meldrum and Barbara Hurst are indicating to me that we are not aware of any relevant information on that matter. We have simply considered the way in which the NHS prescribes drugs and, in particular, trends in that over time.

Colin Beattie: It would have been interesting to see such a comparison.

The one thing that is missing from paragraph 20 is the volume of drugs that is involved in the various countries. That would have been interesting to know. Do you have that?

Caroline Gardner: I do not think that that information is available. We can do it within Scotland and the UK, because we have the figures for the daily dosage units. For countries outside the UK, we just converge overall spending.

Colin Beattie: The same question applies to prescribing in deprived areas. In the past, the committee has focused on the more deprived areas of Scotland. Paragraph 72 states:

> "Practices serving the most deprived populations prescribe on average 46 per cent more drugs per head of population than those in the least deprived areas ... Spending is also 37 per cent higher per head of population."

That creates a huge skew in the way in which prescriptions work because, to produce the sort of average that you bring out, the least deprived areas must be much cheaper to compensate. Given that there are relatively few practices in deprived areas, are the doctors in those areas prescribing far more than doctors in other areas? Is any more information available on that?

Caroline Gardner: There is some more information on that. If you look further on in the report, you will see some of the points that we have drawn out. First, we know that patients who receive many drugs together tend to be older patients or people who live in more deprived areas. Secondly, when we look at the association between deprivation and the prescribing of

particular types of drug, we find that there is not a consistent relationship.

Tricia Meldrum will tell you a bit more about the relationship between deprivation and prescribing at practice level and more generally.

Tricia Meldrum: Very high-quality data are now available on prescribing and patient characteristics that have allowed us to do such analysis for the first time. We found that the strongest relationship was with the use of painkillers, and use of hypnotics and anxiolytics—sleeping drugs and drugs to control anxiety. We found that there was still a significant relationship with statins—in other words, there is greater prescribing of statins in more deprived areas, although the relationship is not as strong as it is for the other two groups of drugs.

We are aware that NHS boards are tackling the issue. It may be to do with factors that we have discussed previously, such as later presentation and later identification of conditions. The aim of programmes such as the keep well initiative, which involve health checks, is to focus attention on such areas.

Colin Beattie: I was interested in the comments that are made in paragraph 75 about the prescription of hypnotics and so on—I presume that they are uppers and downers, which are being given to people who are depressed and so forth. Does that indicate a higher level of depression?

Tricia Meldrum: They are not antidepressants—they are drugs for anxiety. We did not look at antidepressants as part of our analysis. They are a separate class of drugs.

Colin Beattie: I am just trying to tease out some of the differences between the approach in deprived areas and the approach in better-off areas.

Tricia Meldrum: Other research has shown a link between deprivation, depression and the prescribing of antidepressant medication.

James Dornan (Glasgow Cathcart) (SNP): I have a question about paragraph 72, which says that although some practices in deprived areas have high levels of prescribing, other practices in the same areas sometimes have very low levels of prescribing. Can you explain that dichotomy? What can we do to ensure that everyone gets the same service?

Tricia Meldrum: We presented that information with a view to asking whether practices, with the support of boards and prescribing advisers, could look at why that might be happening. The data could be used to identify where we might expect prescribing of particular drugs to be a bit higher or a bit lower, depending on the age and deprivation characteristics of the population that the practice serves. Where things are a wee bit out of kilter, the prescribing advisers and the GPs could look at why that might be and identify whether there is scope to increase prescribing or to decrease it.

We were making the point that although there is a clear association between deprived areas and high levels of prescribing, there are still outliers at both ends of the scale where there is scope for more investigation locally to see what the issues might be and what could be done.

James Dornan: On the face of it, does it look as if people in practices that have a higher level of prescribing are getting a better service, or is it possible that people in practices with a lower level of prescribing might be getting a better service, because the pharmacists are using the drugs more wisely?

Caroline Gardner: It is not possible to give a single answer to that question. It might be more useful to look at exhibit 15, which shows the different prescription rates for different individual drugs. As Tricia Meldrum said, for sleeping pills and anxiety drugs, the prescription rate is about four times higher in deprived areas than it is elsewhere, but the rate for statins is only about one and a half times higher. Given what we know about ill health in more deprived areas and the lifestyle factors such as obesity that can lead to a higher risk of heart disease, there is a question about whether we might expect that prescribing ratio to be higher in those deprived areas. The figures that we see are an average, because practices in an area will have a range of prescribing.

That is why we think that it is important for GPs to sit down with their prescribing advisers and use the data to say, for example, “We look a bit low here. Should we be prescribing more of this particular class of drug?” or “We look very high on sleeping pills. Is there something we could do to reduce that?” It is about targeting what is happening in a particular practice and working over time to shift that to ensure that patients get the best care—whether that is more drugs, fewer drugs or different drugs.

Barbara Hurst (Audit Scotland): We are definitely not querying individual GPs’ clinical decisions.

James Dornan: I was not suggesting that you were.

Barbara Hurst: I just wanted to make it clear that that is down to their professional judgment. What is interesting is that NHS Greater Glasgow and Clyde is one of the boards that is doing really well in its management and support for GPs.

Colin Keir (Edinburgh Western) (SNP): My question is about overstocking, which might have been better as a supplementary question.

Over the past couple of years we have had a few incidents of severe weather conditions. Any industry must take such incidences into consideration when considering deliveries from suppliers to stockists. Have I missed anything in the report that considered that aspect? For example, with regard to the severe winter weather that we had over the Christmas and new year period a couple of years ago, is there evidence that has not been taken into consideration of overstocking of drugs by care homes and pharmacies, which would have skewed the figures slightly?

Caroline Gardner: We have done that specific analysis. What we have seen and what we have heard from GPs, as well as what we have learned from research that has been done in England, is that there is a consistent pattern of people using good schemes that enable them to stock up before periods such as Christmas and new year, when practices are not open. We therefore see a peak in prescribing, but we do not see the reduction afterwards that we might expect as the pattern catches up across the year.

Caroline Gardner: There is a more general point to be made about the incentives all being for community pharmacists to prescribe because of the basis of payment, rather than to manage prescription in a more rounded way.

Colin Keir: I asked my question because, for example, in some areas, roads were out of commission for the best part of a month, so I wonder whether such situations had been considered. My view differs from Ms Scanlon's view, in that in such circumstances the ability to supply people who require a drug shows good practice rather than bad practice.

Caroline Gardner: I do not think that we have any evidence on the situation that you described.

Colin Keir: Okay.

Bob Doris (Glasgow) (SNP): I turn to the variation in health boards' performance on prescribing, as there were dramatic differences between the 14 health boards. The report picked up on differences in the prescribing support that is available. Are any mechanisms in place for boards to share best practice? Are there any imperatives to say that they must do that?

Tricia Meldrum: Yes. There is a Scottish prescribing advisers network. I am not sure whether that is the right title, but there is an umbrella group of prescribing advisers who get together periodically, partly to share best practice, guidelines and work that they are doing. It is quite an active network. It is a small community, so they are quite switched on to what one another are doing.

10:00

Bob Doris: How long has that been running for?

Tricia Meldrum: I do not know—I am sorry.

Bob Doris: It is just that, with such dramatic differences remaining, I am keen to know how effective that group has been. It is such a good report, and we are looking for ways to continue to improve.

I also sit on the Health and Sport Committee. We are finding significant variations in performance between the area drug and therapeutics committees—ADTCs—which put drugs on to formulary and consider these various matters at each health board. Do you believe that the mechanism that is in place for the sharing of best practice is appropriate? Your report suggests that improvement requires best practice to be achieved across all 14 boards, and that we still have to make significant savings. Are the structures that are currently in place working in relation to the sharing of best practice?

Barbara Hurst: Yes, we think that this is an area where there is a lot of good communication across boards. The joy of it, in audit terms, is that it is so data rich. We are hopeful that, if we highlight some of the variations, boards will take those seriously and look at what they are doing differently from some of their counterparts. We hope that that, in combination with the systems that are in place, will help to drive the sharing of good practice.

Bob Doris: Should the boards be considering a target, such that, if you were to look again at this data and return with a follow-up piece of work in two years' time, the poorest-performing boards would be 40 per cent closer to the best-performing boards? We cannot simply monitor the situation as a snapshot in time; we need to consider where we are in two or four years' time.

Barbara Hurst: Yes. As you say, this is a good-news story, so it is hard to think of there being poorly performing boards. However, it would be quite easy for us to take some of the indicators that we have tracked through from the very early days when we first looked at this and find out what happens in two years' time. It will be up to boards to select the areas that they wish to prioritise, but there are some clear messages in the report for different boards about the areas where they might not be performing quite as well as other boards.

Caroline Gardner: I will present one example that we have been impressed by, which might help

to colour that point for you. Exhibit 5 on page 11 of the report shows that NHS Forth Valley is bringing down its spending fast—that is shown by the orange line on the graph, which has come down a lot since 2010. NHS Forth Valley tells us that it is achieving that by learning from what NHS Greater Glasgow and Clyde, which has been one of the best-performing boards, has been doing and by looking at its examples of areas to target and ways to get prescribing advice working in practice. Boards are learning from one another, but there is no one thing that every board needs to do—it is about targeting those areas where boards have room for improvement and ensuring that they are paying attention to them.

Bob Doris: I am not seeking to rain on the parade of what is a good-news story, but it is our responsibility to go even further and to promote best practice in order to save even more money for the public purse and improve patient care. On the other committee on which I sit, we have been considering the roles of community pharmacists quite a lot. There are initiatives for improving prescribing methods, which individual health boards have invested in, but community pharmacists are in every community irrespective of specific initiatives. The ones I meet tell me that, if they had more time and more space in their pharmacy, they would sit down and have a chat with customers or service users who come into the pharmacy to discuss polypharmacy and other drug and medication options. In making your report, did you discover—separate from specific initiatives, but with regard to people popping into their community pharmacist on the high street, sometimes just for a lunch meal deal, for instance, in the case of one of the large commercial operators—that pharmacists need more time to work with patients?

Caroline Gardner: It is clear that there are some good initiatives in place already, and that there is scope for those to go further. We know that good pharmacists can make a big impact on patient care, and there are good examples of that. That takes us back to the point that we make in our report about using the community pharmacy contract to put incentives in place for that sort of development, rather than the incentive being payment per item prescribed. It is an area that is highly variable, because of the way in which the pharmacy service has developed over time. As you say, the different premises and different levels of staffing mean that what pharmacies can do is different in each part of Scotland. There is certainly room to go further, and we think that the contract is the mechanism for putting incentives in place for that to happen.

Bob Doris: Thank you for putting that on the public record.

Mark Griffin (Central Scotland) (Lab): The figures that jump out from the report are the 11 per cent reduction in the cost of drugs against the backdrop of a 33 per cent increase in levels of prescribing. A big part of that has been attributed to more prescribing of generic drugs, but I want to drill a bit deeper into that. I ask my question without an in-depth knowledge of the patent and approval processes, so perhaps you will correct me if I go wrong. Has there been any evidence of changes in the approval process for drugs to be made available for prescribing? Obviously, if the time for which a drug is available for prescribing on patent is reduced, that reduces the cost to the NHS. Have any studies been done on the length of time for which drugs are available on patent for prescribing and whether there are differences in that between Scotland, the UK and Europe? That might explain the higher costs in Europe.

Caroline Gardner: I ask Tricia Meldrum to give us a short tutorial on the drug patent system.

Tricia Meldrum: I am not aware that the length of time on patent is different in different parts of the UK—I would not think so, as the patents are at UK level. Sorry, but I do not know the minimum length of time for which a patent runs, but, at the start of the period that we looked at, one of the big drugs to come off patent was a commonly used statin. Our data show a huge increase in the amount of statin prescribing that switched to simvastatin when it came off patent and the price dropped dramatically.

Another common statin is atorvastatin, which has just come off patent. It was a proprietary drug for seven years. There were moves to reduce prescribing of atorvastatin where it was clinically appropriate for another statin to be used, because atorvastatin was a higher-cost option. However, now that it has come off patent, the price is dropping dramatically, so it is becoming more cost effective. Obviously, the issue of patents has a big influence.

The process for the introduction of new drugs is one stage back from our report, which looked at drugs that have been in place for a number of years. They have been through all the approval and licensing processes, and the issue is just the time for which they will be on patent. The issues to do with new drugs are different and do not have such a big impact on primary care prescribing. The new higher-cost drugs that are coming through are more specialist drugs that would be used in hospitals by specialists.

The Convener: To follow up on that, nonetheless, in paragraphs 62 and 63 of the report, you refer to one aspect of the debate on new and expensive drugs, which is the end of the price regulation scheme at the end of this year and

the proposed shift to value-based pricing. You state:

"These changes make it more difficult to forecast potential changes in the spending and quantity of ... prescribing".

Might that issue undermine the progress that has been made and reported on in the report?

Tricia Meldrum: We just do not know what that will do to prices. We were simply flagging up an area of uncertainty for the future.

The Convener: Mr Doris can ask a question on that if it is very brief.

Bob Doris: I promise that it will be, because the Health and Sport Committee is considering value-based pricing as well. Will Audit Scotland have to make significant changes to its methods of auditing, given that it will be considering the social on-costs of not prescribing in terms of social care and residential accommodation? Has Audit Scotland been able to consider that yet, or does it need more information from the UK Government before it can start to address that?

Caroline Gardner: As Barbara Hurst said, GP prescribing is a data-rich area. As far as we understand, that data, which gives us the core of what is going on for cost and volume of drugs prescribed, will continue to be available. However, next time, we may well want to consider the wider impact, particularly in care homes, for example.

We mention in the report the challenges of polypharmacy. Ms Scanlon mentioned the risks of care homes overstocking drugs because of the conditions that they are trying to manage. We want to open up future work in the area and consider some of the social impacts of prescribing or not prescribing and where the right balance might sit.

Bob Doris: That would be interesting.

The Convener: Mr Coffey, you are always keen to find the positives. It should not be too hard in this case.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Thank you very much, convener. I simply echo your opening remarks and say that it is a remarkable and positive report. However, we always look to see where improvements can be made, and the Auditor General has rightly pointed to a few examples where that possibility exists.

I am pleased to see that the policy of abolishing prescription charges has not resulted in any noticeable increase in the quantity of prescriptions being taken up—I think that that is in the key messages report that the Auditor General gave us. That fact could tell us a number of things. It could tell us that, prior to and after the policy's implementation, people—particularly in our most deprived communities or communities most in need—by and large took up prescriptions and medicines. However, the impact of the policy on cost is significant and should benefit people in those communities.

My attention was drawn to exhibit 6. It tells an interesting story in relation to NHS Greater Glasgow and Clyde. That graphic shows that the health board is the best on the quantity of drugs prescribed per weighted head of population and on cost. That is very welcome, but how can there be such a good story for Glasgow given the high numbers of Scottish index of multiple deprivation zones in the city? We hear all the time that Glasgow has the highest proportion of deprived populations, but the performance from NHS Greater Glasgow and Clyde seems to be very positive. I ask the Auditor General to explain that.

Caroline Gardner: I will ask Tricia Meldrum to give you some of the details, but you are absolutely right that NHS Greater Glasgow and Clyde is doing a really good job. Some other boards, such as Forth Valley NHS Board, are learning from its experience.

As a starting point, if you look at exhibit 8, you will see that NHS Greater Glasgow and Clyde is right at the top end for prescribing support that is available to GPs. It is fourth in numerical terms but, given the scale of the board, a significant amount of prescribing support is available to its general practice teams. We see the impact of that.

I ask Tricia Meldrum to pick that up and give us a bit more detail about what we know about how NHS Greater Glasgow and Clyde is doing that.

Tricia Meldrum: NHS Greater Glasgow and Clyde has a multidisciplinary team, which includes analysts, and makes good use of the available data. There are also some economies of scale. Because NHS Greater Glasgow and Clyde is a bigger board and has higher staff numbers, the team is able to specialise in different ways from some of the other support teams. It also works with dieticians and other people who have specialist knowledge of particular aspects of drugs.

The team members are also based in practices and work directly with GPs part of the time. The team has a history and has been in place over a number of years.

The board has introduced a number of spend-to-save initiatives. It has set quite clear targets and decided to introduce certain posts but stipulated that they should pay for themselves and make additional savings that it can then reinvest in further improvements and further savings.

The board has well-targeted initiatives in place. They are being shared through the national

networks and some of that good practice is being rolled out in other places.

The data are based on weighted population, so they take account of aspects such as the deprivation profile of the population.

10:15

Willie Coffey: That message is strong and it chimes with what Harry Burns told us at a previous meeting—he said that we should grab good practice, make it consistent across Scotland and share it as well and as quickly as we can. That is important.

One opportunity to reduce waste that has been mentioned is from saving by prescribing generic rather than branded drugs. The performance on prescribing generic drugs is pretty good. The answer to a question that I asked recently showed that 83 per cent of drugs are generic, and I understand that that figure has improved by 10 per cent in the past 10 years. The Auditor General said that making further improvements in such prescribing would provide the opportunity to save about £2 million, which would be welcome but would not be a huge gain in comparison with the overall cake.

You have made recommendations about where we can make savings. How do we reduce the waste of drugs? I understand that there are quite a number of clinical reasons why drugs are wasted—for example, when people go into hospital, they do not take their medicines with them; they are given new medicines. The situation is similar when people leave hospital. How can our health boards make further improvements when there might be clinical reasons for the waste that is in the system?

Caroline Gardner: You are right that the performance on prescribing generic drugs has been really good in the past 10 years. There was a lot of branded drug prescription that was hard to justify in cost or quality terms; now, we estimate that the potential further saving would be very small.

We say that further savings of about £26 million are available, most of which would come from reducing waste that relates to repeat prescriptions or drugs that are prescribed but no longer taken and from the category of drugs that Tricia Meldrum talked about—drugs that are classified as less suitable for prescribing. There is no one way of making savings. Most health boards have done some of the things that will make an improvement, but there is scope to do more and learn from one another, in line with the question that Mr Doris asked.

We must reflect the fact that the picture is changing. Every year, more drugs come off patent and more opportunities are available to shift from a branded drug to a generic equivalent. New drugs become available, which makes some existing ones less suitable to prescribe. People need to use the existing infrastructure—such as prescribing advisers and formularies—and keep on using the data day by day.

The spend on prescriptions is big—it involves £1 billion and 91 million prescriptions a year. Keeping attention on that as the situation changes is the way to get the savings and to ensure that patients get the drugs that they need to stay as healthy as they can be.

Tricia Meldrum: A more recent development in the information that is available is that almost all prescriptions now have a patient's community health index number—their unique identifying number—which means that it is becoming possible to do much more analysis at the patient level. We can see how many people have a number of drugs prescribed for them and how often their prescriptions are repeated.

That means that boards and GPs can work together to target areas for medication reviews and can look at people who are taking lots of different drugs. That data set has been linked to prescribing data only recently; it provides much more powerful information for looking at some of the issues.

The Convener: Ms Scanlon has a very short final question.

Mary Scanlon: I ask for advice on saving money, which Willie Coffey asked about. It is not surprising that, as exhibit 11 shows, the average spend on drugs by age group rises as people get older. I have just remembered that the Mental Welfare Commission for Scotland told the Health and Sport Committee that more than 70 per cent of people in care homes were on antipsychotic drugs, many of which were unnecessary. Many people in care homes do not see their GPs, and pharmacists do not go into care homes. Is there a missing link? Should we look at a way of saving money in relation to that group, and how could that be done?

Tricia Meldrum: That very much relates to medication reviews and looking at whether variation is appropriate, which involves clinical judgments. It is not for us to comment on clinical judgments; it is for prescribers—with support from others—to see whether prescriptions are always appropriate. The Royal Pharmaceutical Society recently issued guidance on the care of people in care homes, where it feels that scope for improvement exists.

The Convener: I thank our witnesses. Later, we will consider our approach to the report.

The next item is on a different, though related, topic. I suspend the meeting to allow a change of witnesses and for a comfort break.

10:20

Meeting suspended.

10:27

On resuming—

"Health inequalities in Scotland"

The Convener: Okay. Let us reconvene.

I welcome our next panel, which will give evidence on the section 23 report entitled "Health inequalities in Scotland". We welcome Professor Graham Watt from the University of Glasgow, who is also the co-ordinator of the general practitioners at the deep end project; Dr Susan Langridge, who is a GP at Possilpark health centre; Dr Peter Cawston, who is a GP at Drumchapel health centre; and Elaine Egglestone, who is a health visitor at Govanhill health centre.

I invite any or all of you to make introductory remarks.

Professor Graham Watt (University of Glasgow and General Practitioners at the Deep End): Thank you. I will make some remarks from the point of view of the deep-end group of practitioners. I thank the committee for the opportunity to give evidence, for which we are grateful.

The deep-end practitioners, who work in 100 practices that are scattered across 10 administrative areas, had never met or been consulted by anyone until 2009. We are grateful to the Government for providing the funding that has made that possible. The Government provided welcome funding—it was absolutely key—for a series of meetings. Some of our comments may be critical of the Government, but we are very appreciative of the fact that we would not be here but for its support.

We are also grateful that the Audit Scotland report on health inequalities covers an issue that has been very important to us since our beginning and which we think has been rather neglected in the scheme of things. Some aspects of health inequalities are described as complex and new. What our group is taking about is gross and long-standing—I am talking about the distribution of manpower. There are a couple of things in the Audit Scotland report that we wish to comment on. We think that the exhibit on manpower data is potentially misleading. It has already been misquoted on at least two occasions in evidence to committees. We also think that it overestimates what can be achieved by the quality and outcomes framework as a solution. I am happy to come back to both those points.

10:30

In the scheme of things, one applauds where the Government is in approaching health inequalities by focusing on the early years. It is 35 years since the Black report encouraged Governments to invest wholesale in the early years and it is good to see that it is now turning into policy. It is clear that the aim of that approach is to create a population that is healthy for as long as possible—what is called healthy life expectancy. However, when healthy life expectancy comes to an end, people acquire conditions that they live with for the rest of their lives. The job of the health service is to enable people to live well, long and as independently as possible with those conditions. I think that there is reluctance to acknowledge not only the health service's role in doing that, but the consequences of its not doing that.

There have been a number of rather dismissive statements about what the NHS can achieve in relation to health inequalities. One would agree in respect of the origins of health inequalities, but the health service is a major resource for altering the natural history of people's experience in the second half of their lives. If it does not do that well where there is most need, the effect of the health service will be to widen inequality. We think that there has been insufficient acknowledgement of the potential for the health service to do that. To many people, it is unimaginable that a service that is not meant to do that, could do that, but some of the data that we have presented to the committee have that conclusion.

According to ISD Scotland, healthy life expectancy ends in men in the most deprived tenth at the age of 57 and in the most affluent tenth at the age of 76. That is a difference of 19 years. For women, healthy life expectancy ends at the age of 61 in the most deprived tenth and at 78 in the most affluent tenth. In the deprived areas, people have 10, 12 or 15 years left to live with their conditions; in affluent areas, they have five or six years left to live with them. The difference in life expectancy comes to around 10 or 12 years.

Recent data from ISD Scotland, based on consultations in representative Scottish general practices, show that only 12 per cent of consultations in general practices involve a QOF condition. Therefore, 88 per cent involve other conditions. A paper on multimorbidity in Scotland in *The Lancet* last May, which was based on 350 practices, showed the epidemiology of

multimorbidity. The norm in people above 50 is to have two or more conditions. That is a very simple definition, which underestimates frailty in old people and social complexity in people in deprived areas. However, multimorbidity occurs 15 years earlier in deprived areas. The commonest comorbidity involves psychological problems. That accounts for some of the prescribing data described earlier. Although multimorbidity is commonest in old people—we all have older relatives with many problems—most people with multimorbidity in Scotland are under 65 because of the demography. That is the challenge that the health service is facing. The point that we would like to make is not to look backwards at the inequalities that we have singularly failed to address for 20 years; we want to look forward to a population that is getting older and has multimorbidity.

The paper in *The Lancet* showed that of all the QOF conditions there was not one in which people who had only that condition were not a minority; the majority of patients had two or more. For example, a fifth of the diabetics were on antidepressants while another fifth were on prescription analgesics. The diabetologist might be the man to see for your diabetes, but he might not be the man to see for your depression or your chronic pain. That holds true for every major chronic condition.

Dealing with multiple morbidity is hard work for patients, who have to cope with different drugs, regimes, clinics and doctors, and the challenge is to live well with all that. The health service needs to gear up in order to provide a more integrated experience for patients with multiple morbidity. That work can be done only by generalists, not by an army of specialists, and clearly has to be done in general practice. Moreover, if it is not done best in deprived areas, the net effect will be a widening of inequality.

We think that this is an agenda for the whole NHS—it just happens to be especially important in deprived areas. We have focused on the 100 practices in the most deprived areas for pragmatic and arbitrary reasons but, leaving aside the particular problems of those areas such as the high prevalence of mental illness, alcohol and drug misuse and vulnerable families, I point out that the main difference is simply the volume of the multiple morbidity that practices have to deal with. The solutions are the same, but they need to be prescribed pro rata across the board. Deep-end practices serve areas of blanket deprivation, but there are many deprivation pockets in other practices.

We do not want to be portrayed as arguing that the answer to all these problems is more GPs. That is clearly not the solution. GPs in deprived areas, however, need more time, more capacity and slack in the system to cope with the problems that patients present—which invariably happens in an unpredictable way. They also need to be linked better to all surrounding resources, whether they be area-based NHS services for mental health, addictions or child health or resources in communities such as voluntary organisations and the community assets that have been described.

The main hub of the joined-up approach that we need to deal with these future problems can only be general practice. After all, that is where the health service has its contact with the public. In fact, general practice offers not only contact but coverage, continuity, flexibility, relationships and trust. There is no need to look for those things anywhere else; most patients find all those things in general practice. Although it is underresourced and is not reaching its potential, we think that it is the answer to the problem of preventing the widening of inequalities in later life that the health service will face in the future.

Finally, we are not talking about a single intervention. The past 20 years are littered with short-term interventions that have all been about the beginning of something—for example, screening for this or that condition—and have lacked the follow-through required to help people live with their problems, survive longer in the community and make less use of emergency services. We must invest in serial encounters with patients to ensure a productive relationship in which patients acquire the knowledge and confidence to live better with their conditions and make better use of the resources around them. People in affluent areas are up for self-help and self-management, but the system needs to recognise that going down that road in deprived areas is a much longer haul.

I will stop there, convener. Thank you very much.

The Convener: Thank you very much. Do any other witnesses have anything to add?

Elaine Egglestone (Govanhill Health Centre): First, I thank the committee for giving me the opportunity to speak from the front line. I think that what happens there is quite often filtered through our managers and it is good that I and my colleagues in Govanhill are able to bring certain things to your attention. I should stress that I am not speaking for every health visitor in Scotland, but I have discussed my remarks with my colleagues. This is a great opportunity for me, but it is also a great opportunity for you as our legislators to know how your policies, or Government policies, are translating locally and what that looks like for us at ground level. I will pick up on what Professor Watt said about the early years. Obviously, as a health visitor, that is

exactly what I work on. I have chosen a few examples to give you, because I cannot go into every aspect of my job.

One of the simplest ways in which we can address health inequalities in deprived areas is through infant feeding. Approximately a year ago, things changed. Before then, we in the south-east of Glasgow had a very supportive infant feeding team, funded under the chief executive's letter 36 (2008), available to us and to families. They could go in and support mums with their breastfeeding on the same day that we asked; the maximum time we ever waited was three days. However, the central team now is less accessible and we are seeing that our breastfeeding mums are not feeding for as long.

We know that breastfeeding has long-term health gains. For example, breastfeeding could save approximately £17 million per cohort year by reducing the need for the treatment of and hospital admissions for four infant conditions alone: ear infections, necrotising enterocolitis, other gastrointestinal infections and lower respiratory tract infections. That £17 million is a massive amount for anyone to be able to save. We feel that just as we were getting up and running and what we were doing was beginning to work, the CEL 36 money was removed and our team went. We now have one individual for the whole south of Glasgow, whose sole job seems to be audit and spreadsheets. She has the knowledge, but she does not have the time to come out and support mums. That is a really big issue for us.

I was involved in setting up a breastfeeding support group at the new Victoria hospital in the south side of Glasgow. The new Victoria is great, but is not necessarily the most accessible place for families who do not have their own transport. It is just outside Govanhill, which has a very diverse population. Any of you who know Glasgow will know that Govanhill is culturally diverse and has quite severe deprivation. A wee bit further out from there is East Renfrewshire, which, as you will know, is a much more affluent area. It does not have resources either, so it sends its mothers to us, but we have only a tiny little room, and at times we have had to ask people to leave; for health and safety reasons we cannot have all those people in a small room.

That example of work on infant feeding shows how we can address health inequalities in a deprived area, address the cost issues arising from various infections that can be caused by not breastfeeding, and it indicates the resources that we need to provide the best service possible. As health visitors we are really good at what we do. We have gone back to university and have done two years' extra training. We are good at what we do, but to do it we need Government-level support and we need it to translate into what we do locally.

Dr Peter Cawston (Drumchapel Health Centre): I have been a GP in Drumchapel for 14 years. It is a very rewarding place to work. The real strength that we must talk about is that of relationships and trust. The early years do not happen in isolation. The mother of the young child is often supported by a grandparent who often has the kind of conditions that Graham Watt talked about. The home situation might involve issues such as alcohol, lack of employment or anxiety problems, so the mother will face a lot of issues. The real strength of the primary healthcare team is to have excellent health visitors, district nurses, GPs and practice nurses who know each other. That kind of relationship and communication is a key strength that the primary healthcare team brings.

10:45

Another strength that we bring is our relationship with patients over a long period of time. Over 14 years, those I saw in their early years have grown up to become mothers themselves. Perhaps one of the most underused or least understood resources in the NHS is not the drugs that we prescribe but the relationships that are built up between the primary healthcare team members and patients. Looking to the future, unless we have trust and relationships of that type as well as the time to develop and use them effectively, we may end up with lots of activity where we simply sign off that we have done what we had to do rather than make an effective difference to people's quality of life and life expectancy. Those relationships are perhaps most important in deprived areas, where people are at their most vulnerable and are least able to make use of services without the support of such a relationship.

The Convener: Thank you very much. I want to start with the written submission from the deep-end GPs, much of which is extremely powerful. In particular, its opening paragraph states:

"The flat distribution of general practitioners in Scotland, in contrast to the steep social gradient in health needs"

is one of the

"principal causes of the inverse care law in Scotland"—

in other words, the more care that people need, the less likely they are to get it. That distribution is also

"a partial explanation of 20 years of failure in addressing inequalities in health and a major obstacle as NHS Scotland searches for effective, affordable ways of delivering integrated care."

The paragraph ends by saying:

"The status quo"—

that is, maintaining that flat distribution of GPs—

"is a recipe for widening health inequality".

Professor Watt, you said that you were not arguing for more GPs, but that paragraph is surely an argument for placing more GPs in the more deprived parts of Scotland. Is that correct?

Professor Watt: There needs to be more capacity, but I do not think that we need to import new practices in new places. We need to build around the existing practices because of the cumulative knowledge, experience and relationships that they have.

The most valuable clinical time in practices is that of the experienced GPs, although training can be an attractive option—there is an argument for GP training fellowships. If there were as many GP training fellowships for working in deprived areas as there are for working in rural areas, that would be a good step in the right direction. In essence, however, we need to harness the experience and commitment of the experienced general practitioner. Both my colleagues here will have locums back in their practices today, but locums can do only some of the work, so they will have additional work to catch up on. That is because simply providing an extra doctor does not necessarily provide the solution.

We are not arguing that the shortfall in manpower simply needs to be corrected; there needs to be a halfway house in that direction because doctors on their own cannot address all those problems. They need to be linked to other services. Often, the GP is only the signpost at the beginning of a process. Although our starting point is the flat distribution of GPs—that needs to be corrected so that it is at least a slope—the effectiveness of additional GP time will be enhanced by improving the links to other services.

That joined-up approach needs to be imagined and pursued not just by GPs but the whole service in local areas. Audit Scotland reports that, at a local level, the relationships between CHPs and general practices are often quite dysfunctional. If the relationships that we observe between different levels of the health service were applied to the doctor-patient relationship, it would be completely unacceptable in terms of the quality of communication and the extent of mutual understanding and respect.

May I comment on the numbers in the report, which have been misquoted? Derek Feeley said—

The Convener: Can I ask you about that? Exhibit 13 in the report shows that the levels of deprivation are slightly reflected in the distribution of GPs, but the report also makes the point that there is no data available on whole-time equivalent GPs. Audit Scotland would like to see that data. We have asked for it from the NHS and the Scottish Government, and they have told us that it is not available. However, in your evidence you cite some data that goes back some time, but you make the point that nothing has happened to change the situation. If I read that data correctly, you say that, far from the distribution being flat, there are more GPs in the more affluent parts of Scotland. Is that right?

Professor Watt: Yes, slightly more. You asked for whole-time equivalent data, so we have given it to you. It is the most recent data—it is from 2003, after which the Government stopped collecting it. That was not a deliberate decision. It just happened as a result of the new contract, which engages with practices rather than with individual doctors. The result is that crucial information—which previously was not valued—has not been collected.

Let us just say that the 2003 data is flat—if we add in the training posts, it becomes slightly biased towards affluent areas. The data that Audit Scotland got hold of from ISD Scotland is based on a voluntary—and, therefore, partial—survey in 2009, which is based on numbers of GPs, not numbers of whole-time equivalents. The table in the report is very difficult to interpret. If we compare the data from 2012 with the 10-year-old data on whole-time equivalents, the thing that jumps out is the number of GPs in the least deprived areas, which is very much lower. If we look just at quintiles 1, 2, 3 and 4, the line is pretty flat—the differences are very small. The data is impossible to interpret, because a GP could be someone who works full time or someone who works for two sessions a week. We make the point that nothing has happened in the past 10 years to shift that distribution. There has been no policy initiative to do that.

Some people have said that there are 25 per cent—or 40 per cent—more GPs in deprived areas, but those figures seem to have been arrived at by comparing quintile 1 with quintile 5, and there is a big question mark over the data for quintile 5. I would interpret the Audit Scotland data as showing that there is a question mark over the number of whole-time equivalents in the most affluent quintile. Otherwise, the Audit Scotland data is consistent with, although less precise than, the data from 10 years ago that is based on whole-time equivalents.

The Convener: Okay.

We are the Public Audit Committee. In relation to our work on health inequalities, the NHS would say to us—Audit Scotland acknowledges this in its report—that some cognisance is taken of levels of deprivation in the distribution of resources to NHS boards, but Audit Scotland has also said to us that

it cannot find any evidence of how that distribution feeds down to the front line.

Is it fair to say that you are saying that there is evidence that that additional funding is simply not feeding down to the front line, because it does not reappear in a distribution of GP practices that matches healthcare needs?

Professor Watt: The comment that I would make is an indirect one. In his study of 3,000 consultations in affluent and deprived areas in the west of Scotland—his study was not as wide as to cover the whole of Scotland—Professor Stewart Mercer shows that the length of the consultation is shorter in deprived areas, despite the higher level of multiple morbidity. The consequence is that patients are short-changed. They are less likely to be empowered by having seen the doctor, especially if they have a psychological problem, and the practitioners report being under stress, because after each long, complicated consultation, there is another one waiting and another one after that.

People from the Keppoch practice in Possilpark, which is one of the most deprived areas, said in an article about their experience that the main thing about the practice is that it has more difficult cases. The cases are not necessarily different; it is just that there is a bigger volume of them. The practice team information—PTI—data on consultation rates that ISD has produced for Scottish general practices show 15 per cent higher consultation rates in the most deprived fifth of practices. In relation to manpower, that can be achieved in one of two ways: one is to work longer hours and the other is to spend less time on each consultation. That means that we get incomplete encounters that lack the potential to address a patient's problems. The patient's experience is fragmented and is a series of stops and starts. That does not enable the primary care team to work with the patient and to engage productively over a series of longer encounters. There is on-going work, which will report in the next three months, on the effect of extra consultation time for very complex patients, so there will be evidence on that.

In general, the reason why the QOF is what it is is because the evidence is based on single diseases. It is only very recently that research has turned its attention to multiple morbidity. Almost the entire research establishment and the literature, guidelines and policy are based on the vertical approach to cancer, heart disease and mental health issues, and not on the individual who has all three.

The Convener: Ms Egglestone, when it comes to professions such as health visitors, is it your sense that the additional resources that are said to be provided at board level are actually producing more health visitors in areas of additional need, or is that also flat?

Elaine Egglestone: I have not noticed more health visitors. The only qualification that I would add is that, in Govanhill, we have a very multicultural community with a high population of people from elsewhere in the European Union, so we have a separate EU health visiting team. That population has high levels of deprivation and specific needs, so the team is kept very busy. That is one health visitor and two support workers to do an awful lot of work.

The Convener: In terms of chasing the resources, is it the case that, at board level, people are told that additional resources are provided but, on the front line, patients in areas of deprivation are, to use Professor Watt's words, being "short-changed"?

Professor Watt: Yes—in relation to the legitimate expectation that their needs will be met. The NHS is about comprehensive healthcare that is based on need and is free at the point of use. The rhetoric is clear enough. One perhaps needs to break down the health service into its bits. Emergency care, such as accident and emergency and emergency hospital beds, is equitable, but an emergency bed is too late in the day for most patients. However, that care is provided in an equitable way—there are no credit card checks at the front door. Access to specialists is not equitable. The committee has reported on that in relation to cardiology. That is not a simple issue to address.

The issue that we are addressing is the inequity in what I call serial care. Once someone starts to acquire conditions, that will be part of their life although, we hope, not a great impediment to it. An analogy can be drawn with the early years policy, which is about giving people a good start at the beginning of their life. When people start to acquire conditions, they need a good start to make them knowledgeable and confident about living with those conditions. We should apply the same approach, because at the end of the day we want individuals to be confident and knowledgeable, to have a sense of coherence about themselves and not to be shifting from one crisis to another. The system does not allow people to get past first base in that journey.

11:00

Dr Susan Langridge (Possilpark Health Centre): I apologise to the committee because I have a virus. I do not normally cough and speak with such a croaky voice.

We talk about an assets-based approach—which I am very much in favour of—and moving towards self-management. The difference

between a deprived patient and an affluent patient is that the deprived patient is not at the stage of being able to use their assets. That is not to say that those assets do not exist, but a process needs to be gone through to get them to understand, recognise and be able to use their assets. A lot of work can be done with people to get to that point.

For the assets-based approach to work, we need to do the work behind it, particularly within the primary care health team because that is where the deprived patients go. As Peter Cawston pointed out, we are the people whom patients trust. We have the serial encounters. Generally, deprived patients are fearful of the unknown and we, with the health visitors, are the people who will guide them through the process. Therefore, the resources need to continue to be targeted at that area.

One of the historical problems is that there have been resources but they do not continue. I have been involved with the keep well programme from its inception. It has been a good scheme, but the resource dwindles, gets fragmented and moves away. That is where part of the issue lies.

Mary Scanlon: When we discussed exhibit 13, Graham Watt questioned the figures in it. I would also like to look at exhibits 14 and 15. Exhibit 14 illustrates that there are twice as many pharmacies in the most deprived areas than in the least deprived areas. On the distribution of dentists, there are almost twice as many dentists in the most deprived areas than in the least deprived areas. Would Graham Watt question those figures? He talked about the integrated healthcare team and I see both those professions as part of that team.

Professor Watt: The patterns in exhibits 14 and 15 are what one would wish to see. I am not an expert on manpower for pharmacies or dentists, but I suspect that it is easier to distribute than medical manpower.

For a long time, the flat distribution of GPs was policed by the Scottish Medical Practices Committee—GPs themselves—to maintain what was considered a level playing field. That did not address the public health agenda; it protected a view of the world in which practices should be equally rewarded for being busy. Of course, all practices are busy, but they are busy with different things.

We make a point of not claiming that GPs in affluent areas are not busy. They are very busy, partly because of the demography of the practices but also because the patients are demanding—they want more time to discuss things and come to a decision. However, in so far as they are busy, they are more busy dealing with demand than with need.

The desire for more time is ubiquitous, but it is for different kinds of encounter that make differing contributions to addressing health inequalities.

Mary Scanlon: Yes, I appreciate that. However, in the 14 years since the Parliament was set up, pharmacists have begun to offer services such as health checks, smoking cessation and so on. I think that every pharmacy in the country has its own consultation room. With twice as many pharmacies—not to mention dentists—in deprived areas, does that act as a support to the GPs? That was my point.

Professor Watt: Clearly it will. There is a general problem that the health service has too many services that see themselves as hubs—centres of activity—when they need to be joined up because the patient needs to be at the centre. When the patient has several problems, the pharmacy may be the place to go.

Sometimes, the general practice is the place to go. Looking at PTI data, we showed some years ago that 13 per cent of patients account for 48 per cent of encounters. A minority of patients generates half the health service's work. My conjecture is that they are the patients who most need a personal doctor over a period of time.

Mary Scanlon: Are the pharmacies joined up, given that they offer minor ailment, health improvement and smoking cessation services and long-term condition support? Are they integrated with the GPs?

Dr Cawston: I will answer that from experience rather than speculating in general terms. Over the past 10 years, our relationship with our pharmacy has changed beyond recognition. It now works much more closely with us. We have a pharmacist who comes into the practice several times a week and a blood pressure clinic that is delivered in the pharmacy but booked using our appointments system. There has been a transformation in GPs' relationships with pharmacies.

I am concerned that we are simply here to say that there are not enough GPs in deprived areas. For me, the key issue is what the primary healthcare team can contribute to the reduction of health inequalities. In my experience, that is not even being considered as part of the picture. The issue of health inequalities is seen as something that is dealt with somewhere over there, while the health service does something over here.

I passionately believe that we make a difference to people's lives and that we help to reduce inequalities. However, there are limits. If we can do that work better, we can have a much bigger impact on people's lives. That is not just about

numbers. There are things that we in the practice would love to do more effectively, and we have ideas about how we might do them, but there is a question about how we get from here to there.

I do not like health inequalities initiatives that have little to do with front-line health services and are carried out in a short-term fashion. Over the years, I have seen quite a lot come and go.

In the same way that I have a prescribing adviser, I would like to have a social prescribing adviser—someone who comes into the practice with a health improvement or public health background and who has a relationship with the community that means that they know what is going on. That would give me an alternative. At the moment, either I prescribe or I do that work myself, and very often I do it myself: I give people large amounts of time to deal with their distress, the domestic violence issues that they face and so on, because they will not go anywhere else. That comes at quite a high personal cost in terms of stress. We need to help practices to develop an alternative within the community that can build relationships with local assets so that they can keep in touch with what is going on in the community. Practices should have a strong relationship with health improvement in the same way as they have with prescribing.

I am keen that we do not simply focus on numbers. As I said, the issue has to do with quality and relationships and with improving the effectiveness of what we do in deprived areas. That can impact on inequalities in terms of not only life expectancy but happiness and lack of suffering. The real inequality involves not people dying younger but their quality of life before they die. We need to be able to focus more on that so that we do not get completely tied up in manpower and numbers.

Mary Scanlon: Having spent 10 years on the Parliament's health committees, I know that we must be careful not to tread on the territory of the Health and Sport Committee, which does an excellent job. We are looking at the public spend and value-for-money issues around health inequalities and how they are addressed.

I am sure that Graham Watt remembers briefing the Health and Community Care Committee in 1999 on the Arbuthnott formula, which concerned poverty and deprivation and was designed to ensure that areas such as Glasgow received the necessary funding. The Arbuthnott formula—versions 1 and 2—later became the national resource allocation. I know that you have been involved in tweaking the formula under both the Labour-Liberal Administration and the Scottish Government to ensure that deprived areas get the funding that they need. Given your position of influence, are you concerned about the points that the convener raised? Is the formula right or wrong? Is the problem that the health board gets plenty of funding but that funding is not being distributed according to the formula?

Professor Watt: You exaggerate my input into the resource allocation process.

Mary Scanlon: I remember 1999—you were one of our first witnesses.

Professor Watt: My lack of input was not for want of trying. We had the best data, statisticians and methods, so we started off in a good position to try to distribute resources equitably. The problem was that the data was not as good as it had to be, because we needed to measure need. Measuring need in hospital activity is fairly straightforward: you just count admissions. There is nothing to stop emergencies being admitted to hospital, so need is reflected in use.

However, the situation that we have described in general practice is that there are not enough hours in the day to address need. By definition, unmet need is not represented by activity. If activity data such as PTI data on consultations is used to assess how busy a practice should be, the difference between that information and what is observed needs to be rectified. The elephant in the room is unmet need. That problem will always exist.

The committee that came later—it may have been the NHS Scotland resource allocation committee—had a special look at unmet need and commissioned a team of health economists in York to see whether they could find evidence of it. My recollection is that they concluded that they could not find it. That was because they were sitting at a desk in York. If you sit at a desk in Govan, unmet need stares you in the face at every surgery, but it is not recorded in the data that was available to the process.

That is largely still true, although not for the lack of intention—if the Arbuthnott report and its successor report could have produced a formula to address unmet need, they would have done so. However, the available resources cannot generate activity commensurate with need in a way that can be used as a proxy for need in the formulae.

Mary Scanlon: I have a final question—I do not want to leave out the health visitors. Dr Phil Wilson and others have given quite a lot of evidence to Parliament on health visitors in Glasgow, and last week the chief medical officer gave evidence on the importance of the early years agenda, to which we are all signed up.

I understand that there have been significant changes to health visiting. In the Highlands and Islands, which is the area that I represent, a health visitor has described health visiting as "withering

on the vine". Is health visiting funded to look at the most important years of life and to support mothers? Dr Wilson told us that the way to address inequalities is to get health visitors to look at the early years. Is that right, and is it happening? Is health visiting still alive and well in Glasgow and attached to general practice?

Elaine Egglestone: Health visiting is alive and well in Glasgow. I like being GP attached. Everyone will always say that they could do with more money and staff. In Govanhill, more staff are coming to the team, but not more health visitors. To be honest, we are feeling some trepidation about the rumours that we hear about the role that health visitors will have in our team. It sounds as though we will hand over almost our whole role to staff nurses, nursery nurses and support workers, with the health visitors managing the team and dealing primarily with child protection.

We have gone back to university: we are all midwives or have—as I do—paediatric and neonatal experience, and every health visitor has more than one qualification. Usually, a health visitor is qualified in midwifery and is a registered general nurse. We bring a lot more than a specialist qualification to the table; we all bring a lot of experience, by which I mean not just clinical but life experience and the ability to identify with our families.

11:15

In Govanhill, a lot of money is being spent on a very small portion of the community. We appear to be importing a lot of health inequalities and putting a lot of resources into addressing that very small population, and there is a feeling that we might be ignoring the majority of the population who are more likely to remain here and addressing health inequalities for other countries.

Mary Scanlon: I know that health visiting is alive and well, but is there really a universal health service? Would the move towards an integrated team be more beneficial or not?

Elaine Egglestone: Are you talking about an integrated team in relation to staff nurses and so on?

Mary Scanlon: An integrated team to support young mums or whatever.

Elaine Egglestone: We now have a small nurse practitioner health visiting team that will take on the most vulnerable, including young mums. That will remove some of the more challenging families—

Mary Scanlon: So who is being left out?

Elaine Egglestone: Left out of what?

Mary Scanlon: You said that you are focusing on one group.

Elaine Egglestone: Yes. A massive amount of money, which I believe comes from Europe, is being spent on the small EU population in our community. Those people have a high level of need and that money is making a difference, but then they go back home. That is creating a particular feeling in the community, among us as professionals and among the families we visit, who comment on how much is available in the centre of Govanhill—at the Daisy Street community centre and so on—for the eastern Europeans and how little there is for indigenous populations such as the large Asian population in the area.

There are many things that we could and should be doing for our families but we cannot do them because we do not have a room. We have to buy time at Daisy Street, from the church and so on. Everything that should be available for our indigenous population is available elsewhere. For example, because Govanhill has no under-three resource, if we identify a family with need who have a child under three we have to send them to Pollokshields or the Gorbals. Those are not only deprived families but families who might not have the greatest motivation, and we are asking them to take their child or children to another area. Govanhill is an area of deprivation and need but there is absolutely nothing there.

A nursery was set up under starting well more to give relief for short periods than anything else—it provided something similar to what the parents and children together team provides—and if we identified a family that needed that level of support we could ask them to attend that group. That gave us an opportunity to deal with more than one family at a time. Even if it runs for only two or three hours in the morning, that allows us to see a lot more families in that time, make much more contact and start to build networks for the mums that can be continued on the outside to ensure that they get support and can see that they are not alone, that we are not being judgmental of them and that what we are saying to them is not personal. Many areas could be improved—that would require money, but I have some ideas where savings could be made.

James Dornan: Let me say at the outset that I was not a member of the committee when this piece of work began and that this is the first time that I have come across any of this. I have to say that I was very impressed by the powerful submission and by the witnesses' introductory remarks.

I am an MSP for Govanhill's neighbouring constituency, so I know the problems that Govanhill faces very well. Anyone who stays in Govanhill—anyone in the city of Glasgow—

deserves the same level of service as everyone else. I used to be on the south-east community health and care partnership, so I know that more money was put in to deal with the unique circumstances in Govanhill, although I am not sure that that should impact on other people who stay in the area.

What seems to be coming across is that partnership working is really important. Dr Cawston spoke about that, as did Professor Watt. Given the new health inequalities function of the community planning partnerships, does Professor Watt think that they will have a role in trying to pull together some of the organisations that are required to work together—and which should be working together—to ensure that health inequalities are combated? Also, on breastfeeding, this is meant to be about local priorities. Could such issues benefit from the work that should be done through the community planning partnerships?

Professor Watt: There was a deep-end report—it is available on the web—that was our response to the Government consultation on integrated care. We ignored the first 15 questions because they were all about people sitting round tables in headquarters, which is a continuing challenge that may or may not be addressed this time. We were much more concerned about what was happening at ground level—at area level—where it depends on relationships. In a sense, what needs to be built up is social capital and the quality of relationships.

One of our wishes and proposals is for an attached worker, so that—as with the health visitors—people know one another's names and trust one another based on positive experiences of working together and confidence in what will happen in the future. Many such relationships need to be built up between practices and social work, community addiction teams, mental health services and hospitals. Such relationships all take time and effort to build up. The human resource is the one thing that is not in short supply and we need to be investing in it and in productive relationships. It is about how area-based teams deal with the practices in their area and about how the practices deal with the area-based teams.

We are working on something called the BRIDGE—building relationships in deprived general practice environments—project, in which we try to use the practice's knowledge of elderly patients to make better use of the resources that are available in the community for social and physical activities. It is all about making a connection with a service so that you know who is at the other end of the phone and gaining experience that you can share with patients so that they are confident about making the link. The bridge project has taken quite a long time because we are trying to do it without addressing the fundamental problem of resource—it is being squeezed in.

On the general trajectory that needs to be addressed in order to deliver non-fragmented care, the head of social work and the head of healthcare need to be involved because co-operation by the people at the top affects everything beneath them. However, relationships at the bottom level of the service are also required.

We are fond of quoting a study from Quebec that tried to keep patients out of hospital using key workers. It did not involve any extra resource or restructuring; it involved everyone from the top of the organisation down being committed to joint working and to auditing themselves. The commitment to joint working was measured. Zero meant that the key workers did not know who the other key workers were; 1 meant that they knew who the others were but did not have contact with them; 2 meant that they had contact; 3 meant that they were co-operating but not closely; and 4 meant that they were genuinely collaborating and reviewing their experience. Over two or three years, the score went up. Eventually, they managed to prevent elderly people from being admitted to hospital. It took four years to do that—three of those years were about building the relationships, and then the system was able to deliver.

James Dornan: I think that that was the mindset behind the CHCP, but it was not given four years to build up the relationships that should have worked across the area. That was a great loss to partnership building and ensuring that joint working happened.

Dr Langridge: I echo Graham Watt's point that the key is collaborative working. There is a subtlety about what that is: it is the sharing of experience, and change happening on either side as a result. That will make the approaches that we are talking about work. However, a process of relationship building must go on behind that first.

The committee has seen that already with the prescribing report. For me, on the front line, the key with prescribing is the attached, practice-based prescribing adviser. They are put into the practice, we work with them, we know their names and we truly collaborate. As the Public Audit Committee, you have seen the resulting figure. Glasgow is doing very well. You have evidence that that approach works, so why would you not want to build on it?

James Dornan: Dr Cawston, given that you spoke earlier about partnership working, would you like to say more about it and the role that community planning partnerships can play?

Dr Cawston: I was struck by what was said in your evidence taking on the GP prescribing report about the link between anxiolytic and hypnotic prescribing and deprivation.

The role of anxiety, sleeplessness, suffering and unhappiness that are associated with poverty and the many things that go with it is often missed. It would be incorrect to think that prescribing drugs such as statins is good medicine and that prescribing anxiolytics is poor medicine. People die from suicide and, in fact, people probably die young from misery, because conditions such as heart disease and cancer are caused by lifestyles that themselves derive from unhappiness and difficult circumstances. Drinking, risky lifestyles, smoking and obesity are often linked to alienation, lack of contact, loneliness and domestic violence, for example.

In general practice, we try to address several agendas when we see a patient. On the one hand, we have a list of single-issue guidelines. We try to treat someone's illness according to guidelines that are designed for people with one illness only. If someone has heart disease or high blood pressure, we try to address that. On the other hand, patients often come to us because of the things that cause them great pain and stress, whether that is chronic pain, which is itself often linked to unhappiness, or anxiety, which causes many physical symptoms. The relationship that we build with our patients is important for them, but we cannot tackle those issues on our own.

I became a GP because I believed that I could work and live long term with a community, build up relationships, be part of community planning and long-term planning and help to change not only the individuals, but the communities in which those individuals live, or at least play a part in that. However, that has not been my experience. I have found that all my time is consumed with being reactive and trying to respond to overwhelming demands and needs. That is a poor use of resources, because the primary healthcare team has much more to offer than simply reacting to overwhelming needs.

There are examples of good practice, such as the links project in which we took part last year. We were given some protected time to visit Drumchapel Women's Aid and Drumchapel Law and Money Advice Centre so that we could get to know them and signpost and use them more effectively to support and help patients. That was a short-term project, but it has had long-term benefits. It would not take an awful lot of investment to give us protected time so that we have the ability to build up relationships and go to planning meetings. I have done such activities along the way, but very much in my own time and as a voluntary activity. That is not reproducible on the large scale. I very much believe that that should be a core part of the role of the GP, the health visitor and the whole primary healthcare team, but that is not recognised in how we are funded or in how resources are distributed. It should be a core part of those roles in deprived areas.

11:30

I did part of my training in a much more affluent area in which the GPs lived, their children went to the same school as the children of their patients and the GPs took part in the parents association and what have you, simply as residents. I live just outside the G15 postcode, and so not in the most deprived part of my practice area. I do not know anybody who works in our practice or in the surrounding practices who lives in the practice area. We therefore do not contribute to the area as citizens or residents, so perhaps we could play an additional role, as professionals who work in the area, in helping to change things.

I would love to go to the school and have a competition for schoolkids to produce posters for us to put up in our waiting room. We could work in an entirely different way that would be a more effective use of the GP resource. However, given the configuration of the manpower and the GP contract, I do not see that happening, unless that was recognised as a key part of what we do. That would be a better use of the time that we give.

James Dornan: Can I ask a brief question, convener?

The Convener: We need to keep questions and answers a bit shorter, because we are running over our time.

James Dornan: I specifically mentioned a breastfeeding project. Does Elaine Egglestone think that CPP involvement could help with local issues such as that?

Elaine Egglestone: Previously, when we were a CHCP rather than a CHP and we had the CEL 36 girls locally, we were well supported and we learned a lot, which was fantastic for us as staff. The CEL 36 team were good at sharing their knowledge. More important, however, was that the team was important for families. As I said, the CEL 36 team had five members who would go and sit with mums. We do not have the staffing levels to go in and sit with a mum for an hour or two to help her when there are problems with a baby who is on and off the breast. Breastfeeding is the most natural thing in the world, but it is not the easiest thing in the world. Mums need a lot of resources, but I have to say that we are not giving the support, because we do not have time to do it.

Another issue is about staff training. We have had a load of new staff nurses starting, but they will not be trained on that. So perhaps there is an opportunity for us to have another look at what is needed to support families locally rather than have them traipsing halfway across the city to the Western, the Southern or the Royal for a problem breastfeeding clinic. We definitely need something locally, because those families just will not do that. We know the long-term health benefits of something as simple and basic as breastfeeding.

Colin Beattie: I have three questions, but I will try to keep them brief. The Audit Scotland report comments on difficulties in getting good engagement between GPs, health boards and councils, and we have talked about the need for good partnership relationships to make things work. Perhaps the witnesses can give us a bit more information about those comments.

Dr Langridge: As was said previously, it is about collaboration. What I hear from my health visitor colleague Elaine Egglestone is the recurring theme of somebody who is frustrated because something that the professional knows works and that delivers what we are asking for is removed, through whatever means. I share her frustration about that and I am sure that we could all give examples of it from the front line.

That is why I come back to the issue of true collaboration. Each party must have a vested interest in making things work and moving things forward. The trick is how you get that. How do you manage that from a management point of view? I know how I manage it within my practice team—I have management ways of doing that, as that is part of my job. We are talking about extending our role to bring in resources so that we know one another's names and can improve collaboration. There is no reason why that should not work on a bigger scale in a community partnership, but that is with the proviso that everyone has to be on board and, I have to say, must know what the word "collaboration" means.

Colin Beattie: Would it be correct to say that at present there is not good engagement with health boards and councils?

Dr Langridge: The situation is patchy and variable. That is the issue. In practice, people will navigate their way through the system in order to find individuals and silos that work for them. That is what I do in practice—I find a way through—and I am sure that Peter Cawston does the same.

Colin Beattie: How can that be fixed? Clearly, it is a real problem and obstacle. How can it be fixed?

Professor Watt: There is a cultural problem that goes back to the beginning of the NHS, when different arrangements were made for general practice and the rest of the health service. This issue is much more difficult to address than that of resources, because it is ultimately about the transfer of power and responsibility. My personal view is that, for good reasons that have probably gone past their sell-by date, we tend to have concentrations of power and influence at area level. The power and influence need to be distributed throughout the community.

I like to use the analogy of Lennox Castle. We used to concentrate resources in a big institution where people were put away, but it does not exist any more and the resources are now distributed throughout communities with an entirely new set of relationships. That is perhaps a good metaphor for how power and responsibility need to be redistributed and shared, but I do not underestimate the difficulty of the task. We need good models and examples and we need precedents: as Hugh MacDiarmid used to say, "Not traditions—precedents".

Colin Beattie: I move on to my second question. Your written submission states:

> "General Practitioners at the Deep End would welcome an end to short term health improvement initiatives".

Can you give examples of initiatives that have been started and have not delivered but appear to have stalled and withered away?

Professor Watt: Have a heart Paisley was a national demonstration project, but where is it now and what effect is it having on Paisley? It has probably left a legacy of some information technology infrastructure.

Many projects can be characterised as a first encounter with patients for screening or some other purpose. They always have a problem with coverage, so they start calling patients "hard to reach". They always have a problem with continuity, because the money runs out. General practice has coverage and continuity, but it does not have the means to exploit the coverage and continuity. That is why I would prefer it if we invested more in the continuum of what happens next.

For example, the keep well programme has been successful in processing a huge number of people through a screening process in order to assess their problems, but the question is: what now? Each of those patients needs continuity of personalised care that does not fragment into lots of different directions. The cardiovascular risks that have been ascertained will be part of the patient's agenda, but not the whole of it.

The important thing about general practice is that it is unconditional. It does not come with a label on it for heart disease, for example. Whatever combination of conditions a patient turns

up with, general practice will try to address them. That non-specialist ability is a hugely important resource. In "Puckoon", Spike Milligan talks about a man who invented a machine that did the work of two men but took three men to work it. That is the health service in a nutshell. We have a machine that does the work of two men but takes three men to work it. What we want to invent for the future, because we cannot afford the alternative, is a machine that does the work of two men and requires one man to work it. That requires somebody with generalist skills.

In passing, I note that the evidence to inform a lot of the suggestions is missing. That is why our position is heavily steeped in experience, rather than evidence—although the experience is high quality, because of the length of the commitment. The English school for primary care research gets £17 million a year from Government, and the Wales school for primary care research gets £2.7 million, but the Scottish Government has withdrawn its funding from the Scottish school of primary care for such research, so we will not produce the evidence to inform the policy. We will therefore continue to depend on experience and rhetoric.

Colin Beattie: Given your comments, how have you given the Government feedback, other than through this meeting?

Professor Watt: We have had two national meetings and produced 18 reports, which are available in long and short versions and are always fed into the Government. We have a good relationship with the primary care section of the relevant health directorate.

We have got to the point of making proposals and putting flesh on the bones. The package includes an element of extra time; a focus on the serial encounter; investment in the practice as a hub, with attached workers and link workers to community assets; and connections between practices. The deep-end initiative has brought practices together for common cause, which has been slightly difficult from a management point of view, because that goes across boundaries. However, the approach has empowered practices hugely to share experience and move forward.

More support of front-line practices is needed. Most of the national organisations, such as NHS Education for Scotland, the chief scientist office and Healthcare Improvement Scotland, have very low profiles in the deep end. For most deep-end practices, they are ships that pass in the night. Investment is also needed in local leadership, to develop the collaborative relationship with area leadership.

None of those aspects on its own will be sufficient—they will form a journey, not an instant solution. They represent an agreement to take a different direction, in partnership with all the players. We are at the point of submitting that proposal to the Government. It funded the steering group to have an away day just before Christmas, which was the first meeting that we have held during the day—all the rest of the 25 meetings were held at night-time, after people had done a day's work.

We have reached the curious point where the deep-end initiative is well known in England; we inform an inverse care law initiative in Wales; and there is a deep end Ireland. Last week, a colleague was in Norway, where people know all about the deep-end initiative. The irony is that all that we have done so far is the Scottish thing of producing reports. The challenge is to convert those reports into action.

Colin Beattie: In the interests of time, I will leave it at that.

The previous panel said that, in more deprived populations, 46 per cent more drugs are prescribed per head of population, and the spend is 37 per cent higher. How do practices cope with that?

Dr Langridge: I will speak from the front line. That is a good demonstration of the need in deprived areas. Our tool is our prescription. When huge differences exist, it is nonsense not to reflect them in the resource in the primary care health team.

I will echo what Peter Cawston said. The question is not whether giving an anxiolytic is good or bad. The information tells us that the incidence of mental health problems is comparatively huge in deprived areas. However, those areas do not have a comparative resource that is directly attached to practices. We are talking about attached mental health workers—people whom we collaborate with, whom we know on first-name terms and who have a vested interest. That would be an alternative resource to prescribing an anxiolytic.

In the confines of a 10-minute consultation, there is a limit to what we can do. We either prescribe or invest ourselves, as Peter Cawston said. If we have serial encounters with many people who have such problems, there is a limit to how often we can invest ourselves. Resource needs to be attached and collaboration is needed at a higher level among people who are willing to listen to that, understand it and back it up with the movement of resource.

11:45

There has been a devaluing of the primary care mental health team, historically, since I have been

in practice. You can hear it in our health visitors' comments. At one point, it seemed that the primary care mental health team was going to disappear. That devalued us and demoralised us. The leadership element was undermined. There needs to be a restoration of that position so that we can achieve an equality in the collaboration. That is perhaps one of the things that needs to be worked on in order to solve the problem.

The Convener: Bob Doris has a question. I make another plea for succinctness.

Bob Doris: I have a number of—hopefully—very brief questions.

The Convener: "Brief" sounds good; "a number" does not.

Bob Doris: We will have to audit that.

Professor Watt mentioned that there had been an issue with health inequalities for the past 20 years. Sir Harry Burns told the Health and Sport Committee that health inequalities had emerged over the past 40 years and were due to significant economic inequalities in society. That cannot be tackled at a local level, but there are things that you can tackle, which we are looking at today. The Health and Sport Committee has just launched a significant health inequalities inquiry, which will run for the next few months, and I hope that there will be good input into that.

The Audit Scotland report says that people in deprived areas are twice as likely to miss hospital appointments as those in the least deprived areas are. I think that up to 12 per cent of people in deprived areas miss appointments. That represents a huge cash cost to the health service, but it also represents a significant cost in terms of the ability to address those people's care needs. Given the time, will you make brief comments on how we can address that? Is that pattern of missed appointments repeated at a GP surgery level?

Dr Cawston: The picture that you describe is recognisable. A high proportion of our patients do not go to hospital appointments. That leaves generalists such as ourselves handling quite complex conditions that we would be more comfortable having specialist support to deal with.

The situation means that we and health visitors spend a huge amount of time chasing up children for orthoptics appointments. Children are now getting screened at nursery, but they are not going to orthoptics services. That means a huge extra workload for health visitors, who have to try to get children to go to developmental assessments and so on. If children keep missing appointments, that can sometimes lead to child protection procedures.

The cost to patients' health can be huge. If someone with epilepsy repeatedly does not attend appointments and is having seizures, that is a huge cost to their health and increases their risk of dying.

The issue that you raise is just part of the extra burden that the primary healthcare team is trying to carry, whereas someone from a more affluent area will actually get access to services that they would not have access to otherwise.

Bob Doris: Is there a follow-up process? If someone misses an appointment, we can send them a letter, but are we allowed to pass the matter on to a supportive third party who can chap on their door and say, "We notice that you did not turn up for a healthcare appointment. Is there anything we can assist you with?"? There must be a balance between confidentiality and directly helping vulnerable people to access the healthcare that they need. Are there any initiatives to encourage people to attend appointments?

Professor Watt: Deep-end GPs are keen on attached workers for mental health, alcohol and addictions issues because the referral is local, immediate and familiar and the appointment is therefore more likely to take place. That is more important in deprived areas than in affluent areas, as people in deprived areas are less likely to make a journey to a strange place. Maybe in the future, that will be different.

Dr Cawston: To be honest, having someone whom people do not know going around and chapping on their door would make no difference. That would simply be paying someone to knock on a door. People who have waited quite a long time for an appointment routinely tell me that they did not receive the notification through the post. I do not know whether they did. I do not know whether the notifications are sent out in the first place.

It might make a difference if a GP phoned up and said, "Why didn't you go? Don't you realise how important this is? I'm really disappointed that you didn't go. It really matters to me that you should go. Will you please make a big effort to go?" However, if a stranger said that they were the out-patient appointments liaison person and that they had come because the person did not go to their appointment, I do not see how that would make any difference—that person probably would not even get in the door.

Dr Langridge: I echo Peter Cawston's point—I do not think that the suggested approach would work. The issue reminds me of the work that Stewart Mercer has presented on enablement and empathy. We do not get enablement without empathy. The key point about did not attends, which is backed up by research, is that patients do things if they feel that somebody cares. For

somebody to feel genuinely that a person is sincere and that they care, they have to know and trust that person and have been through a series of encounters with them.

I have certainly experienced that. I remember a patient who did not turn up for a breast appointment, so I went to her house. A series of events happened as a result, and she survived breast cancer. There is an issue with the anonymous person. To answer the question briefly, I do not think that any initiative has shown that that approach works.

Elaine Egglestone: If we are informed that a child has not attended appointments, we might follow that up with a phone call or a visit to discuss with the parents why it is important that the child attends. However, we cannot do that for everyone, so we have to decide who needs that most.

It is not unheard of for us to accompany someone to the hospital, if necessary. All the teams have at least one support worker. Usually, we would ask a support worker to go with someone to the appointment, having ascertained exactly why they did not go previously. In our population, that is sometimes because people do not know how to get to the hospital, because they cannot read the bus destination boards or they are not confident about using the underground. To get from Govanhill to Yorkhill is a fair journey, particularly for someone who does not speak or perhaps read the language.

Sometimes, the reasons are financial. That applies not only to one population, but to the community as a whole. Every pound is a prisoner, and sometimes the issue is just the cost of getting to an appointment. Obviously, we cannot do anything about that. However, for children, after two DNAs, it becomes a child protection issue, following an incident a few years ago with a child not having their plaster cast removed.

Dr Langridge: There are many such initiatives, which have grown up from a recognition of the need and the vulnerability of children. However, we have just initiated them off our own bat, and there is no official evaluation.

Bob Doris: I have a comment, rather than a question—I scrubbed out two questions after your appeal, convener. The powerful message is that following up missed appointments is essential, but it cannot be done by a cold-calling anonymous person; it has to be done by someone who is embedded in the community and who already has a relationship with the patient.

So that we do not drift towards the Health and Sport Committee's work and we keep to public audit, I point out that, given that in the most deprived communities 12 per cent of hospital appointments are missed and the situation with GP appointments is similar, dealing with the issue would not only improve patient care but potentially save money for the health service. You have given a powerful message.

Professor Watt: One of our proposals is to have a lay link worker in the practice who can oil all those wheels.

Dr Cawston: Can I just correct Mr Doris? I do not think that missed GP appointments are in the same category, because we are open access, so someone who has missed a GP appointment can simply make another one. Someone who misses a hospital appointment is simply struck off and goes back to square 1, so they will not see anybody. There is a distinct difference between not turning up for a GP appointment, which has much less impact, and not turning up for a hospital one.

Willie Coffey: I have only one point, to which I invite a response from the panel. I have been really impressed by what I have heard. It has been quite moving to hear about our colleagues' commitment and dedication. In his opening remarks, Professor Watt gave the stark statistic that healthy life expectancy for men in deprived communities is 57 years, whereas it is 76 in more affluent communities, and the statistics for females are just as bad.

Will the interventions that we have talked about, such as the deep-end programme and the keep well initiative, begin to turn that situation round? I know that it could be a generation—or perhaps even a lifetime—before we see the gap closing. Is the kind of work that we are doing in the health service beginning to make inroads? If it is not, what else should we do on top of that to assist?

Professor Watt: It is a bit like Eric Morecambe playing Grieg's piano concerto—we have all the right notes, but we do not play them in the right order.

The key intervention is an unconditional continuity of care for whatever problem or combination of problems people present with. That is the starting point, after which we can play other things in. That puts the patient at the centre. It does not put the professional who does a particular thing, at a time of their choosing, at the centre.

The centre is the patient experience. A practice needs to build a compendium of stories around patients, in which they become more knowledgeable, more confident and better at using services and living with their conditions. The initial gains will be made in morale, coherence, quality of life, empathy and enablement. As people become more knowledgeable and confident, they will stay out of hospital. Things will happen to them less chaotically. That is the aspiration.

I cannot give you evidence to show you that that works, but the opposite provides quite a reasonable argument: surely impersonal, fragmented, partial and discontinuous care that is delivered by people who are stressed and who are not thinking about the future is a recipe for premature use of emergency services. Therefore, the question is not whether but how.

Willie Coffey: Can I hear from some of the other witnesses?

Dr Langridge: I have been involved in the keep well programme. Part of the answer to your questions is yes, we are starting to do the right thing. There is a good concept in the keep well programme, which is reflected in what we have talked about. It is a case of doing more.

If you are asking me whether there are areas that we are neglecting, I think that we might not have started keep well at an early enough age. Originally, it started at 45; now, it starts at 40. If it had been down to me, I would have started it with people in their 20s. That is a personal observation.

In addition, I would put more input into the early years in a more practice-based, intensive way. Mary Scanlon asked whom we are missing out. We are missing out patients who cannot be categorised as difficult enough to get into a service, but whom we know have issues. The sad fact is that, with a little extra support, those people could be turned around. They are part of the community, and changes in them will impact on other people whom they are connected with. I have read about research that has been done in America that shows that.

I will try to be brief. The short answer is yes; the long answer is no.

Dr Cawston: I will mention a patient who illustrates the kind of situation that we are talking about. Her dog died and she became very distressed. For some people, losing their dog is deeply distressing. It turned out that she had been having severe angina for three months and was suffering from a severe lack of circulation in her legs. She was also drinking heavily and was immensely lonely.

We have managed to get her to go to specialist appointments and have been able to help her to stop drinking. Gradually, she is working towards the idea of starting medication for her conditions. Part of that is about looking at fostering an animal or finding some other way of addressing her loneliness. We have talked with her about the fact that loneliness is a major cause of her ill health and we are trying to help her to address that.

That is a long-term project, not an initiative. For me, that is a long-term commitment to that woman, which involves asking how we can improve her healthy life expectancy through addressing the key factors in her life bit by bit; that is not about hitting her with the 20 things that need to change all at once.

If that approach is reproduced at a mass level, it must make a difference. The question is whether doctors such as me have the time and resources to do that with lots of people, or whether we should select the individuals for whom we think that it will make a difference. I think that, if we do that with lots of people, we must make a difference to healthy life expectancy.

The Convener: Does Ms Egglestone want to add anything?

Elaine Egglestone: I echo what my colleagues said. We are on the right lines, but we have a long way to go.

The Convener: Thank you very much. I greatly appreciate the witnesses' evidence. That was a long session, but the committee has pursued the subject in a number of reports, so it seemed right to take the time to explore where we are going.

Professor Watt: Can I say one thing?

The Convener: You can, if it really is just one thing.

Professor Watt: What can GPs do to address health inequalities? They can increase the volume, the quality and the range of what they provide for their patients.

The Convener: Okay. Thank you very much.

We will have a break for two minutes to change witnesses.

12:00

Meeting suspended.

12:04

On resuming—

The Convener: I welcome our second panel of witnesses on this subject: Dr Linda de Caestecker, director of public health for NHS Greater Glasgow and Clyde, and Dr Anne Scoular, who is a consultant in public health. The purpose of this session is to examine how health boards target funding to tackle health inequalities and how performance is monitored.

I invite Dr Caestecker to make a few opening remarks.

Dr Linda de Caestecker (NHS Greater Glasgow and Clyde): Thank you, convener. I thank the committee for the opportunity to give evidence this morning.

As public health doctors who work at health board level, we, like others, very much welcome this report, which highlights once more the issue of health inequalities. Indeed, we particularly welcome it given that the NHS Greater Glasgow and Clyde area contributes hugely to the inequalities that have been highlighted.

However, although we are here to discuss the report's focus on healthcare services, I must point out that, as others have made clear, we can truly tackle health inequalities only if we take a much broader approach, have a more equitable distribution of wealth, resources and power across society, have more state regulation of unhealthy environments, promote good work and meaningful activity and have a very strong partnership with local authorities and others through community planning partnerships. Like Harry Burns, who gave evidence a couple of weeks ago, I want to highlight the importance of early years interventions in tackling health inequalities and am more than happy to say more about what we in Glasgow are doing on that issue.

As for the report itself, I agree with Graham Watt about the NHS's key role in not only addressing health inequalities but ensuring that they do not widen. I want to make four points about the report, the first of which relates to overall resource allocation. The report suggests that the NHS Scotland resource allocation committee formula that you have already discussed attempts to take account of deprivation. However, coming from the greater Glasgow and Clyde area with its very high levels of deprivation, I do not believe that it adequately does so, for two reasons: first, the way in which it takes account of supply factors; and secondly, as Graham Watt pointed out, the inadequacy of our community data, which means that deprivation is not properly reflected in the assessment of need and therefore the morbidity and life circumstances measure. For example, although we spend a large amount on our drug services—indeed, we spend more per head of population than other areas—we still have unmet need. The technical advisory group on resource allocation, of which I am a member, is trying to make the MLC component of NRAC more sensitive to deprivation.

I note that exhibit 8, which sets out resource allocation across the boards, looks at the issue on the basis of individual CHPs and therefore reaches the conclusion that resources are distributed equitably at a national level. According to the exhibit, east Glasgow is second only to the Western Isles with regard to resource allocation and East Renfrewshire receives the least per head of weighted allocation. However, both those CHPs are in the greater Glasgow and Clyde area, where the allocation itself is determined locally. We have our own resource allocation model, which gives more resource per head of population to our most deprived areas and less to our more affluent areas.

The other issue that we have to think about with regard to local resource allocation is the national policy's overriding focus on access targets. It is absolutely appropriate to have waiting times targets and so on, but the fact is that we have to use much of our resource on meeting them. Not only that, the overriding concern about retaining the current configuration of services makes it difficult for us to divert resources into early years interventions or addressing health inequalities.

My second point is about access. The committee has already had quite a lot of discussion about "did not attend" rates, which is appropriate, given the strong social patterning that we see in DNA rates. The issue is not just as simple as transport or locally delivered services. For example, our DNA rates are just as high for our local paediatric clinics as they are for Yorkhill hospital clinics. However we are doing a lot of work on the issue, particularly with our managed clinical networks. For example, in the diabetes MCN, we are looking at specific groups with specific needs, such as ethnic groups or groups in deprived areas, and at how services can be configured through our clinical services review to try to reduce DNA rates.

We are also looking at "cannot attend" rates. It is appropriate that people are offered a quick appointment, sometimes at short notice, whenever it is available. However, attending such an appointment might be more difficult for people in some of our most deprived groups who live chaotic lives. However, if they do not attend, they might be classed as "cannot attend". NHS Greater Glasgow and Clyde has recently undertaken an equality impact assessment of its access policy to look at the potential risks and plan ways of addressing them.

As the committee will know, more affluent people are more likely to take up our screening programmes. Again, there is a risk that we might widen health inequalities through those programmes. For example, one of our new screening programmes is for bowel cancer. There is no major difference by social group for the incidence of bowel cancer, but there is for the uptake of bowel cancer screening. There is therefore a risk that the programme will widen health inequality. People are called for bowel cancer screening according to their birth date. They are therefore not called according to what community they live in. For example, we do not say, "Right, Possilpark is going to be the focus of bowel cancer screening this month, so we will put energy into trying to get the uptake rate up." The screening is not done according to households.

When we put in place new screening programmes, we need to think all the time about health inequalities and how to plan the programmes in a way that will not widen inequalities.

The third point is about the inverse care law for primary care, which the committee has talked a lot about. We support what the deep-end practices would say about the increased complexity and need in the most deprived areas. However, as Graham Watt said, this goes much wider than just GPs; it is also about, as the committee heard, health visitors and other members of the primary care team. We certainly allocate more to health visiting services in our more deprived areas. I can say more in response to the committee's questions about how we are looking at our health visiting services on a skills-mix basis to ensure that our most vulnerable families get the most intensive support. However, it is also about links to benefit services and other agencies' services.

We allocate resources to primary care mainly through a nationally negotiated GP contract, over which we have limited influence. However, certain aspects of the contract, such as section 17C agreements, give us a more flexible way of funding GP practices so that we can give additional resource to those in the most deprived areas. Work is currently going on in NHS Greater Glasgow and Clyde to see whether we can make more use of such aspects of the general medical services contract. However, if there is going to be Scottish negotiation on the contract, I would very much encourage us to focus on how we address health inequalities and anticipatory care.

Although Anne Scoular and I agree that the inverse care law in primary care is important, what is more important is what the committee heard about in the previous evidence session about the connections, how primary care works and the quality of prevention services. We have learned a lot from the keep well programme—Anne Scoular can say more about that in answering questions—about looking at critical control points and getting the quality as good as possible. It is therefore about access and engagement. We found that the use of outreach workers—people going to folks' doors to keep them engaged with the practice—works in the keep well programme. The quality of consultations is crucial, as is inequalities-sensitive practices, the support that practices get and some of the tools, such as intelligent templates—electronic tools to ensure that consultations are patient focused.

The committee heard a lot from Peter Cawston about social prescribing and the referral on to other services. There are some simple things such as having really good, up-to-date electronic directories for primary care so that practitioners know what the services are, how to refer patients to them and how to describe them to patients. That should mean that, in a 10-minute consultation, the practitioner is able to refer a patient to a service and know what type of service it is.

That is all that I want to say. We are happy to answer questions.

12:15

The Convener: Thanks very much. Clearly, you feel that the national distribution to boards does not adequately reflect levels of deprivation in different board areas, but you acknowledged that an element of the distribution formula does do that. The Audit Scotland report also acknowledges that, but it goes on to say in paragraph 28, about additional resources for deprivation, that

"there is no national or local information about how NHS boards allocate these resources locally."

Further, paragraph 29 states:

"there is no information about specific spending on addressing health inequalities."

How can it be possible that a health board cannot track or tell Audit Scotland or us how it is spending those resources to try to address health inequalities?

Dr de Caestecker: We can certainly tell you what we are spending. In that regard, I used the example of the north-east sector of our Glasgow CHP, which is one of our most deprived areas. We can show that we spend more per head of population in that area than we do in, say, East Renfrewshire or East Dunbartonshire, which are more affluent areas.

The Convener: When Audit Scotland says that

"there is no information about specific spending on addressing health inequalities"

and

"no national or local information about how NHS boards allocate these resources locally",

is it just wrong? Do you have that information?

Dr de Caestecker: We have some information. It depends whether you are saying that we do not have information on what we spend in our deprived areas compared with what we spend in our affluent areas. Obviously, on the acute side, where the majority of our spend goes, it is difficult to say what we spend on people coming from the deprived east-end areas of Glasgow compared with what we spend on those from other areas. However, we can look at our admission rates, our treatment rates and many activity rates by deprivation and show that there are higher rates.

The Convener: You feel confident that you can demonstrate that you can track how you spend the

additional funding that your board gets allocated because of levels of deprivation in order to address health inequalities, although you might wish it was more, and that you can provide that information.

Dr de Caestecker: For the reasons that I gave about the focus on access targets and retaining the current configuration of acute services, I do not think that we have an opportunity to shift resources specifically into tackling health inequalities in a way that, as a public health doctor, I would like to see.

The Convener: In your introductory statement, you said that you allocate health visitor resources not predominantly but disproportionately to areas of deprivation because there is more need there. A lot of the discussion and some of the Audit Scotland report have been about the distribution of GPs not just as GPs but as the centre of the wider primary care team. There has been a lot of talk about the QOF and all the rest of it. Is it not the truth that your life would be a lot more simple and you could allocate resources more effectively if you employed the GPs instead of their being private contractors?

Dr de Caestecker: Yes.

The Convener: Thank you very much. James Dornan will come in now.

James Dornan: I am surprised that the deputy convener is not coming in now. You have caught me on the hop.

The Convener: Well, you asked first. She is coming in next, though.

James Dornan: I am sure she is.

My question carries on from one that I asked the previous panel about community planning partnerships. How does the health board ensure that the contribution of primary care to reducing health inequalities is taken account of by the community planning partnership as part of the single outcome agreement?

Dr de Caestecker: We work hard with our community planning partners to make it work. For our single outcome agreements, we have agreements with our six local authorities on issues that relate to health inequalities. Some of that is around behaviours such as smoking and alcohol-related harm, but a lot of it is around employment, education and so on.

It is right to say that GPs per se are not intimately involved in community planning. However, a lot of our work involves trying to create health improvement services that take much more of a neighbourhood approach. That has been influenced a lot by the asset-based approach that Harry Burns and others talk about. Health visitors and members of the primary care team are involved, but it would be good to get GPs much more involved in the neighbourhood approach. Anne Scoular might want to talk about some of the work that we are doing in Drumchapel and other areas to try to make that a reality.

Dr Anne Scoular (NHS Greater Glasgow and Clyde): Yes. I will be brief. In the keep well programme, we are keen that we should learn from the very long history of short-term projects through which we have sought to address health inequalities, including have a heart Paisley. That project did not wither on the vine, because it has been woven into what the keep well programme is continuing to develop.

We want the keep well programme to become much more embedded. Part of what Linda de Caestecker described is something called community-oriented primary care, which I think responds directly to the concerns that Graham Watt articulated about having primary care teams who understand intimately the needs of their patient populations and, as Peter Cawston outlined about Drumchapel, have a clear understanding of the wider determinants of health. Not all GPs have Peter Cawston's laudable passion for public health, but we want to see more of that.

The work that we do joins up primary care teams, as diagnosticians of what is wrong in the community, with other services. We encourage the teams to bring in other services in the community, whether they are provided by voluntary or statutory organisations, to share learning mutually about where pathways can be better. I have had a lot of surprises from facilitating that work, which is small scale. One of the challenges is how we grow it, but it has important nuggets for doing things well. We have done a lot of useful collaborative work with some local organisations, we have changed some of the pathways for referral management into Glasgow Life and our Glasgow and Clyde weight management services and we have changed some of the food and nutrition resources that were available, because they were just not working. We need to get that close to services and their interrelationship, and we need to grow public health organisations on that sort of area level so that they then become influential at the CPP level and, more important, at national level. All of that must be a coherent whole.

As everybody who has given evidence to the committee has said strongly, health inequalities have an NHS dimension, but we must get the other bits working in synergy. I think that "synergy" and "connections" are the two words that summarise that work.

James Dornan: Further to that, are you saying that the GPs with whom you work are feeding into the CPP in the local area?

Dr Scoular: Yes. It is an indirect link, which I think could be strengthened. At the moment, GPs are feeding into a keep well initiative. As many people have said this morning, keep well should be much more than a clinical intervention; it should be the beginnings of a relationship between a patient and a healthcare provider in primary care. We have fought hard to retain keep well as a primary care-based, general practice-based initiative. However, it has got to link up coherently with the health improvement initiatives. Obviously, our local CHPs have strengthening links with CPPs. I think that, as we build that sort of approach, it begins to address some of the long-term fragmentation issues that have been a problem because of how we have developed things and how structures have changed over the years.

James Dornan: What can we do to encourage the GPs who do not take part in that approach to see the importance of doing so? You said that some do but that some do not because they do not see the benefit in taking part.

Dr Scoular: I acknowledge what Peter Cawston highlighted, which is that, at the moment, we are taking this approach as enthusiastic amateurs and have not built in the time that is required for GPs to do it. Peter Cawston is doing it because he is a passionate believer in doing it and I do it alongside my other jobs as a busy public health doctor. If we are serious about doing this, we need to build the structures, put in place the necessary investment and ensure that people have the time that is required to do it. I believe that the approach contains the right ingredients to address the drivers of health inequalities.

We talk about health inequalities as if they were one topic area, but they are not. Myriad things drive poor health over the course of someone's life. We cannot just say that we are investing money in health inequalities as one lumpen mass. All the work that Sally Macintyre did in the original task force shows powerfully that health inequalities are driven by different things at different points. We need to invest seriously in all those things.

Dr de Caestecker: One of the things that we have done in NHS Greater Glasgow and Clyde is to appoint a GP to lead our deprivation interest group. That flowed partly from the deep end. We have given dedicated sessions to a GP to bring together people from the broad primary care team—not just general practice—to specifically consider mental health or child health, for example, and set up areas of work in partnership with other agencies.

Mary Scanlon: I have just had a bit of déjà vu, because, for the past 14 years, people have been asking why things are not joined up and why there is no synergy. Exhibit 7 shows that almost everything is pretty stable and that nothing has changed. Why is the approach to health inequalities not joined up? We have known for 14 years that it is not. Why is it not adequately funded, especially for the early years, where there is evidence of the need for it?

Dr de Caestecker: I do not think that we, as an NHS board, can answer your latter question. We use the evidence that there is for early years work. As you heard earlier, we have the family nurse partnership, which is funded nationally. We welcome that, because it has a strong evidence base, although it is a resource-intensive intervention. I want to take the key learning from the pilots and use it in mainstream services.

You know that we have an ambitious parenting programme in Glasgow, which is run in partnership with the local authority. It is not a phenomenally expensive programme, as it uses existing staff, but there is a resource requirement that has come through community planning.

As I have said, we target our health visitors on our most deprived areas, which means that our more affluent areas have to accept that they do not have as much resource as other areas. However, we are also doing a bit of planning work to ensure that, with the new 30-month assessment and the growing evidence of what works in early years, we have worked out what additional resources we need in our children and families team and where we might find that within the board's overall allocation. We are continually trying to do that.

Why is the approach to health inequalities not joined up? Aspects of it are more joined up. It is a shame that the CHCPs did not continue in Glasgow, but in areas such as East Renfrewshire, West Dunbartonshire and Inverclyde, where we have integrated CHCPs, they are working well and we are hearing good stories of how the services are much more integrated through that. We look forward to the integration of health and social care, particularly if it includes children's services. That will bring benefits.

As Anne Scoular said, things must be joined up at an extremely local level first, and we must build it up from there. That is quite time-consuming and resource-intensive work, but we are really trying to tackle it.

Colin Beattie: Are you satisfied that practices in the deprived areas are adequately resourced? What indicators do you use to ensure that, and how do you make it happen?

Dr de Caestecker: We cannot make it happen, because it is a nationally negotiated contract. GPs are distributed and funded through the national contract.

Colin Beattie: How do you monitor that? If you believe that GP practices are underresourced, how do you escalate the issue?

12:30

Dr de Caestecker: As I said, we try to use aspects of the contract that allow us to provide funding in a different way. We also have our locally enhanced services, which enable us to fund GPs on the basis of secondary prevention, for example. We have good data from our locally enhanced services on their quality and outcomes. Would it help if we said a wee bit more about that?

Colin Beattie: I am trying to understand how you can, when you realise from monitoring GPs that a resourcing problem exists, escalate the matter. Are there instances in which you have done that?

Dr de Caestecker: We agree up to a point about the funding for GPs, but that is not the most important aspect in tackling inequalities. However, we have tried to influence the contract through our Scottish Government colleagues. We have been asked for our views on the public health aspects of the new GMS contract and we have fed into that.

Colin Beattie: Do you believe that GP practices in more deprived areas are adequately resourced? I am not talking just about money.

Dr de Caestecker: I would like resource to be skewed more towards areas of inequality and to more deprived areas. We are trying to achieve that through the extended primary care team. The issue relates particularly to our child and family teams. The health visiting team, with the skills mix that is attached to it, is a key part of the primary care team. We want those teams to have additional resources in our most deprived areas, so that they can adequately support our most vulnerable families. We are planning ways to provide such resources.

As for GPs, I do not think that it is appropriate to have a completely flat distribution. We need a contract that allows a much more socially patterned distribution. However, given the current resources and the contract, it is important that we make the best use of the resources that we have in such areas. I would be happy to say a bit more about that.

Dr Scoular: The key issue is to ensure that support services work coherently. Graham Watt mentioned picking up the pieces afterwards. We are doing a lot of innovative work to help people such as practice nurses, who mainly do the business of long-term condition management. As members know, long-term conditions drive about 80 per cent of our inequalities in health in middle age.

NHS Greater Glasgow and Clyde is doing a lot of work to provide electronic systems that will ensure the right prescribing, which relates to the committee's previous agenda item. We are providing electronic prescribing support, which is shaped by the advice of our managed clinical networks. That enables primary and secondary care to develop systems that cross primary and secondary care, and to respond to people's needs—and not just people who have a single disease.

We have recently developed electronic decision-support systems to help primary care practitioners to do the right things for people who have combinations of conditions—or multiple morbidity. That development is important because of the issue that Graham Watt described, which is the growing burden of premature multiple morbidity in our most deprived areas.

Those systems will also help in relation to older people. As we live longer, we get different inequalities. We focus a lot on multiple deprivation, but we should remember that age is also a driver of different patterns of inequality. We cannot put all our eggs in one basket, although deprivation is an important one.

Mark Griffin: In answers to the convener, you said that you would prefer the funding formula to be tweaked to take into account more of the factors that affect health inequalities. You said that it already takes those factors into account but that the extra money is taken up by the need to address the effects of inequalities, rather than by the need to tackle the inequalities themselves. If the funding formula was tweaked, would the additional resources go into tackling inequalities, or would they simply be swallowed up by tackling their effects?

Dr de Caestecker: Because so much of the resource that is allocated to a health board has to go into acute care, we are above parity, as you probably know—we are above where we should be, if the formula is accurate. Part of our argument is that what we spend is based on need. The patients are coming into hospital, and they are being treated. How come the formula says that we are spending £60 million more than we should be, if the formula is correct? At the moment, all that we are arguing is that what we are currently spending is based on the demands and needs that come to our services.

Much of any additional money that comes in is ring fenced, for early years work for example, or for work around certain health improvement,

efficiency and governance, access and treatment—HEAT—targets or the keep well programme. We would absolutely target that money at our most deprived areas, and we have shown through some of our programmes that we have done that.

Mark Griffin: That leads to what was going to be my follow-up question, which was to ask whether it would be appropriate for money to be ring fenced specifically for those methods. You have answered that.

Dr de Caestecker: We need to give local areas a lot of freedom, based on their local arrangements and needs. When money is ring fenced for a specific issue, we spend it on that. That has been the advantage of the keep well project, and those funds will now be in our mainstream allocation. The programme is well developed and we have made it as efficient as it can be. It is okay for that to be in our mainstream allocation now.

Bob Doris: I wish to pursue the point that the convener started on, in relation to the resources that you get for areas of deprivation under the NRAC formula. If we consider the current model, looking at exhibit 8 in the report, and if my arithmetic is right—it might not be, so tell me if it is not—areas that I represent in north Glasgow and east Glasgow are, using the weighting mechanism, probably getting up to a third more resources than, say, East Renfrewshire. I am keen to know what my constituents can expect for that. We can talk about preventative spend, for example, but what does that mean on the ground? More specifically, what does it mean for what my constituents have and how that money is spent? That comes back to the assets-based approach.

We have heard about social prescribing. GPs might ask patients, "Do you fancy doing this at Glasgow Life?" We should be asking people what they like to be doing in their community and finding the resources to make that happen. Is any of that going on in relation to the additional resources that NHS Greater Glasgow and Clyde get for the constituents whom I represent?

Dr de Caestecker: Most of that additional resource will be going into direct services, whether they involve allied health professionals or primary care teams—all the services that are delivered through a CHP for the local community—and that resource is higher in the most deprived areas. The questions of how to involve local communities and how the money is spent are addressed through the public forums that form part of the CHP. They have taken a long time to establish, but they are working well now. Patient groups and representatives of the local population have a say in delivery of services through CHPs.

On the wider question of what people would like if they are being asked to be more physically active, we are continually addressing that by asking communities, for example, where they want their smoking cessation services to be for those who wish to stop smoking. We are asking people what would help them by way of the physical activity services that they want. We try hard to get local views.

Bob Doris: I have two brief follow-ups. First, given that I mentioned two areas in Glasgow, perhaps you could arrange for me to visit one of those public forums to see how they work in practice.

Dr de Caestecker: Yes.

Bob Doris: That would be helpful.

Probably more important than that for the committee, though, is the issue of weighting. I accept that a lot of that is about recognising that there is more demand in acute services and more need for allied health professionals to mop up the consequences of health inequalities. However, given that a preventative spend agenda is the direction of travel for public policy, do you earmark a percentage of that additional spending specifically for preventative measures? You cite examples of preventative measures, and we can perhaps put a cash sum beside that. Is there a cash sum that you put beside that? What percentage of additional weighting is it? How can we follow that pound?

Dr de Caestecker: The example that I would use is our health improvement teams. We have health improvement teams whose main focus is prevention, community development, working with local groups and so on. They are allocated a resource that goes into each health improvement team at sector level. At CHP level in Glasgow there is a resource allocation model that includes a weighting for deprivation. That is why our team per head of population in East Dunbartonshire is much smaller than our team in east Glasgow.

Bob Doris: You can say what you are spending on health improvement and that you will weight that towards the areas with greatest deprivation, but when it comes to the money that is in your health improvement budget, do you use a set percentage of the overall additional money you get for deprivation from the Scottish Government or do you just pick a number each year?

Dr de Caestecker: What we get is the overall allocation weighted according to deprivation. That does not differentiate for health improvement, acute services or whatever. A slightly different formula is used for mental health services and maternity. However, if we get additional money, say for healthy weight, it is allocated via the NRAC formula. It is weighted again for deprivation, so

Glasgow would get a bit more than would be given per head of population. However, we do not get a specific allocation for prevention, and X per cent more. It is in the overall allocation that we get. Does that answer your question?

Bob Doris: It does, although it clarifies that NHS Greater Glasgow and Clyde does not have a set percentage of the additional resources that it gets to take account of deprivation through preventative spend. You spend money on prevention, but do not have a set budget or a strategy for slicing the additional resources specifically for prevention.

Dr de Caestecker: It is not a case of "Here's your allocation by age and sex and here's your additional allocation." Crude population is the biggest driver in the formula. It is then weighted by 0.9 for remote and rural areas—we are not very remote and rural—and there is a 1.1 weighting for deprivation.

The Convener: I think that Bob Doris's point is that you do not ring fence that 1.1 for spending on deprivation.

Dr de Caestecker: To do so would mean that we would be spending a very small amount on deprivation.

Dr Scoular: Perhaps I could widen out the point. It is a bit like the concept of health inequalities, which is, as a set of issues, complicated and differentiated. When we talk about prevention, it is easy just to think about primary prevention, which is preventing a condition from happening—for example, initiatives on healthy weight, smoking and breastfeeding.

However, we should remember that prevention has an equal, if not more important, role for people who have already developed problems or conditions, such as coronary heart disease or diabetes, because a person with diabetes has quite a high risk of developing coronary heart disease and other complications. Good clinical care incorporates all the right preventive interventions for people who have existing conditions. If we are doing all the right things, there is a vital prevention role there as well. The division between prevention and high-quality clinical care is artificial. We need to remember that a lot of the prevention work and the valuable prevention impact are bound up in good-quality clinical care across the primary-secondary care interface.

Bob Doris: I have no further questions at the moment. I appreciate what you have said, but it is sometimes difficult for us to take that into account when we are asking our questions because, as an audit committee, we are trying to follow the pound.

12:45

Dr de Caestecker: I could come back to you with more specific information on what each weighting in the formula equates to in terms of money. I think that you will find that we spend substantially more—certainly in our deprived areas, but also on prevention—than you see in the weighting. I would need to come back to you with the figures.

The Convener: If you are willing to do that in correspondence in response to Mr Doris's question, that would be appreciated.

Bob Doris: Thank you.

The Convener: I thank Dr de Caestecker and Dr Scoular for their evidence this morning, and also for their forbearance in waiting so long past the time when we expected to hear from them.

"NHS financial performance 2011/12"

The Convener: The next item on our agenda is item 5, on NHS financial performance. Follow-up correspondence that we sought from the Scottish Government has been circulated. Does anybody want to comment or ask questions?

James Dornan: Excuse me, convener, is it not item 4?

The Convener: Yes.

James Dornan: I am sorry; you said that it was item 5.

The Convener: I apologise. It is item 4. That is important, because item 5 will be in private and we are still in public session. However, the item is as I described it.

Mary Scanlon asked for the correspondence, I think.

Mary Scanlon: Yes. I asked because I wanted to understand better the £1 billion backlog, given that a percentage of it was for buildings that were no longer required. I also wanted to know what was low risk and what was high risk. I am grateful for the response because I think that we now have a far better understanding of where we are.

However, if I may, convener, I want to ask another question, given that £240 million of the backlog is categorised as high risk. I raised the matter in the budget debate last week because we had just been given the papers. The Cabinet Secretary for Finance, Employment and Sustainable Growth—I am sure that he knows more about this—said that the main high-risk backlog maintenance is in the capital budget. We are talking about backlog maintenance, so is there an existing budget for that or does all maintenance come out of the capital or revenue budgets? I want to understand that, because my understanding

from the Auditor General's report is that it probably comes from the revenue budget; she highlighted the significant backlog. The cabinet secretary says that it is the capital budget and that that is determined by Westminster.

Given that so many of the elements are high risk and are urgent priorities because they could involve catastrophic failure, major disruption and so on, I would like to know whether Westminster decides all the capital budget for backlog maintenance and, if not, how much is decided within the normal allocation to health boards.

The Convener: Are you asking that we write back and ask whether the backlog maintenance is part of the capital budget or part of the revenue budget?

Mary Scanlon: Yes. I would like clarity on that, because what I was told is not what I had understood.

The Convener: Does anyone object to our asking that? It is a straightforward question.

Willie Coffey: I do not object, convener. I just want to put something on the record. The £1 billion ticking time bomb problem that we were presented with a number of weeks ago, not only at this committee but in the chamber, now seems to be one of £161 million. That is the figure for the high-risk category in Mr Feeley's reply. The backlog maintenance figure is £161 million—not £1 billion, as we were previously led to believe.

I am pleased to see from Mr Feeley's reply that NHS boards are well aware of the backlog and are tackling it. The reply is more encouraging than what we were led to believe before.

James Dornan: Can I ask for clarification of two figures in the papers? We have the £161 million figure for the high-risk category, but at the back we have the £240 million figure that Mary Scanlon mentioned.

The Convener: The figure is actually £252 million when the special health boards are included. There seem to be two different figures.

James Dornan: I would like clarification of that.

The Convener: We can ask for clarification.

Mary Scanlon: That would be helpful.

The Convener: Mr Coffey has made his point. Whichever of the figures it is—

Willie Coffey: It is not £1 billion.

The Convener: —it is less than the total, which is £1 billion.

Do members agree that we should write to ask for clarification of those two different figures and whether the backlog maintenance in table 1 comes from the capital budget, the revenue budget or is a bit of both?

Members *indicated agreement.*

The Convener: Thank you. We now move into private session.

12:50

Meeting continued in private until 13:06.

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