The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

# HEALTH AND SPORT COMMITTEE

Tuesday 15 March 2016

Session 4

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## HEALTH AND SPORT COMMITTEE

### 14th Meeting 2016, Session 4

**CONVENER**

*Duncan McNeil (Greenock and Inverclyde) (Lab)

**DEPUTY CONVENER**

Bob Doris (Glasgow) (SNP)

**COMMITTEE MEMBERS**

*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
Dennis Robertson (Aberdeenshire West) (SNP)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Dr Catherine Calderwood (Scottish Government)
Dr Angus Cameron (Scottish Government)
Dr Graham Kramer (Scottish Government)
Professor Craig White (Scottish Government)

**CLERK TO THE COMMITTEE**

Jane Williams

**LOCATION**

The James Clerk Maxwell Room (CR4)

# Scottish Parliament

## Health and Sport Committee

*Tuesday 15 March 2016*

*[The Convener opened the meeting at 09:45]*

## Chief Medical Officer's Annual Report 2014-15

**The Convener (Duncan McNeil):** Good morning and welcome to the 14th meeting in 2016—indeed, to the last meeting in this session—of the Health and Sport Committee. As I normally do at this point, I ask everyone to switch off their mobile phones because they can interfere with the sound system and the proceedings. You will note that members and others are using tablet devices instead of hard copies of the papers.

We have apologies from Bob Doris and Dennis Robertson, who for understandable reasons cannot be with us.

Nanette Milne has just entered. Hi, Nanette. Are you okay?

**Nanette Milne (North East Scotland) (Con):** Yes. My train was 50 minutes late, so I apologise.

**The Convener:** It is great to have the chief medical officer along. If members will indulge me, however, I want first to take the opportunity in the last meeting of the session to thank, in his absence, Bob Doris, who has been my deputy convener throughout the session. Many colleagues have made my job easier over the past five years. I think that those of us who have been members of the committee for that length of time will all agree that the committee has been very hard working and that the job has been very interesting. We hope that we have made some changes.

We can take credit for our level of engagement, which we are very proud of and which will feature in our annual report. The chair of PNH Scotland, Lesley Loeliger, has said:

> "I'd like to thank you and the committee for the work carried out on our petition. The willingness to understand such a complex subject and determination to continue until a better system was in place was extraordinary.
>
> As chair of a tiny charity, with no background in political matters, I was extremely nervous each time I was called to give evidence and I was, however, treated with such kindness and courtesy that the whole process proved extremely rewarding.
>
> The Health and Sport Committee has, through its handling of our petition, shown the best of politics and demonstrated how government can and should work."

We all take credit from that.

**Nanette Milne:** I do not know whether any other member was, but I was on a previous health committee with Duncan McNeil, when the smoking ban went through. You were very kind to me on that committee, as I struggled as a new member on my own. Likewise, as convener of this committee, you have been very good and very helpful. I thank you for that, in a personal capacity.

**The Convener:** Thank you very much, Nanette—that was nice of you.

We need to press on. Our first item of business is evidence from the new chief medical officer for Scotland on her first annual report. On behalf of the committee, I welcome Dr Catherine Calderwood, who is the chief medical officer for Scotland; Professor Craig White, who is divisional clinical lead in the directorate for healthcare quality and strategy in the Scottish Government; Dr Graham Kramer, who is national clinical lead for self-management and health literacy in the Scottish Government; and Dr Angus Cameron, who is the medical director of NHS Dumfries and Galloway. I thank you all very much for giving of your time to be with us.

I invite the chief medical officer to put some comments on the record, after which we will go to questions.

**Dr Catherine Calderwood (Scottish Government):** Thank you very much, convener. I am delighted to be here to talk about my first annual report. I believe that this is the first time that the chief medical officer's annual report has been taken as an item of business in the Health and Sport Committee. There are several firsts.

My report, which is entitled "Realistic Medicine", contains, as is traditional, the state of the health of the nation in the statistics in its second part.

In the first part of the report, I wanted to write to doctors throughout Scotland, reflecting what I had been hearing from them as I travelled around the country in my first few months as chief medical officer. I heard about the pressures in the national health service and about doctors' desire to keep caring for their patients, as they always have done, but their finding that that is difficult, at times. I also heard that some doctors are disillusioned or unhappy in their jobs and that morale is low. I heard from them that they are worried about advances in medicine and about whether people are having treatments and procedures that are perhaps not what they would choose in the same circumstances. There is quite a lot of evidence in the literature of where doctors would choose less treatment and fewer tests and procedures than they offer their patients, and that there is perhaps a disconnect between what they feel the people they are treating prioritise and what they would prioritise. I wanted to talk to them about that.

I also wanted to reflect personalised care—patient-centred and patient-focused care. My children asked me: "What is an out-patient, mummy?" and I described that as a patient who is not in the hospital. My 12-year-old daughter said, "Isn't that a person, then?" We are moving from the person as patient to the person who is in need of treatment in the NHS as part of their much wider lives, and who will live the rest of their lives with no other concerns to do with the NHS.

We have started a conversation, which has been extremely well received. I have had letters and emails and there has been Twitter activity all over the world. In a single week, "Realistic Medicine" was retweeted and reached 133,000 people. I have had nothing but positive responses on Twitter. People have said that it is a conversation that they welcome—not just doctors, but nurses, pharmacists and members of the public.

I will finish my opening remarks by quoting a general practitioner in Aberdeenshire:

> "Your document is probably the first CMO annual report that I have ever actually read. I was really impressed that it appears to challenge the status quo. It chimes with my feeling that we should be moving to finally confront what I see as the elephant in the room: the adverse effect of our own actions on demands that fall upon the NHS that we so often blame on patients."

Many similar comments and personal stories have been shared with me because we have started the conversation.

I am very pleased to be here, and to hear the committee's questions, which I hope to answer.

**The Convener:** Thank you. Our first question is from Malcolm Chisholm.

**Malcolm Chisholm (Edinburgh Northern and Leith) (Lab):** I think that we are going to deal with the report in its two parts, so I will ask about obesity later. You have introduced the first part of the report, and you have mentioned all the people by whom the report has been positively received. I want to tease out the detail.

On one hand, some of it is not very controversial—for example, you describe people with multiple conditions, people for whom the guidelines are just being followed and people perhaps being overmedicated. On the other hand, one paragraph of the report, which I will read a bit of in a moment, has made me wonder whether you are going a lot further than that and perhaps getting into more controversial territory. The couple of sentences that I have in mind are on page 14:

> "While the reduction in heart disease rates can be attributed to the use of primary prevention with statins, and better control of hypertension and diabetes, trends show that the fall in heart disease rates pre-dated widespread use of these treatments, and has continued at the same rate as before. One explanation may be that the majority of the decrease has come about from the improvement of lifestyles and environment."

Some people who read that might think that you are going further than they are comfortable with, because one interpretation of that would be to doubt whether statins and medication for blood pressure have had a major effect. People might even then draw the conclusion that you are questioning their effect. Perhaps you do not have that in mind. I found that section very interesting. Of course, it relates to the general issue of managing risk and the extent to which you do that.

**Dr Calderwood:** The point has been raised by others; you are not alone in thinking that the report may be taking a controversial line on that issue.

Dr Cameron, who is a former GP, will talk in a moment specifically about the figures on statins.

We have evidence of overprescription across Scotland: for example, 30 to 40 per cent of antibiotics are prescribed for self-limiting respiratory illnesses—that is, illnesses that would get better if we did nothing. I do not need to tell this committee about the harms of overprescription of antibiotics.

We also have evidence of variation in prescription patterns across Scotland. If we look at prescribing across GP practices we can see the same drug being prescribed very variably in ways that cannot be explained by variations in the demography of the population.

There is certainly good evidence of overprescription and overtreatment. We then come to where risk lies for individuals. Angus Cameron will give an example of the risks of statins, as Malcolm Chisholm has brought up statins specifically.

**Dr Angus Cameron (Scottish Government):** It is important to recognise that the graph shows a steady decline from the 1950s in the rate of heart disease in the population. The important thing is to distinguish between the onset of heart disease—having a heart attack—and death. The rate of death from heart attack has come down steadily; there is no doubt about that. That improvement looks as though it coincides with the use of statins. The conclusion to be drawn is that, if you have a heart attack or a stroke or peripheral vascular disease, you would be very well advised to take a statin.

On primary prevention—giving a medicine before an illness, when the person is totally asymptomatic—it is more difficult to be certain about which individual patient will benefit. The big groundbreaking trial—the west of Scotland coronary prevention study—showed that giving statins to people who do not have heart disease reduces the incidence of heart attack, but it requires almost 400 people to be on the medication for a year for one heart attack to be avoided. Because statins are basically safe and are now very affordable, a strong case can be made for saying that people who are at risk should take them. However, it is important that patients understand—I do not think that they do—that you may require to take a medicine that may give you no benefit because you are not at risk anyway and that reducing smoking and taking more exercise will still have a bigger impact on your level of risk. The important thing is that patients understand the limitations of statins.

**Malcolm Chisholm:** Statins are a grey area; I presume that medication for high blood pressure is not, although it is referred to in that same paragraph.

**Dr Calderwood:** Again, other interventions are very effective in reducing blood pressure—for example, weight loss, stopping smoking and taking more exercise. The blood pressure tablet might work for a person, but the question is whether that is the right treatment for that individual. Might there be other effective interventions? That comes back to personalised care and discussion about medication and the possible side effects of any treatment with the individual, bearing in mind their individual level of risk, which will be different from that of the next person in the waiting room.

**Malcolm Chisholm:** I have a final question, convener.

Although the first part of your report is addressed to doctors, obviously your narrative is about talking to patients about what they want. Scenarios can be imagined in which the medical profession takes those points about the possibility of overtreatment on board but patients demand things that you do not think are strictly necessary or are only marginally beneficial. How is that potential conflict resolved?

**Dr Calderwood:** I will bring in Dr Kramer in a moment. That is a question that I have asked myself. I had to start somewhere with the report; the doctors were the obvious place because I am the chief medical officer. We are very keen to engage with patients—with people. The Health and Social Care Alliance Scotland is going to do some work with us on that. You are absolutely right that that needs to be done in parallel with the work with doctors.

10:00

**Dr Graham Kramer (Scottish Government):** In my other job, I am a GP in Tayside. Malcolm Chisholm has asked a very good question about a real issue. There is a worry that patients may opt for more complex and expensive treatment than doctors would recommend, and that they have higher expectations of their treatment. That can happen, but I think that most of the evidence suggests that when doctors discuss things with people and share all their concerns, patients often opt for the less invasive and less expensive treatment. That happens when they really appreciate the risks, and when treatments can be aligned to their particular preferences and to what matters to them. The evidence suggests that the trend is going the other way and that we will not see so much overtreatment.

**The Convener:** Moving beyond statins and on to the effects of other interventions, I suppose that that is where the GP's confidence to recommend a befriending group rather than antidepressants and so on comes in. The GP may not have confidence in or knowledge about community capacity to offer that type of realistic alternatives. We have long said on this committee that sometimes people do not need a doctor, but just need the type of support that a good friend can offer, but that type of facility is already thin on the ground and we are cutting the budgets for them. Do you hope that your debate will encourage some of that as an alternative to pills?

**Dr Calderwood:** The walking groups that have been set up are a good example. They are run by charities that want to come in and offer such alternatives, which are about friendship as well as being about the benefits of physical activity. World Walking, for example, started as rehabilitation for people who had had heart attacks, and it expanded from there. What I hear when I am giving talks around the country is that those groups are frustrated because they feel that they are not known about. At the moment there is a disconnect, with GPs wanting to do something different, when perhaps the something different is not in the same area or they do not know about each other.

I hope to facilitate much better links so that GPs know what is available in their area and that charities are willing and able to help. We need to evaluate such alternatives because we want GPs to provide them much more systematically. It would not be right for the charities alone to have to provide such interventions if they are doing a lot of good.

**Dr Cameron:** It is very difficult to build up capacity in communities to provide alternatives to the biomedical approach. Kaiser Permanente, the American healthcare group, describes the situation very well; we too often respond to what are primarily social problems with a medical model. I will explain that. For example, for an elderly person who has difficulty with mobility and perhaps suffers from breathlessness, visual impairment and hearing loss, the consequence of the several long-term conditions that they have accumulated is social isolation, which makes their experience of illness far worse. There comes a stage at which, although medicine might be helpful, the thing that will really make a difference to their life is relief from social isolation—helping them to get out and engage in the community.

My concern about the clinical strategy is that we use too much resource on medicine at the expense of addressing patients' real needs, which might be more social and psychological. The other problem is that, if we use more medicines in older people, we undoubtedly cause more harm—we cause falls, confusion and so on. It is really important to do what has been achieved in Scotland, which is integration of health and social care, and to rebalance for many people the emphasis in provision of medical and social care.

**The Convener:** I understand the point, but integration of health and social care is a structural thing. We are dealing with a cultural thing—patient demand, the need to do something and the pressure on GPs, who respond to that. A GP might have no confidence or even knowledge that there are alternatives out there, but he has to meet that demand and need. How do we break that cycle of patient demand and GPs responding to it?

**Dr Kramer:** I will give a quick response. You are right that there is patient expectation, and GPs are working in a time-famine situation and having to come up with pragmatic medical solutions. Their not having knowledge and understanding of what is available in the community and not having the necessary relationships will encourage them to prescribe medicine rather than to prescribe more than medicine. As a GP, I find it challenging to prescribe things other than tablets. That is why things such as the link worker programme in the deep-end practices in Glasgow are really useful. Under that programme, a trained worker can find out what is available in the community, make the connections between the community resources and the general practice and make personal connections for individual patients. We do not necessarily have to rely purely on GPs; we can use the available skills mixes to increase social prescribing.

**Mike MacKenzie (Highlands and Islands) (SNP):** Good morning, Dr Calderwood. I hope to explore a similar issue, but with a more rural focus, because I represent the Highlands and Islands.

When I recently spoke to some GPs, they made the same point about overtreatment and overinvestigation, but with a slightly different emphasis. Over time, the committee has heard of a trend of health boards under financial and resource pressures moving towards a lot of care, clinical decisions and diagnosis being carried out by health professionals who are further down the salary scale than GPs. We all understand why there is a pressure to operate on that basis, but the GPs to whom I spoke made the point that certain amounts of training and experience are required and that, really, only GPs can decide with confidence not to treat. They were worried that, far from costs reducing, cost pressures would be larger, with people slavishly following protocols and so on. What are your thoughts on that?

**Dr Calderwood:** There is a lot of evidence that more junior doctors do more investigation and treatment than more senior doctors, which absolutely comes back to your point that the experience of more senior doctors allows them to recognise that they do not need to take every single blood test or do every single scan or X-ray. GPs often have the advantage of knowing someone over time and knowing their family and social situation.

Equally, I hear frustrations from GPs about people being sent to accident and emergency departments, investigated up, down and sideways and then admitted when the GP has a different view on how they should have been handled. Much less investigation might also be better for the patient. That has to be part of a conversation, and we in the medical profession have to recognise some of those issues. Before I started working on the report, I heard the same stories, and they are part of what incentivised me to write the report and start this conversation.

I do not have the solutions yet, but we need to start putting those issues out into the open and discussing them. I will be visiting the deans of the five medical schools across Scotland with my report, and one of the thoughts behind that is the suggestion that we talk to the trainees—the medical students—before they become doctors about realistic medicine and the practice of medicine itself. That should be embedded in their training—and, indeed, in the way they start to think—right from the beginning.

**Mike MacKenzie:** That is useful, but I suppose that my point was not so much about junior doctors as about other health professions—for example, nurses doing work that previously would have been done by GPs but doing it with less certainty or in a more risk averse way, which would ultimately lead to higher costs. However, I am glad that you have identified those issues.

One of the big problems across the Highland and Islands is attracting rural GPs. That mystifies me, because I cannot think of a more rewarding and fulfilling career than being a GP, particularly in a rural area. To what extent are overmanagement and the trend towards employed GPs—or salaried GPs—eroding the sense of vocation that was part of the motivating force for people to stay in rural areas?

**Dr Calderwood:** Traditionally, we have seen people from rural areas, in all sorts of professions and occupations, move to the cities. Increasingly, though, we are beginning to recognise your point that this is a very positive and different way of practising medicine that offers a lot of different opportunities. That said, we recognise that we might need to train those doctors differently, rather than as generic GPs.

There are remote and rural training programmes, and in the last month or so, we had a recruitment drive. We are also talking to universities about students from remote and rural areas being allowed to do some of their placements at home or close to home so that they can learn about remote and rural practice. Indeed, the University of Glasgow already does that.

We have begun to recognise the need to do things differently so that we recruit and retain people in rural areas instead of having the traditional migration to cities. We also recognise that we need to train people in a different way to better reflect the needs of that population. After all, being a GP in inner-city Glasgow is completely different to being a GP where Mike MacKenzie is from. Until recently, our courses have not reflected that, but now that we have recognised that fact, we hope to make progress.

**Nanette Milne:** I found your report very exciting, because it links to the committee’s work on palliative care and Sir Lewis Ritchie’s work on out-of-hours care. Given the potential for very exciting developments in future, I feel quite sorry to be leaving the Parliament at this time.

When I graduated in medicine in 1965, the set-up was very paternalistic. I know that a number of my generation quite liked it that way, and I think that they might be dreading what lies ahead, so they will probably need some convincing that a new form of NHS is better than what they grew up with. A job of work needs to be done around that.

Your comments on prescribing and so on link with the committee’s work on cancer medicines. A big ethical question that needs to be thrashed out relates to the benefit that patients may derive from end-of-life drugs. Moreover, in relation to end-of-life care, Marie Curie always highlights the fact that we as a society simply do not speak about death, and I think that it is important that we address that.

My question kind of links into that. We know that drugs are heavily evaluated—and quite rightly so. After all, cost effectiveness has to be looked at. However, I—and, indeed, many others—have a worry that many other things in the NHS are just not scrutinised in the same way. Many procedures or systems that are in existence must have gone out of fashion, but new things just get tagged on to the old. That some people are still using those procedures or systems must be a significant cost to an NHS that is and will always be under financial pressure. I wondered about your thoughts on that. Is there a sensible way of evaluating other parts of the NHS?

10:15

**Dr Calderwood:** I am pleased that you brought that up, because I had considered including a chapter on value-based medicine. However, coming back to Mr Chisholm’s point about controversy, I decided that it was a little bit too controversial for my first annual report. Perhaps I will include it next year.

I entirely agree with you. We have the quality-adjusted life years measure, and we apply it rigorously to drugs, because they have a cost; someone has to pay for them. An example that Dr Milne will be familiar with relates to someone with head and neck cancer, who will have a five-hour operation and a further five-hour operation several days later and will then spend a prolonged period of time in intensive care. We do not evaluate the cost of that treatment or have a conversation about whether, on cost or on some other basis, it should be carried out. We do not come out at the end with a price tag.

I have deliberately chosen that example, because it actually has a significant price tag, and it often has a poor outcome; in other words, a low amount of additional quality of life is gained from it. It is almost inequitable to have the same conversations about drugs, just because they have a price ticket on them, and not have such conversations about other areas of practice. It almost disadvantages the people who need the drugs.

As you might know, before starting this job, I worked part time for a couple of years for Bruce Keogh in NHS England. Under the English commissioning system, the cost is carefully looked at. For example, a receiving trust will have a menu; if someone comes in for that head and neck procedure, the trust will predict, as far as it can, the length of stay in the intensive care unit. That comes with a price on it, and the referring trust will have to talk about that cost and where it will find the money to meet it. In England, my mindset was that that was the way that the system worked, and I think that many more doctors in England are aware of that than doctors in Scotland, simply because we do not have to be aware of it.

Sitting behind us is Christine Gregson, a junior doctor in Lothian who is also acting as clinical leadership fellow in my office for a year. She must take some credit for the report—she was my editor-in-chief—and I have asked her to look at this subject to see whether there is any appetite for looking at the value, down to cost, of some of those other procedures. I will also be speaking to some of the chief executives in NHS Scotland, as they, too, might be interested.

However, what we do with that information concerns me, because this is not about rationing. It is not about saying, "Your procedure's too expensive" or "You aren't someone we think that the money should be spent on." Maybe that is the danger zone that I did not want to stray into in my annual report. However, we could turn it the other way, because what I saw in England was that it drove quality of care. A trust would not be paid unless it provided a multidisciplinary team, specialist nursing and so on. Of course, it was all decided by GPs; the trusts that gave very good care got more business, and the ones where the GPs did not think that the care was as full, as specialist or as good were not sent any patients. You could turn it into a positive discussion, but it would be difficult to do.

**Professor Craig White (Scottish Government):** On the parallels that have been drawn with the committee's work on palliative and end-of-life care, it is no coincidence that you feel a resonance with some of the issues that have been considered. The title of your inquiry report, "We need to talk about palliative care", very much reflects the fact that, as we know, conversation and greater openness in that area can lead to different decisions, the delivery of higher-quality care and less costly and less invasive interventions. That is similar to the chief medical officer's commitment to having similar conversations in relation to other branches of medicine.

One of the Government's 10 commitments in the strategic framework for action on palliative and end-of-life care—which, as you know, is not just about prescribing; it is about multiple dimensions of care, which might be more difficult to evaluate—involves commissioning clinical and health economic evaluations as part of the framework, and we hope to be able to start to link the impact on quality and cost with more and more people having the opportunity to discuss what matters in the end-of-life period. Because we are linking that work, we will be able to link that with the conversations that come out of the realistic medicine work and develop our improvement plans for other conditions and parts of the system.

**Nanette Milne:** I was interested in Dr Calderwood's comments about commissioning in the NHS in England. The comparison here would be with GP fundholding, which, given that my husband was a GP fundholder, I have some experience of. As we know, that was not a politically acceptable arrangement in Scotland, and I do not think that it will come back in the near future. However, there are parallels, and I think that, in many instances, the system worked in patients' interests. I remember that one of the first things that my husband did at that time was to employ a firm of physiotherapists, so that people with bad backs were seen straightaway and could get back to work. Before that, there had been quite a long waiting time for physiotherapy, so the innovation was good for the patient and cost effective for the health service. I quite liked that approach, but I am not in a political majority in this country.

**The Convener:** We wish you well with this and the committee understands what you are saying, because we have touched on that value base in a number of pieces of work, including work on access to new drugs for rare diseases, assisted suicide and palliative and end-of-life care—we get all the fun stuff here. We agree that the language that you use in taking such work forward must be sensitive.

The committee never reached a view on that either, but I think that I speak for the committee when I say that we recognised that there was an issue about what was best for the patient and the question of informed choice. From some of the evidence that we took, we know that that is a difficult issue. Terminally ill patients felt that they were being sent home to die, and clinicians and doctors felt that they were treating people with chronic obstructive pulmonary disease completely differently from those with cancer, even though there was going to be a similar outcome. I am sure that the next health committee will want to consider some of those issues. After all, when new drugs and innovations are introduced, you sometimes wonder who they are for if the outcome is poor and the last days of someone's life turn out to be miserable. We focused on the question of how such discussions are had, but it is an extremely difficult issue.

**Rhoda Grant (Highlands and Islands) (Lab):** The report seems to focus on doctors. One of the quotes in the report is:

> "I want to start a conversation among doctors about changing healthcare."

It seems to me that the issue is not about doctors but about including other people, because doctors only have a prescription pad, and that seems to be a concern. Everyone who goes to the doctor tends to come out clutching a prescription to do something quick to change a problem that has probably been caused by a lifetime of bad lifestyle choices that cannot be changed in a 10-minute conversation. Therefore, the doctor hands over a prescription for a medication that might make a difference.

Surely we need to think about how we have the conversation about future healthcare with a much wider group of healthcare practitioners than doctors and, as was said, with the voluntary sector. We need to think about how we find the time to work with people to provide them with alternatives to medication. Otherwise, we are going to say to GPs, “You have 10 minutes. You tell them that they are bad or you give them a prescription.” Nobody is going to sit there for 10 minutes lecturing somebody knowing that it is not going to make the blindest bit of difference because what they are doing is habit.

How do we have the conversation much more widely than just with doctors? In a way, doctors should be the last resort, not the first, but they seem to be at the forefront of all medical treatment.

**Dr Calderwood:** My report as chief medical officer was to the doctors because I am regarded as the leader of that profession and I felt that, when I was starting out, I needed first to speak to the people whom I know—I am a doctor. However, I absolutely agree with you that it is about a multidisciplinary team; it is about a range of NHS professionals who provide care.

The report addressed to the doctors is a start for me as chief medical officer but it does not mean to exclude other groups. I have a meeting set up in St Andrew’s house with the chief nursing officer, the chief pharmaceutical officer and others to discuss realistic medicine as part of a multidisciplinary team, so we intend to take the wider conversation further. It is interesting that my responses have been from a wide range of practitioners. Therefore, I think that there is recognition that the report was not just about or for doctors.

We are moving towards recognising the benefit of other groups. It will take some time to realise our intention to practise care—particularly primary care—differently, involving other groups of people, because my GP colleagues tell me that patients want to come and see the doctor. They do not want to be palmed off with someone else, as they would sometimes consider it. Therefore, there is a need for education about the fact that the best person to see might not be the doctor. There are general practices, such as Dr Milne’s husband’s practice, that have a musculoskeletal specialist at the front door so that the GP does not even see the patient, because they are triaged before they get an appointment.

There are pharmacists working in general practices. You will know that we are setting up increased training for pharmacists. There are 140 pharmacists across general practices in Scotland. There are nearly 1,000 general practices in Scotland, so you will tell me that there are not enough pharmacists for anything like one in each practice but, again, it is a start. Those pharmacists see patients completely separately from the GPs. They come for medicine reconciliation with advice from the GP only as necessary.

There are two prongs to the approach. There is welcome upskilling of different professions to take on different aspects of people’s care, but there is also a need for a change in culture so that people do not think that they need to see the doctor each time. In fact, someone else may be better. Nurse specialists are particularly good examples. I have an antenatal clinic. I still see patients on a Friday, and we have an epilepsy specialist nurse who comes to see the women who are pregnant and have epilepsy. That nurse is by far the best person for them to see. I see the women from the obstetric point of view for risk counselling and so forth, but somebody whose whole life and training have been spent in epilepsy is the right person for them to see for conversations about their epilepsy and the drugs for that.

It is about sharing those conversations. Again, I am not proposing that this is a quick fix or an immediate solution, but we have a recognition that things need to change and that it is not always the doctor who is the right one to solve the problems.

10:30

**Professor White:** I want to extend that and engage with the part of Rhoda Grant’s question about people and the changing models of care. The our voice framework, which has been developed following work with the Scottish Government, the Convention of Scottish Local Authorities and third sector organisations, including the Health and Social Care Alliance Scotland, is going to look at different local infrastructure so that people can be involved in planning and commissioning new models of care and new services. It is looking at the way in which people are involved in discussions, how that might traditionally have been supported and how it might need to change in future. The our voice work and some of the learning from the national conversation on the future of health and social care, which the cabinet secretary has spoken about previously to the committee, are linked with the conversation with the professions.

**Rhoda Grant:** I know that this is an enormous question, but how do we change the NHS? We find new and innovative projects all over the place, but the structures of training and delivery are stuck. Mike MacKenzie talked about rural health. We know that that is exciting and interesting, but it is not rewarded and nor is it held in esteem. We hear similar things about GPs. The career structures and the esteem that certain professions are held in become a block to encouraging people into those professions and allowing them to learn.

Rural medicine is general medicine. I recently spoke to nurses in a rural hospital, who need to deal with everything from road accidents to paediatrics and heart issues. They have an enormous range of general knowledge, but they are not rewarded for that. If they were specialist nurses, they would have gone up the grades but, because they have that broad knowledge, they do not. I suspect that the same is the case with medics and the like. We do not look at what is required in different areas and how we are going to make the change. The same issue applies in deprived areas, which we will come on to when we discuss health inequalities. How do we make those careers attractive and get away from the old structures that almost blind us to the way things are, so that we can change the health service and make it fit for the future rather than one that is stuck in the past?

**Dr Calderwood:** You raise a good point. I spoke to Mr MacKenzie about the recognition that GP training for remote and rural practice needs to be different and special because of the broad range. I could certainly talk to Fiona McQueen, our chief nursing officer, about that when I meet her in St Andrew’s house. You are correct that remote and rural practice is not regarded as a specialism in its own right. It is just where people happen to work rather than being defined as an additional set of specialist skills. I can make that point about whether we need to recognise remote and rural practice as a specialism in nursing or other practice that requires different training and, if you like, to be treated as a specialist subject. I will take that away.

**Professor White:** The health workforce director is one of the people who have been involved in workforce planning and looking at the skill mix that will be required for the different models of care. As members might remember from the committee’s palliative care work, we are looking at an educational and workforce framework for health and social care, to reflect the fact that different skills and conditions might be required in future—for example, in relation to location and rurality—and so the future models of workforce planning and development will need to be different.

**The Convener:** I will pick up on Rhoda Grant’s theme. The national health service has a clinical system, a cabinet secretary and a chief medical officer. They talk about doctors and nurses. We look at the workforce and we measure success on the basis of how many doctors and nurses we have, not what they are doing. Are you satisfied at this point with the job description that is applied to your role as chief medical officer? Should it be broader? Should our perception of the national health service include social care and wellbeing? We have discussed those topics here. They are equally important as, if not sometimes more important than, some of the medical interventions. Over the piece, we are struggling as a committee. On the one hand, we have a gold standard health service; on the other hand, much of our social care and our wellbeing is delivered through an adversarial system. In some cases, those services are privatised or outsourced, the time for care is limited, and there is no concept of continuity or quality of care.

What has the chief medical officer to say about those issues? How do they affect the strategists such as Professor White? Being independent of Government, how do you feed that in? What influence do you have to affect the political landscape that might deliver change over time?

**Dr Calderwood:** You are starting to talk a different language now by entering into that territory. At the risk of bringing on more questions, I also worry about the preventative side. We concentrate on picking up the pieces and we have not invested in stopping the problems happening in the first place.

You mentioned care after hospital. Longer social care has not been valued, and we do not have a real emphasis on how important that is. We have not looked at how long people spend in care or seen that as being as important as the shiny hospitals with operating theatres and the expensive equipment and machines. As chief medical officer, I would absolutely say that some of that needs to be brought out into the open and into discussion.

Integration is a good start. We are no longer saying that one matter is a problem for hospitals and another is a problem for social care, and ne’er the twain shall meet. There is a them-and-us attitude with all the negative language about bedblocking and the burden of old age. I keep saying to people that old age is not a burden—people living longer is a success story. We are living longer, healthier lives because of the progress in medicine. The other aspect is that care of the elderly is not going to go away. You will see in my figures that more people are living longer with more comorbidities, so we must tackle the situation.

Starting a conversation would be the first step. With the budget changes, integration is going to force change, because acute and social care services must communicate with each other. Your point is very well made about—

**The Convener:** Some of those moves are based on evidence. Who is driving them? The holder of the title "chief medical officer" can apply private and public influence, but how can they drive the strategy? The matter is outwith your remit, is it not?

**Dr Calderwood:** Yes—absolutely.

**The Convener:** We have been talking for years about not having any separation in the patient journey. Who is driving this? There is not a cabinet secretary in the Cabinet driving that other side of the coin. How does it all fit into the strategies?

**Dr Cameron:** I do not think that the situation out there is quite as bleak as you suggest it is.

**The Convener:** I am not normally as bleak as this.

**Dr Cameron:** I think that the tensions between health and social care will be picked up by the integration joint boards and the structures underneath them, down to localities. They are placing a lot of weight on the integrated resource framework—that is another set of initials, I am afraid—and looking at where money is spent and value is obtained. Ultimately, I suspect that they will be faced with a decision about whether to go for more medicine or more care workers to provide support for our elderly. When they experience that tension, which they will do as budgets are integrated, and when they have information in an incredibly rich and detailed way, they will be able to start to make decisions to move resource and commitments to the most appropriate area.

That does not deal with your question about the chief medical officer's remit, convener. However, I think that the world is going to change—significantly, I hope—so that we strike a much-improved balance between health and social care.

**The Convener:** What I am suggesting—in a bleak way—is that there is clinical dominance of the debate; clinicians are the insiders here. If that continues to be the structure and the means of influencing policy, the situation will continue. The position is already unequal in relation to not just terms and conditions but how the work is recognised.

This committee is supportive of integration joint boards, but what is the game changer to ensure that, for example, a sports scientist can work with someone who has a weight problem or high blood pressure and achieve a better outcome than a general practitioner might get? There are many other innovations out there, but the battle is unequal.

**Dr Cameron:** I completely agree. "Realistic Medicine" tries to talk about exactly that—how we can be realistic about where medicine can add value. There are without doubt a lot of areas where medicine adds fabulous value. I am sure that we all agree on that. However, there might be times when we in medicine have overreached. What do I mean by that? If we treat people who are low threshold, we cannot get as much benefit because they are not very ill anyway, but the risk of intervention is usually exactly the same whether someone is mildly ill or extremely ill. If we look at trends in medicine over the past 20 years, we can see that the threshold for treatment has got lower and lower, which I think is taking us to a stage at which we are being unrealistic.

Let me give you an example. The management of chronic kidney disease has been guided by the output of an expert committee, and its analysis of when someone has chronic kidney disease means that the vast majority of people over 80 are labelled as having the condition. As soon as someone has a disease label, they need treatment—one follows the other—but we must accept that, when a person reaches 80, their kidneys slow down. We must ask whether we are being unrealistic in putting a lot of resource into treating what many doctors think is normal rather than a medical thing.

The whole thrust of "Realistic Medicine" is to say that, although medicine offers massive value—it has conquered a large number of diseases and will continue to do so—as doctors and suppliers of medicine we must be realistic and spread the message to the public that there are limits to what we can achieve.

**The Convener:** Professor White, do you want to comment on that?

10:45

**Professor White:** My point relates to the convener's point about balance in who is involved in commissioning and planning services and to Dr Cameron's point about integration joint boards. There is an opportunity, when the health and social care partnerships submit their plans for local communities, to make sure that not only the chief medical officer, the chief nursing officer and the national clinical director for quality—all of whom were involved with the clinical strategy—but also the chief social work adviser and other experts within Government look at those local plans and, as the convener says, challenge, provide scrutiny and ask whether the models of care are shifting to be of the sort that we are talking about. We have opportunities to make sure that there is not clinical dominance of the scrutiny and review of the plans that the partnerships submit.

**The Convener:** Does Malcolm Chisholm want to come in on the issues in the second part?

**Malcolm Chisholm:** I will go into the second part of the report, but first I have a final question on the first part.

What are the implications of what you are saying for the clinical guidelines? Scotland has been proud of the Scottish intercollegiate guidelines network guidelines for years. One interpretation of what you are saying is that you will have to rip them up, although it might be a bit extreme to put it in that way. You say that everybody agrees with you. Does that mean that the royal colleges are quite happy to rewrite their guidelines? Is there any resistance to what you are saying?

**Dr Calderwood:** The point that is being made about guidelines is that people with multiple conditions end up having each condition treated according to a different guideline. We do not join up the treatment of the person as well as we might do. It is not about ripping up the guidelines; it is about treating the person with multiple conditions as a whole person and not on the basis of one guideline saying one thing and another saying something else. We have to temper what we are doing for individuals.

The increased number of guidelines has made that an issue. Perhaps we have not stepped back to ask whether some of the guidelines, rather than acting in synergy with one other, are causing problems for people. A pharmacy colleague of mine sent a man for review because he was being prescribed 58 different tablets, with all the side effects that you can imagine. Of course, whether he was taking them all is another question.

We are not advocating ripping up the guidelines. We merely advocate using them in the context of the whole person rather than a disease.

**Malcolm Chisholm:** Moving on to part 2 of the report, I am interested in obesity, and the information that is provided on that is very alarming. For example, the report says:

> "almost two-thirds of adults ... in Scotland were overweight or obese".

It is not the function of your report to come up with detailed solutions to obesity, but it refers to the supporting healthy choices framework.

A lot of what is in the bullet points that summarise the framework is about promotion and education, but we do not seem to be getting anywhere very fast on the issue. The one item on the list that is directly to do with action on obesity is formulating

> "healthier products and menus across retail and out of home catering".

If I am to put just one specific question or make one suggestion, it is that, given the extension of free school meals, which was announced a few days ago, it seems to me that, whatever the controversy around that policy, it is a good opportunity to promote healthy eating. Is it time to revisit the guidelines on free school meals? I know that the parents of young children who eat school meals are not always overly impressed by the healthiness of what they are eating.

There is also the more general question of how we can really deal with obesity. I am thinking particularly of childhood obesity, but of course it is a massive problem for older people as well.

**Dr Calderwood:** Thank you for your question. It is on an area that I am very interested in. I am almost at the stage of saying that sugar is the new tobacco. We have evidence of all the harms that overweight and obesity are causing, and I think that we need a raft of measures to address them. That has worked successfully with tobacco reduction.

You are right to be worried about children. You might have seen in my report a graph that outlines the inequalities. Although obesity in primary 1 children is falling in Scotland as a whole, that is only because the obesity rate is falling quickly among children in the wealthiest communities. Among children in our most deprived communities, the obesity rate is rising quickly. We have not solved that problem at all even though, overall, the obesity rate for our children looks better.

The messages are getting through, but not to everyone equally. I firmly believe that we need to look at the issue as we have looked at tobacco. We have a big and growing problem that is starting early, and we are among the worst in Europe, if not the world. Things have not worked because the issue is more complicated than people simply eating too much and not having the willpower to stop themselves eating. That is oversimplistic. There is a lot of new evidence on the availability and the price of food being the drivers for people's choices.

We have an obesogenic environment. School meals are one issue, and I also have an issue with NHS premises and NHS staff canteens. Our healthy choices are not ambitious enough. A healthy living award is given for 50 per cent of produce being healthy. The other 50 per cent may not be healthy, and both choices are freely available to people. There are always promotions of unhealthy, sugary foods, and we do not promote fruit and vegetables.

We have multilayered issues to tackle. We are making some inroads, and we will refresh the obesity strategy for Scotland. Just last week, I was discussing that at a ministerial meeting, and some of the points that Malcolm Chisholm has made about reformulation were part of that discussion. However, obesity is a big problem—if you will pardon the pun—and currently we are losing the battle.

**Mike MacKenzie:** On general public health outcomes, I am always struck by the fact that Orkney, Shetland and the Western Isles perform highly in United Kingdom quality-of-life surveys—they are almost always in the top three. They have very good health outcomes despite the fact that per capita incomes in those places tend to be pretty low. What lessons can we learn from that that might be applicable to other parts of Scotland?

**Dr Calderwood:** I immediately think of the association between mental and physical wellbeing. The two are undoubtedly interlinked. People like living in those places, their lives are happier and their health outcomes are better. Perhaps that is where we should start. Income is irrelevant if the person’s mental wellbeing is good.

You are right to make the point that the inequalities are not just down to income. One part of the report that worries me is about our health outcomes being so inequitable, and a lot of that is to do with income. Making everybody more wealthy will undoubtedly improve some aspects, but that is not the only solution.

We in Scotland recognise our problems, but I do not know whether we have the solutions for them yet. Perhaps there are lessons to be learned from looking at the Highlands and Islands and those examples of where people feel better in themselves.

**Mike MacKenzie:** Is there scope for our planners to think about these matters? Planning has been dominated by the idea of place making. Is it possible for planners to make a positive contribution by thinking about healthy places?

**Dr Calderwood:** It is interesting that you mention that. Maybe you saw the announcement in England last week that 10 towns are to be built with an environment that promotes health, walking and safe play, that has green spaces and in which the availability of the less good things is restricted. There will be a limit on fast-food outlets and places that sell alcohol, for example.

There is also some evidence that some inequalities are due to our not focusing enough on people’s environments. For example, has poor housing, particularly in inner-city Glasgow, been tackled enough? Is it part of the inequalities that we see?

We need to recognise that health is much wider than doctors, nurses and other staff, and to recognise the importance of all the other aspects of people’s lives. We are only just starting to do that. We have started to do it with mental health, but a lot of evidence is emerging about physical health, too.

**Mike MacKenzie:** Thank you. That is useful.

**The Convener:** Colin Keir has a supplementary question. I will then bring in Rhoda Grant.

**Colin Keir (Edinburgh Western) (SNP):** Good morning. My question is about what you said in answer to Mike MacKenzie’s question about planning. I worry that planners perhaps do not have the necessary understanding, and that more discussions should take place. For example, in my Edinburgh Western constituency, there are controversial plans for major growth from the urban area into the rural parts, and every plan that comes up states that a new general practice surgery will be included. Are you aware of any formal consultation by planners or discussions with them about the availability of GPs, or do they just think about what is going to be built?

**Dr Calderwood:** I am not aware that there is such consultation. I do not know whether others can comment.

**Dr Cameron:** I will add a couple of comments, although they might not be terribly helpful. As I understand it, if developers are to get approval from planners, they have to describe the community benefit that might stem from developments, and they often provide health centres and so on as part of the community benefit.

If I may, I will respond to another question, which, as I understand it, was about why the health status of people who live in the islands is surprisingly good. There is a lot of evidence that it is less about the planning of buildings and environments and more about community cohesion. Our previous director of public health did a lot of work on that and showed that small communities that are cohesive and have a lot of interaction tend to be healthier. He was able to do some measurements and to correlate feelings of wellbeing with some inflammatory markers that act as indicators of imminent disease. It is a significant effect. It is not the only one, obviously, and it does not mean that we can abandon healthy lifestyles and so on, but there is something about established communities.

A lot of relevant work has been done on South American Indians. My outlook is becoming a bit broad here, but preservation of cultural identities is important. In particular, elders telling stories seemed to be the deciding factor that gave one group much greater health benefits than were enjoyed by a more dispersed group that mixed with the other communities in the area and lost all its traditions and cohesion. You could say that this is becoming a bit speculative, but there is a strong hint that community cohesion helps health.

**Mike MacKenzie:** Thank you. That is very interesting.

**Dr Cameron:** I can try to find a reference for that work and send it to you. I might not have described it correctly.

**Mike MacKenzie:** That would be useful. I am keen to read that.

**Rhoda Grant:** I sound a slight health warning about the islands, because there are life expectancy statistics for the Western Isles that are on a par with some of the worst statistics for Glasgow. It is just that the numbers are much smaller and tend to get hidden in wider surveys.

However, the situation in those areas bears out the importance of community cohesion. There are issues with some of the aspects that are discussed in the report, such as the “unworried unwell”. I am not sure that they are unworried—I think that they are the disempowered unwell.

11:00

That relates to the points that Malcolm Chisholm raised about diet and people not listening to messages. It is very difficult to listen to a message if you are living on an income on which most of us could not understand how someone could feed a family. Pie, beans and chips will stop a child crying at night—it may not be very nourishing, but it may be the best that you can do. There is a gap in our understanding of what people are up against. Giving them health messages is not helpful, because it disempowers them further, rather than empowering them. The question how we empower people who suffer health inequalities is raised in the report. Those inequalities are a symptom of disempowerment that happens much earlier in people’s lives. How do we change that and give people the same opportunities for health, which is to a huge extent coupled with wealth? By giving out health promotion messages on tobacco and sugar products and the like, we empower better-off people because they can take steps to deal with all of that, but we are actually disempowering people who suffer from health inequalities even further, because we are eating away at the little self-esteem that they have by telling them that they are being bad.

How do we change the message and provide the opportunity for those choices to be made?

**Dr Calderwood:** You have hit the nail on the head about messages, which are not working in the way that we would like them to. In fact, as you said, they are increasing inequality.

I am speaking at a conference on Friday on health literacy; I will bring in Graham Kramer, who is an expert on that area.

**Dr Kramer:** Rhoda Grant is absolutely right: most of the health messages, and in particular the language that we use, are not applicable to people from very low-income and disadvantaged groups. It is a really difficult issue. Perhaps the solution is multifactorial—I do not think that we can say that there is one solution. We need to tackle the problem on all levels, including on an individual level. It is about empowering people in their interactions with their health professionals, and not disempowering them. It is also about empowering communities and thinking about how we can give a voice to people who are least likely to have a voice, which is very difficult.

We hope to showcase at the conference on Friday some work that has been done with children in deprived communities in the United States. The children have been taking on the junk-food industry and creating stories about how they feel targeted by some of the big corporations, particularly in relation to sugar. They have written poems and delivered those messages in their schools. There is something about communicating through peers that is really powerful, and it seems to be translating into greater health awareness and a greater desire to tackle health problems in those communities. I will send the committee information on that, because it is very powerful stuff.

**The Convener:** Thank you for that. I have one brief question before we let you go. The second part of the report raises an issue that we have not done much on, which is mental health as a driver for inequalities and shorter lifespan. I want to give you an opportunity to say something about that. I got the impression from reading the report that there is a serious focus on that area. The story is very predictable: mental health problems translate into greater illness and earlier death. How does that fit into the strategy?

**Dr Calderwood:** That brings us back to your point about the status of different aspects of health. Mental health has not been a high priority, and stigma and lack of awareness are associated with mental illness. We have not invested in our mental health services as we have in physical health services. There are many statistics about poor physical health among people with mental illness because they are not, even though they are in a health service, getting the same level of care as other people. We have acknowledged that now, and large amounts of investment have recently been announced for adult mental health services and for child and adolescent mental health services in order to try to improve access, particularly where there has not been access to good psychological therapies.

We are starting that journey. We need to reframe what people feel about mental illness—how they feel about coming forward and presenting when they have problems. We also need our services to be as good as they can be to treat people. I often give the statistic from my specialty, which is obstetrics, that postnatal depression is the most common complication of pregnancy: 12 per cent of women have postnatal depression. We treat clots in the leg, we treat blood pressure and we treat lots of other things, and most people do not know that the figure is as high as that.

Although we have a long way to go, recognition is always the start, and we have now recognised that mental health services need investment. The recent commitment to changing the level of investment is a good start.

**The Convener:** Thank you all very much for your attendance and valuable time this morning. We are already looking forward to your next annual report.

11:06

*Meeting suspended.*

11:14

*On resuming—*

## Subordinate Legislation

### Healthcare Improvement Scotland (Delegation of Functions) Order 2016 (SSI 2016/86)

**The Convener:** Agenda item 2 is subordinate legislation. We have two instruments that are subject to negative procedure to dispose of today. The first is the Healthcare Improvement Scotland (Delegation of Functions) Order 2016. I ask the committee to note that this is the order on which the committee took oral evidence last week. No motion to annul has been lodged and the Delegated Powers and Law Reform Committee has made no comments on the order. If there are no comments from members, does the committee agree to make no recommendation on the order?

**Members** *indicated agreement.*

### National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2016 (SSI 2016/127)

**The Convener:** There has been no motion to annul the regulations and the Delegated Powers and Law Reform Committee has not made any comments on the regulations. If there are no comments from members, does the committee agree to make no recommendation on the regulations?

**Members** *indicated agreement.*

# Annual Report

11:15

**The Convener:** We move to our annual report. Members will see that the report that is before them is a factual account of the work that the committee has carried out during the current session. Do members have any comments?

**Malcolm Chisholm:** I observe that there were seven bills to deal with. That must be a record for one year.

**The Convener:** I think that it is a record. The committee has been very busy over the piece.

Does the committee agree to publish the annual report on Thursday 17 March?

**Members** *indicated agreement.*

11:17

*Meeting continued in private until 11:23.*

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