HEALTH AND SPORT COMMITTEE

Wednesday 19 December 2007

Session 3

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HEALTH AND SPORT COMMITTEE
14th Meeting 2007, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Angus Cameron (Dumfries and Galloway NHS Board)
Dr Frances Elliot (Fife NHS Board)
Dr Charles Swainson (Lothian NHS Board)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 19 December 2007

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

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning, and welcome to the 14th meeting in session 3 of the very hard-working Health and Sport Committee—we are meeting for the second time this week.

Ross Finnie (West of Scotland) (LD): The second time in 24 hours.

The Convener: It is a 24-hour task. I am so sorry.

I remind everybody present to switch off their mobile phones, whether they are sitting at the table or in the public gallery. Michael Matheson is running a little late, but he will be with us shortly. He is currently stuck in traffic—we all know what that feels like.

Item 1 on the agenda is to ask members to agree to take item 3 in private. Item 3 is our consideration of the budget process, which we must conclude today. Considering draft reports in private is the normal practice. Is that agreed?

Members *indicated agreement.*

The Convener: I see mobile phones being switched off all round. How wonderful! That is power.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am not sure that we want that in the *Official Report*, convener. It might go to your head.

Ross Finnie: I am still wrestling with the ability of someone to be running late while stuck in a traffic jam.

The Convener: I can see that we need a break.

Balance of Health Care Inquiry

10:02

The Convener: Under item 2, we continue our inquiry into the balance of health care. I refer members to paper HS/S3/07/14/1, which contains the written submissions that were helpfully provided to us. Today's evidence-taking session with national health service boards follows last week's evidence from community health partnerships. I remind members that the session is intended to be similarly exploratory in nature, with the aim of giving us ideas to inform an inquiry remit.

I welcome our witnesses who are from Lothian, Dumfries and Galloway and Fife. Our witness from Shetland is not running late; she is not coming at all, because the planes cannot take off today. That seems the best excuse ever—I wish that I had had that one for school. Dr Angus Cameron is the medical director of NHS Dumfries and Galloway; Dr Frances Elliot is the medical director of NHS Fife; and Dr Charles Swainson is the medical director of NHS Lothian. I invite our witnesses to say something briefly before we launch into questions. [*Interruption.*] The witnesses have all waived their right to do so, which is wonderful. We move on to questions from committee members.

Ross Finnie: We are dealing with this subject in an outline form—we are trying to get shapes and directions where we can. Some of your submissions were positive, and some were not. Efforts to move the balance of care have been a long-running saga. I will raise a functional matter. To what extent are clearly identifiable policy drivers in place? Are you doubtful about that? Are there some areas that you wish to highlight to us at this preliminary stage of our inquiry? Are there issues just with the balance of delivery, or are there also issues with policy drivers?

Dr Charles Swainson (Lothian NHS Board): I will have a stab at that. The policy drivers are clear, in the sense that the discussion document "Better Health, Better Care" builds on a series of policy documents from previous Governments that set out a clear direction of travel and put in place several mechanisms to allow health boards to respond to that. In truth, everybody welcomes that direction of travel, which, as the member hints, is built on years of gradual movement.

I guess that the question is about what barriers might exist to implementing a clear policy direction. There are several such barriers. One is that, although it is easy to talk about measures such as a single shared assessment of the needs of people who require health and social care, or aligned or pooled budgets and the mechanisms

that can help to give effect to those, in reality, such measures can be difficult to achieve when different funding streams and accountabilities must be handled at the same time. Over the years, I have been struck by the fact that a great deal depends on the people who are involved and on their willingness to engage across the structural barriers and, in essence, to take the necessary risks.

The Convener: We have heard about that personnel issue before.

Dr Frances Elliot (Fife NHS Board): Another issue is that policy drivers can potentially act against one another because of our understandable focus on acute services and acute care, particularly emergency care. We are a responsive public service and therefore have to deal with whatever presents. We also have the pressures of expensive new technologies and drugs, which are often initially commenced in secondary care and which consume a considerable proportion of health service expenditure. Although we have policy drivers to encourage us to devolve care to local communities and to encourage primary and community services to take responsibility for care, there is always a balance to be struck in the way in which boards must then deliver acute services.

Ross Finnie: I want to press you on that point, which strikes right at the heart of the issue. You say that we have understandable pressures, but how do we measure them? Ninety per cent of care could or should be delivered in the community, which is why the committee is exercised about the difficulty of achieving that. If 10 per cent of the care can get 90 per cent of your attention, we will always be in the same situation that we are in now. Can you help us to square that circle, to use that silly phrase?

Dr Elliot: I am not a fan of targets per se, but we have set targets for acute services. In some services that are delivered in the community, we do not have the same emphasis on targets to deliver on access and waiting. An issue arises about the balance in relation to the way in which the service is driven by reporting and the way in which, of necessity, boards put in place measures in their delivery plans to achieve targets. It would be helpful to have greater emphasis on what some of the community-delivered services need to achieve.

Dr Angus Cameron (Dumfries and Galloway NHS Board): Shifting the balance of care is entirely consistent with the rest of the health agenda, which is about a move to structured and proactive care. Shifting the balance of care is not about saying that we will treat in the community someone who has a severe heart attack—that is completely wrong. However, we know that we can provide a lot of care to deal with the risk factors and to make it less likely that that person will end up having an acute coronary episode.

I see shifting the balance of care as being more about going downstream in the illness, doing preventive work, reducing risk factors and dealing with diseases before they become acute crises. There is a lot of muddied thinking about shifting the balance of care, in which something that is currently done in the acute sector is put in the primary sector. I have great reservations about that—when somebody is severely ill, there is a lot to be said for a high-quality centre of excellence. However, that does not mean that it is not possible to shift the balance of care significantly in a range of diseases.

I come from a rural area. Shifting the balance of care to communities is much more important and really sought after by patients and the public in such areas. For example, the uptake of chemotherapy in the west of Dumfries and Galloway is much lower because people are much more reluctant to travel. Originally, they had to travel 150 miles to Edinburgh, but now they travel to Dumfries. Even so, the uptake of chemotherapy is much higher around Dumfries than around Stranraer. We are now moving chemotherapy out to that area and having the care delivered by nurses and, to an extent, general practitioners. The treatment is not ordered by them, but it is enabled by them. That is a good example of shifting the balance of care and making it more accessible, because more people will take up the care.

Ian McKee (Lothians) (SNP): I wonder whether you are being a little underambitious in your statements about services that are presently provided in acute care and which could be provided in secondary care. No one doubts that there are lurid examples of illnesses that could not be treated in primary care, but many of the drivers for change and for getting illnesses treated in primary care at the moment seem to be down to reasons that are outside the health service, such as geography. All of a sudden, the health service finds that it can provide in the community a service that, for some reason, it finds difficult to provide in the community in an urban area—it suddenly becomes easier when the service has to be rendered 50 miles away.

Could we not, even in urban areas, try to find all the services that are provided in acute care at present and determine whether it is really necessary to provide them in that sector? Although major services do not need to be moved, perhaps much of dermatology, respiratory medicine and a variety of other services—you mentioned oncology—could be done in the community if the shift was right. At present, we are

making excuses for not doing that because the shift is difficult to tackle. However, I might have a false impression, so I am interested in your views on that.

The Convener: Perhaps the witnesses from urban areas could answer first.

Dr Swainson: I agree with Ian McKee. The biggest gains are in the central belt and urban areas of Scotland. Just over 10 years ago, the chief scientist office funded a study that I ran with other colleagues and all the health boards. That study found that at least 25 per cent of emergency admissions to hospital at the time could be perfectly well dealt with by colleagues in primary care in the community if they had the tools and services to do so. I doubt whether that figure has diminished with the passing of the years. In fact, it has probably increased for exactly the reasons to which Angus Cameron referred.

There is a mixture of things going on. There are groups of patients with long-term, largely chronic illnesses who—if provided with good, proactive care and a degree of emergency and supportive care in the community to get them through crises, particularly at night and the weekends—can be looked after perfectly safely and well in the community and do not need to access acute hospitals. We see that in patients with acute deterioration, if you like, in a long-term condition. We now have very good evidence that it is possible to achieve those shifts and that they are well supported by patients as well as by GPs and others in the community. I can point to figures in Lothian that demonstrate that admissions to hospital for complications of diabetes or heart failure and admissions to mental health hospitals for acute deteriorations in serious psychiatric disease have all gone down because there has been investment in different services in the community that can support those patients in different ways.

In the case of mental health, that has allowed us to reduce the number of mental health beds and to switch the funding that was associated with those to community services. However, it is sometimes difficult to bring off that trick. How do we mobilise and shift across to a different community services model resources that are often fixed in one place—in buildings, beds, people and so on? That is one of the challenges.

10:15

The Convener: Does Ian McKee think that it would be useful to ask for further information on the reduction, with figures?

Ian McKee: Yes.

Dr Swainson: We can supply that.

The Convener: Alternatively, you could point our clerks to where the information can be obtained.

Dr Elliott, do you want to comment on the interesting point about geography? Having lived in Newton Stewart for many years, I understand that the drivers are different in rural areas.

Dr Elliot: We have opportunities for better working across primary and secondary care. We certainly have examples of community staff who are supported by outreach from secondary care. For example, our rheumatology service in Fife is largely community based, and we also have respiratory nurses and cardiac failure nurses who are based in secondary care and who support not only patients but staff in the community, to enhance their knowledge and understanding of modern treatments.

An important point is that the community health partnerships are looking at much better care planning and individual case management in the long-term conditions work on which they are leading. We need to concentrate on that strand of work and extend it from the traditional specialties in acute services, where it is more commonly in place, to a wider range of services that support the community. That involves not taking resources out of secondary care but getting increased value by sharing expertise with primary care.

The Convener: I call Helen Eadie.

Helen Eadie (Dunfermline East) (Lab): Good morning. I can see from—

The Convener: I beg your pardon. I am so sorry. Dr Cameron wants to comment.

Dr Cameron: I am not sure that I am going to add any major gems. I was just going to say that I agree with Charles Swainson about diabetes and mental health, but I would mention asthma and epilepsy as well. We have shown that, with those illnesses, if there is really good care in the community and management plans are agreed with patients so that they pick up on exacerbation and know what to do about it, we can dramatically reduce the number of admissions.

In the past, jealousy about access to diagnostic tests made life more difficult for the general practitioner, who had to refer to a specialist to get access to a test. We made radical changes to that and we find that GPs are perfectly capable of ordering various tests appropriately. That allows a lot more care to be managed, and investigation to be done, out in the community.

The Convener: Thank you. I call Helen Eadie.

Helen Eadie: Thank you, convener. I will try again.

One theme that runs through the papers that were provided by the witnesses, the Royal College of Nursing and others is an issue about the workforce. For example, the briefing paper from NHS Dumfries and Galloway mentions

"Professional barriers amongst secondary care clinicians".

We need to think about that problem.

The Royal College of Nursing says that, in order to achieve the shift to the local areas, we need a more robust and accurate picture of how many nurses will be required in the community. However, it also mentions that the workforce planning process, from which all the figures are derived, does not take into account the proposed shift of care from hospitals to the community, which needs to be adequately resourced.

What are your views on the point about the professionals who are required to deliver in the community? If there are problems, we need to know about them.

Dr Elliot: That is a crucial point in relation to shifting the balance of care. Through our local workforce plans and by working with our colleagues in other boards on regional workforce planning, we are starting to consider the resources that are required. Some work has been done through the British Medical Association with local medical committees to engage practices locally so that they tell us about their workforce—they are no longer required routinely to report that information to us. We are starting to discuss with our local medical committee how we engage not just GPs and their staff but dentists, optometrists and pharmacists in looking in a more structured way at workforce planning for independent contractors and our community staff. That is crucial.

It is a complex subject because the roles of many of our health care professionals are changing. In children's services, for example, new screening programmes can free up time for health visitors and other community staff, and we must therefore look positively at how we can use their skills and expertise to help us shift the balance of care. We have to be broadminded in considering all the community and primary care staff, and we must also find out from clinicians the skills and competencies that their staff need to take on activity to shift the balance of care.

Dr Swainson: I do not detect particular resistance from secondary care staff. The majority to whom I speak are pleased to engage in the discussion. They are generally looking for reassurance that the proposed alternative to someone going into hospital will provide the same quality of care.

The point is interesting for me. I have visited a number of general practices and other community services in the past few years, and I have learned a great deal. Capacity and capability may be highly variable but can be excellent. Many of my hospital doctor colleagues are ignorant of what can be done in primary care, so there is a communication exercise that needs to be gone through locally.

The other issue is that the models of care are different, particularly in large urban hospitals, where patients with many conditions are looked after by relatively specialist teams. For example, patients with diabetes will be looked after by at least a medical team, if not a specialist diabetes team.

When you talk to general practices and community health partnerships about how they will create services to look after people with a range of chronic conditions, you find that their approach is quite different. They do not say that we need a lot of specialist teams duplicated across every practice; they say that we need to consider the generic capacity and capability of nurses, allied health professionals and others in general practice, primary care and community services and that we need to train them specifically to look after that wide range of people. The conversation is different, as is the workforce planning.

I can give the committee an illustration of that. In the past year, we have been investing with our community health partnerships in services to underpin the care of people with heart failure and chronic respiratory conditions in particular. The conversation for next year is about how we can support people with heart disease, diseases of the tummy and so on. The CHPs have said that that is fine but that they are interested in a generic model, in which a group of nurses can look after a wide range of people rather than there being a nurse for this, a nurse for that and a nurse for the other. That is a completely different training model from what we are used to, and we need to get our heads round it in planning both the number of nurses that we need and how we train and support them.

The Convener: I am very interested in those comments because we are often lobbied about specialist nurses—for diabetes or asthma, for example. You mentioned the generic model, and I know that in my area—the Borders—people are considering having a neurological nurse who can deal with a range of conditions rather than trying to supply a nurse for each particular condition. We are all lobbied about specialist nurses, so you make an interesting point.

Dr Cameron: I agree with the point. Particularly in rural areas, generalist staff are extremely valuable. We have struggled with the provision of

specialist neurology nursing in our rural area—a specialist can end up spending most of their time in a car because of the geography.

Primary care teams are, to an extent, deskilled, as they are told, "This is a specialist case; it is not your responsibility," and they do not build up, gradually and over time, the experience to cope with situations. The other thing regarding workforce planning in primary care, rather than community care, is that practices tend to be amazingly flexible. They are small business units and are very light on their feet—if they are given a problem or an objective, they will rapidly marshal their resources and deal with it. I am jealous of that because I work in a health board, where it takes considerable time to change routines and everything else.

Charles Swainson is absolutely right—primary care tends to be extremely flexible, and people will chop and change, undertake more training and deliver services in a pragmatic way to deal with the demand in their particular community.

The Convener: I want to move on—we will come back to Helen Eadie later.

Rhoda Grant (Highlands and Islands) (Lab): My question is on cost. Angus Cameron mentioned in his submission that delivering primary care in rural areas is more expensive—I think that he was alluding to that in his previous answer, when he said that a specialist nurse might spend more time travelling around in a car than seeing patients. How can that be addressed? Can a comparison be made with the cost of having people in acute services?

Dr Cameron: Sorry—I probably gave the wrong emphasis. The Arbuthnott formula considered the excess costs of delivering care in rural areas, and the allocation to health boards has been more or less appropriate. I am certainly not expert enough to second-guess that. There is a move to shift the balance of care into primary care, and the shift in costs is more noticeable in a rural area than it is in an urban area, for obvious reasons. I am not able to quantify that; I am just aware that—as Charles Swainson described—there is always a difficulty in extracting costs from secondary care and from redeveloping in primary care. The difficulty is even more acute in a rural area, where the costs are greater.

Rhoda Grant: The NHS Scotland resource allocation committee has rebalanced some of the Arbuthnott funding, certainly for rural health boards. If that funding allocation was to be implemented, would it prohibit rural health boards from rebalancing from acute care into primary care?

Dr Cameron: There is a risk that it will make it harder for us to do that, because delivery of care in remote and rural areas is more challenging and, inevitably, more expensive.

The Convener: I will bring in Dr Elliot and then Dr Swainson, whose boards cover rural areas as well as being partly urban.

Dr Elliot: Part of the value of community health partnerships is that they can start to address some of those issues. Although we cannot afford to put particular specialist resources into every practice, working either at the wider CHP level or at a locality level within the CHP is one way of dealing with them. We have a number of initiatives in which a lead practice takes responsibility for some specialist aspect of care delivery—in Fife we do that with diabetes and asthma, and we have started to do it with coronary heart disease. Nurses are aligned with one practice, but serve a group of practices in a locality. The efficiency of that resource is maximised. Rather than trying to split the resource into a number of very small pockets and not being able to maximise the benefit, clinics can run alongside the practice nursing staff and GPs and, therefore, can support a larger number of people in the community.

Dr Swainson: The area that I want to touch on is telehealth and telemedicine. We have not yet fully exploited that in Scotland, but we have had some very good initial studies—

The Convener: You have anticipated Mary Scanlon's question.

Dr Swainson: I will wait.

The Convener: I am happy for you to wait for Mary Scanlon to ask her question. I promise Mary that no other member will ask it. She often has to delete her questions, but we will be good to her today. We move on.

10:30

Dr Simpson: I should declare an interest. I am still working on an e-health single shared assessment for the Edinburgh drug action team—I think that the work is partly funded by NHS Lothian, so I still have a connection with the board.

Historically, many conditions were treated entirely in a hospital setting. All patients with diabetes and hypertension, for example, used to go to hospital for treatment. The main question that seems to be emerging from the discussion is whether we should retain a generalist approach in general practice or have a specialist or semi-specialist approach. We need to explore that tension a little further.

We have worked hard to introduce managed care networks on high-level issues across regions, and the approach has worked well. Will the witnesses comment on the concept of more

vertically integrated networks, in which practices have a degree of specialism if they are comfortable with doing so? Some 30 per cent of GPs have a specialist interest, and some GPs work in hospitals. How do we deploy the diversity to which you alluded in a much more structured way? For example, we should be able to say, "This practice is good at treating diabetes, but that one is not and will require more support." How do the witnesses envisage that that complex picture will pan out? How can we be much more structured and aggressive in our approach, to ensure that the shift takes place?

The Convener: I invite Dr Swainson to be the first to respond, because I stopped him in full flow earlier.

Dr Swainson: Thank you. Richard Simpson described an area in which we want to make progress and which is a key role of community health partnerships. He is right to say that practices vary enormously in size and in what they can do, given the interests and training of partners and staff. We need to regard that variability as a strength and make use of it. I can envisage a blurring of the boundaries between generalists and specialists. After all, all doctors went to medical school and went through proper training programmes. GPs learn an enormous amount through experience and are willing to take on new roles, as Angus Cameron said.

I can envisage a world in which some large practices run what are almost specialist clinics for the practices in their area. Why should we not have such a model? We should not have to be tied into an approach in which a practice is contracted only to look after a particular group of patients and does nothing else. We need to find more flexible ways of using the resource that we have. We should acknowledge that a practice that has strengths in the management of people with drug and alcohol problems, for example, might be less interested in other, physical diseases, so we should be able to share expertise locally. If we pushed the development of such an approach we would serve people well, because we would be able to provide a specialist service to a whole community rather than just to the people who are registered at a particular practice.

Hospital and specialist services would be able to play into such a model, because they would be asked to support the focus in the community rather than work in every practice—in Edinburgh that means that a group of specialists must try to support 125 practices, which cannot happen. It is much more realistic for specialists to support networks of local services in CHPs. Specialists can do that and I think that they want to do that. The whole agenda that Richard Simpson mentioned is ripe for plucking.

The Convener: Are you talking about accrediting practices as specialists in certain areas, in the way that law firms are accredited as specialists in commercial work, litigation or criminal law, for example?

Dr Swainson: No. We do not need to be as formal as that. There are plenty of other ways of ensuring that quality of care is up to the mark.

Dr Cameron: I find Richard Simpson's question difficult to answer, because part of me says that generalists are extremely important in the health service and can deliver efficient care. I worry a lot about the lack of continuity that patients experience when there are multiple hand-offs.

As we know, patients do not have just one illness. These days, people are living longer and experiencing multiple chronic illnesses. It can get very disappointing for patients when each illness is dealt with by a specialist. The experience can often leave people feeling a little bewildered. People view continuity of care as extremely important. The generalist scores in that regard by providing good, thoughtful care where appropriate and making referrals when they know they are out of their depth. General practitioners often provide continuity of care not only for the individual but for the whole family. One can argue that that is a paternalist view of medicine, but I strongly believe that that is what the public wants. There is great benefit in ensuring that the generalist is retained.

However, if GPs and other primary care staff are able to develop a specialist interest, they appreciate that and get more out of their job. We need generalists who are well trained across a broad spectrum of health issues, but who also want to develop a specialism in one or two areas. Practitioners get much more professional satisfaction from that combination, and it helps retention.

Dr Elliot: There are a number of examples across Scotland where that approach is being taken. It started in the days of fundholding, when practices took on a specialist interest for their practice population. There are also examples of a practitioner undertaking a specialist role on behalf of a number of practices for the local community. There are mechanisms whereby that can happen. However, I agree with Angus Cameron that we need to maintain generalist skills in general practice. Those skills are at the core of primary care in the United Kingdom. It would be remiss of us to lose that. In saying that, I declare an interest: I am a GP.

The Convener: I accept your argument about the need to retain generalist skills. How do patients know that their practice has specialist knowledge? I return to the question that I put on

accreditation. How do people find the doctor or practice to consult for that specialism?

Dr Elliot: The general practitioner remains the focus: they refer their patient to the practitioner with the specialist interest. That is how the examples in Fife work. Practices often include the specialist interests of their clinicians in their practice leaflets, which are available for patients.

The Convener: I was just trying to work the issue back from the patient's point of view.

Dr Simpson: We did not learn enough from the model that Sir John Brotherston introduced in Livingston. For the benefit of other committee members, I should explain that, under Sir John's model, GPs' special interests were combined into practices, with 10 GPs to a practice. Because Livingston was a new town, health care for its people was developed from scratch. Each GP also worked in the hospital for five sessions a week, but retained their general practice interest. We did not learn enough from that experience, partly because Livingston hospital was not created until well after Sir John had left the scene. The point about cross-referral across practices is important.

I have a final point. Another problem for patients of large GP practices is lack of continuity of care. As part of the move towards specialism, should the GP contract be revised to take account of the shift? That would hold out the prospect of patients having a personal doctor rather than having to see one or another partner.

The Convener: Perhaps you do not want to tread there.

Dr Cameron: I will try to answer. The question is difficult. Often, patients select a GP partner for good reason. For example, female patients will select a female GP partner to attend for maternity and gynaecological conditions. They may also take their children to another partner in the practice because that GP is known to be good with children. What is important is ensuring that the practice has the capacity to deal with its patients. In that way, patients have a reasonable chance of seeing the doctor they prefer to see within a reasonable time span. When there is real pressure on a practice and there is not sufficient capacity, patients tend to be given the choice of seeing doctor X or waiting two weeks to see their favourite doctor, doctor Y.

The Convener: Mary Scanlon, would you like to ask your surprise question?

Mary Scanlon (Highlands and Islands) (Con): You will be pleased to learn that I have found that the evidence that we have heard this morning has answered most of my questions. It has been very interesting.

I want to ask about the point in the paper from Dumfries and Galloway NHS Board about improved access to diagnostic testing, which referred to the computed tomography scanner in Stranraer. I thought that access to diagnostic testing would go hand-in-hand with telemedicine. Is that the driver for telemedicine? Is telemedicine costly? In the shift to primary care, is enough being done in relation to telemedicine? In the Highlands, that is an on-going issue and it seems that there is a lot more that can be done.

On what could or should be done in primary care, many of you have mentioned diabetes this morning. An American intern who was working with me for a while did a lot of research on obesity and what local health authorities are doing in that regard. Is there any preventive work that should be being done—with children, for example—on obesity? Are we doing enough on obesity?

The Convener: We will deal with the question about telemedicine before we deal with the supplementary question about obesity, which was absolutely unconnected to the first—not that that matters. I think, strangely enough, that telemedicine is your area, Dr Swainson.

Dr Swainson: We used to think of telemedicine and telehealth as a matter for remote islands, then we managed to bring it into the Highlands, so it became a matter also for slightly more remote areas of the mainland, but I think that all the huge gains have been in the urban areas of Scotland.

We have not really exploited the power of telemedicine yet. It is always presented as a solution to problems relating to people's inability to travel to get medical attention, but it is much more than that and, in any case, travel issues affect people in urban and semi-urban areas just as much as they affect people in the Highlands, although the problems are less obvious. Sometimes, the issue is to do with people being poor.

I chair the Scottish Centre for Telehealth steering group, which is why I am particularly interested in and committed to the subject. We are beginning to get crucial evaluations of the clinical effectiveness and cost effectiveness of some of the projects that have been running for a couple of years. When set against the costs of having health professionals travelling around their patch, I think that the service is likely to be shown to be cost effective.

Telemedicine makes a huge difference to whether you can create and sustain a local service as opposed to a centralised service in a local patch or country, but compared with places such as Canada, New Zealand, parts of Australia and the African continent, we have not yet exploited

the full power of telehealth. Scotland could and should be a world-leading place for it.

Dr Elliot: I chair the national picture archiving and communications system—PACS—programme board for NHS Scotland. We are making good progress on rolling out the ability to take images and have them read anywhere in Scotland. Locally, we are looking at ways of enabling our practice nursing staff to refer patients for straightforward diagnostic tests, such as plain films and ultrasound. Until now, only general practitioners have been able to do that. We are discussing and negotiating with our radiology department to ensure that we can use the facilities in our community hospitals as well as our two district general hospitals to enable practice nursing staff to refer for particular conditions.

That is where community teams come into their own: if we have an agreement about which health care professionals can refer people, and local access to the diagnostic facilities is backed up by the telehealth links—whether that involves images, video links or e-mail and telephone communication—we will have the building blocks that will enable us to exploit telemedicine in Scotland. However, as Charles Swainson said, we are only scratching the surface at the moment.

10:45

Dr Cameron: I agree with what has been said about telemedicine: we are probably only a small way along the journey of developing all the potential. We are doing a lot of medicine by e-mail. A GP will often have a problem to which he does not know the answer, but he does not have to send the patient to see a consultant; he can send the consultant an e-mail, which will be dealt with at some stage in the next 24 to 48 hours. That provides an excellent service for the patient and it cuts down work for everyone concerned.

We have done a little experimentation with telemedicine in dermatology. Some people would think, "This is ideal. We can take a digital picture, send it down the wires and get a diagnosis and advice," but that approach is a bit challenging for the dermatologist, who is used to being able to see conditions in three dimensions. Such work has certainly had some benefit, but we have a long way to go to develop everything that we can do in telemedicine.

The Convener: I do not know whether members would like a briefing note on exactly what telemedicine is. I have heard you describe lots of things as telemedicine. I appreciate that e-mails are a different matter entirely. Are we talking about communication with the surgery or the local hospital?

Dr Swainson: Telemedicine is as broad as your imagination wants it to be.

The Convener: Oh jings, that is broad. We will leave that subject and move on.

Ian McKee: I have a supplementary point to raise. Dr Swainson might remember that we had a successful telemedicine scheme in the Sighthill and Wester Hailes health centres for maternity services between 25 and 30 years ago. There were reasons why it failed, which I will not go into, but it showed that we could improve maternity care for people in deprived areas by using specialist services quickly through telemedicine. The tragedy is that we are still talking about the potential of telemedicine almost 30 years after we started using it successfully in an urban area.

The Convener: We will leave this subject now, but we might want to find out more about it. Some of us who have not worked in the medical profession would like to know exactly what telemedicine is. I am always grateful to members of the committee who have worked in the profession for giving useful supplementary evidence.

I invite the witnesses to answer Mary Scanlon's question on obesity.

Dr Elliot: We have the drivers and the opportunities to tackle the obesity problem, but obesity is not just a health matter; it needs to be tackled not only by the health service but by local authorities, education departments, the voluntary sector and communities themselves. It is a broad-based issue. We have to consider diet and education and encourage participation in activities in the community and at school from an early age. The health service has a key role to play in secondary prevention, if you like, by providing advice and support to people who have a problem that they want to tackle or who have developed an illness as a result of obesity. The health service cannot tackle the problem on its own; we all have to work together on it.

Dr Cameron: I agree entirely. As you know, GPs are commissioned to provide enhanced services. Recently, a series of proposals were made, which health boards could pick and choose. One of the proposals was on treatment of childhood obesity. It was interesting to carry out research: the best results seem to have come from a scheme in Leicester that involved local exercise groups run by people who were not health professionals, but good role models. It was suggested that having an elderly doctor advise an adolescent or young person to lose weight was not really going to cut the mustard and that having a role model and getting people together in groups produced much more success. We have to be imaginative. I do not think that having health

professionals encourage people to lose weight is particularly appropriate.

The Convener: Some of us around the table are feeling a bit uncomfortable about who should give advice to whom about losing weight.

Dr Swainson: The problem is that by the time people present to the health service for treatment of obesity, it is too late. A much more wide-ranging programme is needed to tackle obesity. People in the health sector clearly have a part to play in that programme in devising strategies, policies and work to prevent people from becoming overweight.

The Convener: That is a point. We have been aware of cross-cutting work in various portfolios.

I invite Michael Matheson and Ian McKee to ask questions. With the committee's leave, they will conclude today's questions—unless a hot supplementary bubbles to the surface.

Michael Matheson (Falkirk West) (SNP): Good morning. I am sorry I was late; I got caught up in an accident on the motorway.

Ian McKee referred to the telemedicine experiment in Sighthill some 25 years ago and Richard Simpson commented on the programme in Livingston many years ago. When I was listening to what they were saying, I was struck by the fact that a range of attempts has been made over a considerable time to get a modal shift from secondary care to primary care. What is different now that suggests that we will be more successful in creating such a shift under the current arrangements than we have been over the past 10, 15 or 20 years?

Dr Elliot: A number of things are now in place that perhaps we did not have as uniformly in times past. We certainly have local leadership with community health partnerships. In particular, clinical leadership with management support is extremely important, and a product champion is an extremely useful individual in the context of shifts in care.

The point was made in the discussion on vertical integration that we have local managed clinical networks or managed care networks for many chronic conditions. In Fife, coronary heart disease, stroke and diabetes groups come together from the primary and secondary care sectors. Patients, the public and the voluntary sector are involved. Where there is such an aggregation of interested individuals, significant changes can be made, because ideas come from them. They then need management support and other support to put their ideas into action. We now have the structure and mechanisms in place to make changes, although, of course, we need to encourage and nurture clinical leadership and other leadership to take work forward. Boards and community health partnerships are important in trying to foster such encouragement and clinical leadership. Those are some of the things that will help us.

Angus Cameron referred to the GP contract and enhanced services. That is potentially another mechanism that will, with the quality and outcomes framework—which sets standards for the level of care for a number of chronic conditions and other practice-related issues in general practice—enable us to make significant changes. We now have levers for making changes that we must use to our advantage.

Dr Cameron: In summary, Michael Matheson's question is: what is different now that will help us to shift the balance of care? Capacity has changed. Over the years, we have invested much more in primary care and in much better premises. A range of individuals in primary care teams have a range of skills, and GPs nowadays go through extensive training to become generalists after which they take on other roles. Therefore, we have better capacity.

We recognise that the need is different. Care for chronic illnesses should be delivered in a structured and proactive way; it should not be episodic. The table in "Better Health, Better Care" is good at describing in just a few words the shift in the type of care that we should provide.

Treatment has also changed enormously. In previous years, it was difficult to have as many drugs to treat diabetes or hypertension, and that made treatments much more limited. There is now a vast range of options for a range of chronic illnesses that GPs are well placed to manage.

In short, there is more capacity and more recognition of what we should do and what the need is, and we now have the armamentarium to deal with much more in primary care.

Dr Swainson: This debate has gone on for the nearly 60 years in which the NHS has been in existence. Some of the tensions stem from the creation of the NHS. We took a managed service that included only hospitals and associated services and created an independent practitioner branch that looked after people in primary care. That is the tension that we must overcome.

For several reasons, we are better placed in Scotland than is the rest of the United Kingdom—certainly England—to push the process further and harder. We have NHS boards that are accountable to the Scottish Government and that are responsible for the totality of the services that they provide—primary care as well as hospital-based care. Clear responsibility for boards to work closely with local authorities is embedded in the description of community health partnerships. Those partnerships are now up and running as

vehicles for joining up services between local authorities, health boards and the voluntary sector.

What else can we push? The work on the proposed outcome agreements between health boards and local authorities will help to cement in both groups of organisations clear accountability for delivering improved services. However, accountability remains an issue. How are local authorities and health boards held accountable for the parts that they play in the delivery of services? There is a clear mechanism for health boards, through the accountability review process.

The analysis of costs shows that most services that are delivered in the community and primary care either cost the same as or are cheaper than hospital-based services. The winner for me is that, whenever patient and carer satisfaction is examined carefully in comparisons, people always prefer community-delivered services. The public and users of services are well behind us; we should use that support as a lever and driver for change.

Michael Matheson: Your answers are helpful, but I am still trying to establish how much care that continues to be provided at secondary level could be provided at primary care level. You have mentioned a number of examples of what you are now doing at primary care level. Are you able to quantify how much secondary care you are providing in the health board areas that you represent that could be provided at primary care level?

Dr Swainson: It is a moving feast. We cannot provide a precise number or say that so many thousand people can be looked after in the community in the next few years. Everything depends on the kind of change—in general practice, community capability and capacity, and technology—that my colleagues have described. New drugs and, sometimes, new diseases can drive change—just look at how HIV has changed the landscape.

We can learn lessons from what has happened already. Personal care services pilots in Scotland demonstrated that significant shifts could be made in practices that took up contracts. With relatively small amounts of money, those practices were able to develop significant capacity and capability. One practice in Edinburgh, which has published its results, was able to reduce the number of emergency referrals to hospital by about 40 per cent and the number of referrals for consultant opinions on patients by a little more than that. The reduction was not confined to particular areas—it was across the range of medicine. It took the practice five years to learn how to do that, but that is the lesson. We know what results an enthusiastic practice that is large enough and interested enough to do that work can get.

The issue is a strategic one for health boards, which need to decide what targets to set for shifting the balance of care and how to express those in numerical terms—and to find ways of meeting them. In our submission we gave the narrow, measurable example of emergency medical admissions to hospital. Given that we know that preventive work can be done, why do we not set an ambitious target for four or five years' time and work towards achieving it? The policy has remarkable buy-in from people. Those who work in community health partnerships—clinicians and managers—would be delighted to have something to get their teeth into and to have the opportunity to think about what they need to put in place to meet the target.

11:00

Dr Cameron: A good example is the investment in community mental health teams in our area, which we began two years ago and which has changed our hospital radically. We were at 100 per cent occupancy for far too much of the time and, unfortunately, treatment was compromised by the fact that there were too many patients there. Since the investment in primary care, two things have happened: the number of admissions has gone down sharply, and the average length of stay has gone down. Because of a less stretched and tense atmosphere in the ward, patients get better sooner and can go home to be supported by the community mental health teams.

We have also developed chronic obstructive airways disease teams in the community. It took a leap of faith to invest in them but, in just under a year, they have reduced the average length of stay by people with chronic bronchitis from seven days to four days and reduced the number of admissions so much that we plan to close four beds in the acute medical wards. Those are one-off examples and they might be specific to our area, but they demonstrate that if we have the faith to put money into community services, we can reduce pressure on acute services.

The other area that must be carefully examined is follow-up. Following the introduction of the consultant contract, a lot of work has been done to decide how often consultant review is required. Many consultants are aware of and work on their new-to-return ratio, but we could do a lot more, for example, after ear, nose and throat, ophthalmology and orthopaedic surgery. I find it difficult to understand the need for a patient to return to hospital. If they do not do so, that might take away some professional satisfaction for the surgeon concerned, but the patient can easily be reviewed by their GP or primary care team. If there are problems, they can be referred back to hospital; otherwise, they can save a journey and a

lot of time—and that can save precious out-patient appointments.

The Convener: Do you wish to add anything, Dr Elliot?

Dr Elliot: I have nothing to add to what my colleagues have said.

The Convener: That is fine. Let us try to make the next question the last one.

Ian McKee: This should not take you too long to answer. I am interested in your views on the health and fitness of community health partnerships. We have heard a lot about how they can play an important part in the shift from secondary care to primary care. We heard in earlier evidence that, in some areas at least, a lot of GPs have walked away—they were involved in local health care co-operatives but the concept of a much larger community health partnership does not seem so intimate, so they have lost touch. I know that community health partnerships are responsible to councils and health boards. Being the director of an organisation that is responsible to the health board and the council sounds a bit frightening.

You mention two forms of community health partnership in your evidence, Dr Swainson: the West Lothian model and the model in Edinburgh. Are you learning any lessons from them? Is one better than the other, or are they just different horses for different courses?

Dr Swainson: I will take the last bit first. It is probably too early to say whether one model is better than the other. Quite a lot depends on the people and personalities involved and on what they are wanting to drive. We are fortunate to have excellent people in Edinburgh and West Lothian, but they are pursuing slightly different agendas to suit their local populations. Both models are working successfully, but it is too early to tell whether one is better than the other.

One of the key elements in both those models, and in developments in the health of CHPs more generally, is the strength of engagement with the council and the willingness that is being shown. I mentioned the risks that people are prepared to take. The most successful models—at least those that have been written up—seem to be those where organisations have agreed to pool their resources in some sensible way and to manage their services in a single group, so that the public and the users of those services do not see the difference, while an account is made back to both organisations for the outcomes that have been achieved. That is quite hard to do when there are two completely different systems with different accountabilities.

The relationship between CHPs and GPs is a moveable feast. In a large CHP, it is quite understandable that most GPs or practices do not see themselves as engaging with an organisation of that size. When the work is at the community planning level, GPs are much more engaged and want to take part in wider discussions about the health and well-being of the community in which they work.

Dr Elliot: One of the challenges is to get the clinical leaders to engage with GP practices, which often complain that they do not want interminable management meetings to discuss policy and strategy. They are men and women of action and they want to get on with things.

The Convener: Two of our men of action are happy with that; they are nodding.

Dr Elliot: One trick is to have a local group where the clinicians—I mean that in the broadest sense—from across the professions take the lead on setting out to do something. That is where we have started to realise that we have to have communities of interest within the CHPs to take on specific elements of work. The Fife model is that, across health boards and the council, there are two local management units to each community health partnership. We have started to engage the clinicians more in cross-system working, but we also have a clinical interest group that is starting to look at some of our targets for long-term conditions and anticipatory care. It is starting to be a driver for change. If the clinicians feel a sense of ownership, they will make things happen and change.

Dr Cameron: We have a different structure. We have a population of 150,000, so our CHP covers the whole area, but we break that down into local health partnerships that try to combine health and social work, which works quite well, particularly when the teams are co-located. That makes a fabulous difference and it is so important.

I agree with Frances Elliot that clinical leadership is crucial. Some years ago, one of the benefits—and one of the problems—of general practice was that it was completely autonomous and there was an enormous variation in the standard and amount of care that was given. Practices group together much more these days. That has led to a loss of autonomy. GPs might not be directly accountable to a health board, but they are accountable to their peers. Once GPs look at what the others are doing in, for example, prescribing, accountability can be improved in an important way.

That is a rather oblique answer to your question, but there are advantages to working in CHPs, although it relies on clinical leadership. Frances Elliot is absolutely right to say that GPs tend to be

action-oriented. If they do not feel that something is happening, they very quickly lose interest.

The Convener: I have to say for myself, and I am sure for the rest of the committee, that this has been an interesting and informative session. We were wondering where we were going with the inquiry, but you have brought real focus to the issue. Thank you very much for your evidence.

Do members want the clerks to prepare an approach paper that we can discuss? It does not have to tie us down in any way.

Michael Matheson: Yes; in the new year.

The Convener: I take it that members are content with that.

Rhoda Grant: Could we also ask Sandra Laurenson of NHS Shetland to send us her comments on the meeting? She will see the *Official Report*.

The Convener: Indeed. She is stuck in Shetland because of the fog. The Health and Sport Committee gives the weather as well.

11:09

Meeting suspended until 11:22 and thereafter continued in private until 12:48.

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