HEALTH AND SPORT COMMITTEE

Wednesday 16 April 2008

Session 3

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HEALTH AND SPORT COMMITTEE
10th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Harry Burns (Chief Medical Officer for Scotland)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 16 April 2008

[THE CONVENER *opened the meeting at 10:03*]

Chief Medical Officer (Annual Report)

The Convener (Christine Grahame): Good morning and welcome to the 10th meeting in 2008 of the Health and Sport Committee. I remind everyone, including people in the public gallery, to ensure that their mobile phones are switched off. No apologies have been received.

For agenda item 1, I am delighted to welcome Dr Harry Burns, who is the chief medical officer for Scotland. Dr Burns graduated in medicine from the University of Glasgow and worked for 15 years as a general surgeon. He then entered health care management as medical director of Glasgow royal infirmary, after which he worked as director of public health for Greater Glasgow NHS Board. He took up his post as chief medical officer for Scotland in September 2005.

Members of the committee may be particularly interested in Dr Burns's evidence in the context of our inquiry into health inequalities, although they may ask questions on any aspect of his remit, which encompasses the development of health policy, clinical effectiveness, quality assurance, accreditation and research. All members have copies of his annual report, which is interesting reading.

I invite Dr Burns to make some introductory remarks before members ask questions.

Dr Harry Burns (Chief Medical Officer for Scotland): Thank you very much. I will set some context for discussing the annual report.

Sir Muir Gray, who is one of the giants of public health in the United Kingdom and a good friend of mine, always says that the place of public health officers is to be where the action is not. Our role is to draw attention to areas that the wider system would perhaps rather forget. In my report, I set out to shine a light specifically on early years services for children and on children's mental health in particular. That is not to suggest that no one in Scotland is interested in those matters, but they are often neglected in the grand scheme of things. I was particularly interested and anxious to do that in the light of emerging evidence that very early life experiences can play an important part in determining adult health. In particular, inconsistent parenting, stressful and abusive environments, and environments that do not support learning and development seem to have long-term effects on people's physical health. We are interested in trying to unravel how those effects play out in determining increased risks of heart disease, diabetes and cancer in the poorer areas of Scotland. We have just completed a two-day meeting in Edinburgh that involved a number of international authorities on health inequalities in which that idea was actively explored, and I am pleased to say that there was international support for us in Scotland in particular and for people in other countries to pursue that line of investigation.

I am happy to take questions on my report and to explain points that I made in it.

Mary Scanlon (Highlands and Islands) (Con): I want to discuss what is, for me, probably the most shocking thing in your report. In your introduction, you state:

"We substantially underestimate the amount of violence in our communities."

I am shocked that violence costs the national health service alone almost £400 million. That is the financial cost; obviously, there are social costs and costs relating to people's wellbeing. As I say, I am shocked by the figures, but I am pleased that the problem has, at least, now been quantified. What are you doing to address the problem?

Dr Burns: Foreign delegates at the two-day meeting that I mentioned were interested in that subject, and many complimentary comments on Scotland's approach to it were made. In that regard, I cannot speak highly enough of Detective Chief Superintendent John Carnochan and his colleague Karen McCluskey of Strathclyde Police's violence reduction unit. I do not know whether the committee has had the opportunity to speak to them, but they have tackled the problem in an impressive way. In essence, they have looked closely at the data relating to violence and applied a public health approach. When we want to establish the cause of an outbreak of an infectious disease, for example, we consider who gets it, and when and where they get it. Clusters and patterns of disease are then developed. John Carnochan and Karen McCluskey have shown that the perpetrators and victims of violence, when violence will happen, and even the streets in which most of it will happen can, to a large extent, be predicted. In a sense, they have adopted an approach in which violence is seen as a public health problem, which has created a lot of international interest.

The next stage in developing a public health approach to the problem was to count the prevalence or incidence of incidents. That is where the data came from. We know that many violent

incidents are not reported to the police. By counting the number of cases that turn up in accident and emergency departments, we know that the numbers of assaults and so on that take place are greater than the numbers that appear in police figures. Of course, the reason is that people in many areas do not want incidents to be reported to the police because of their "I know who did it and I'll get him myself" attitude.

The next part of a public health approach is identification of the individuals who are at risk and the putting in place of a prevention strategy.

The violence reduction unit, in association with my deputy, Peter Donnelly, has produced a programme that starts off in the very early years. The diagnosis of the problem has shown that it starts because children do not learn empathy and attachment when they are brought up in a family in which there might be abuse or a lack of parenting, for example. As a result, the children are primed not to respect other individuals. The problem then develops. For example, children may be excluded from school and, to pass the time, they may then go on to self-medicate with alcohol, drugs and so on. They may wander round our city centres at night and at weekends. There is territoriality, which is how gang fights start.

The response to the problem is graded. It starts off in the early years as we try to understand what produces attachments and emotional intelligence, if you like, and as we ensure that children are supported at school so that they will not be excluded. We then move on to diversion therapy—projects such as evening or midnight football to get young males off the streets. We want to ensure that society works for those young people and acknowledges their emotional and educational needs.

The reason for highlighting these issues is to make it plain to colleagues in local government and every other part of the system that we have to take a joined-up view. Detective Chief Superintendent Carnochan and Karen McCluskey have given evidence to the joint ministerial task force on health inequalities, and I am sure that when the report goes to the cabinet secretary it will contain a number of recommendations in that regard.

Mary Scanlon: I support everything that you say and I am pleased that the problem has been highlighted in your report. A problem cannot be addressed unless it has been identified and acknowledged.

If I read it correctly, your approach focuses mostly on children. Is that the best approach? On page 45 of your report, you talk about primary, secondary and tertiary prevention, with tertiary prevention being described as

"the rehabilitation of people with an established violent behaviour or affected as a victim."

I do not mean to sound critical, but are you putting your resources mostly into children because you accept that a generation has been lost, or do you consider it equally important to try to reverse not only the tendency towards violent behaviour among many people but the attitudes that those people are passing on to future generations?

Dr Burns: No—we absolutely do not accept that a generation has been lost. The report highlights children because I feel that the importance of effective parenting is underappreciated. I am talking in particular about parenting in the very early years, and perhaps even antenatally.

In tackling health inequalities, it is really important not to give up on any section of society. The evidence shows that health inequalities in Scotland are greatest among people between the ages of about 25 and 50. Younger males of working age experience the greatest relative levels of health inequality. We have to find better ways of tackling that.

A lot of research is required into the evolving psychobiological model. As you said, convener, I come from a surgical background; I therefore step into areas of psychology and psychiatry at my peril.

Mary Scanlon: Especially with Richard Simpson here.

Dr Burns: Absolutely. However, I am absolutely convinced that some psychological therapies or interventions are worth exploring in terms of building resilience. I always struggle to find words to describe what I think the missing ingredient is, but "resilience" is probably the best word to describe the ability to respond effectively to adverse circumstances and be in control of one's environment, which is strongly associated with physical health. Lack of resilience is found markedly in people who have physical ill health. We have managed in Scotland to unravel the biological link between those two properties—that research is unique to Scotland. We want to do more research on that in order that we can establish what we can do not only with older offenders, but with older people who are out there living and working, and still experiencing ill health. We do not give up on anyone.

10:15

The Convener: I will let others in now, then come back later to Mary Scanlon.

Rhoda Grant (Highlands and Islands) (Lab): I will ask a follow-on question on this topic before moving on to a new topic. Like Mary Scanlon, I noticed the report's focus on children and young

people, which fits with the information that we received when we did our budget scrutiny on drug and alcohol abuse. The evidence showed clearly that if we did not do something about children being brought up in such circumstances, there would be a time-bomb effect. I am pleased that your report focuses on the matter.

I note with concern, however, your statement on page 19 of the report that "huge numbers of children" are involved, but because of the "sensitivities" surrounding family life

"services are unable to prevent severe harm to many children."

How do we deal with that? If we cannot, surely we cannot support children in those difficult situations.

The Convener: For the sake of the official reporters, can you point us to what you are referring to on page 19?

Rhoda Grant: It is the sentence in the middle of the third column that starts with "Nevertheless".

Dr Burns: The issue is partly societal. The question is at what point public services, the authorities or the Government intervene in how parents bring up their children. There will always be sensitivities around that; it is one of those situations in which social workers are damned if they do and damned if they don't. They must tread a difficult path in that respect.

One practical issue that concerns me is information sharing. There is no doubt that we have an extremely effective health records system in Scotland—it is one of the best internationally. We have collected many items of information on individuals, which we keep—and scrutinise—in the national health service under tight security. However, there are other pockets of information out there that could, if they were put together, cause a different pattern to emerge. Because of the Data Protection Act 1998 people are rightly nervous about putting data together—we must protect people's information. However, most public health practitioners appreciate the power of having a complete picture. It would be good to find a way of mapping all the information so that concerns that should be obvious are allowed to emerge.

I have an example from close to home. When my son was in primary 1, he used to come home and talk about a "bad boy" in his class. Fifteen years on, my son is 20 and a medical student; the bad boy was sentenced a couple of weeks ago to life imprisonment for murder. At the age of five, another child spotted a problem, which the services were no doubt aware of throughout the succeeding 15 years. However, why did not we get together to intervene to prevent that problem from getting worse? Detective Chief Superintendent Carnochan is keen on such an approach, but we can do that only if we bring information together. Data protection legislation is reserved to Westminster, but it seems to me that we could be a lot smarter in how we use data. We could build up pictures that would help us intervene more effectively in sensitive situations of the sort that we have been discussing.

Rhoda Grant: I will move on to my other question in order not to take up too much time.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Perhaps the convener wants to take more questions on this topic.

The Convener: No, I will let Rhoda move on. We can come back to data protection.

Rhoda Grant: My other question is on health inequalities. The report goes into many health inequalities, but it misses the inequalities that result from living in rural areas. I think the Government's task force has done the same. I am interested in your views on that. Why has the issue been missed out? Is it because it is not seen as a priority? If that is the case, how can we get it further up the agenda?

Dr Burns: Every time health inequalities are discussed in the fora that I attend, rural deprivation is talked about. So far, the difficulty has been that measurement tools—such as the Carstairs classification and the Scottish index of multiple deprivation—rely on factors such as car ownership to build a picture of deprivation. In rural areas, car ownership is an absolute requirement in a way that it is not in urban areas. Therefore, the method underestimates small pockets of deprivation. However, there is no question but that health boards such as Highland NHS Board are making great strides in identifying areas of deprivation and the services that are needed.

The difficulty with presenting the issue in the annual report is that I try to create the report by pulling down national statistics, which are swamped by the big issues. The fact that rural deprivation is not mentioned is a feature of the way in which the report is put together; it is not a reflection of the amount of effort that is being put into the issue or of the amount of thinking that is under way to identify deprived areas. Often, two or three houses or a small community are disadvantaged because of matters such as location or lack of employment. That work is, properly, being done in health boards.

Rhoda Grant: The problem with keeping that work within health boards is that the information then has no effect on national planning and resource allocation. In the NHS Scotland resource allocation committee report, the element for rural funding has pretty much been taken away—the Arbuthnott formula has been reversed on that. If we keep that work within health boards, there

could be a problem with funding. Obviously, more funding is required. For instance, the general practitioner out-of-hours contract highlights the funding differential just for providing basic services in rural areas. How can we get a national focus on rural deprivation, rather than see it as just a health board problem?

Dr Burns: We do that by pulling up the information from the grass roots differently from how we collect the high-level statistics on which most annual reports are based. I argue that health boards are the appropriate source of information on that kind of deprivation. They bring together that information. On GP funding, some members will be aware of the difficulties and tensions around the renegotiation of the GP contract. However, we are aware of the rural deprivation issue and we are keen to pursue it. Let us see what the ministerial task force on health inequalities says about rural deprivation.

Rhoda Grant: Will the task force consider that? That is one of the issues that was missing from its remit. Our health inequalities inquiry included rural inequalities, but that has not been specified as part of the task force's work.

Dr Burns: The issue has been discussed by officials. At the end of the day, whether it appears in the task force report is a matter for ministers.

The Convener: In my ignorance, I was not aware that health boards produce that information on deprivation.

Dr Burns: Health boards have a responsibility to measure need and to respond to it. Therefore, those needs are brought to the attention of the local board and, where appropriate, the health department.

The Convener: For members, I point out that my understanding is that the ministerial task force on health inequalities will report before the summer recess, so we will be able to consider that when we return after the recess.

Ian McKee (Lothians) (SNP): I am interested in health inequalities. My question has two parts. The first is about the fact that people at the more affluent end of the spectrum benefit from health initiatives more than those at the other end and that therefore, paradoxically, such initiatives often lead to a widening of the health inequalities gap. Should we just accept that, in tackling people who are at the bottom end of the scale, we might obtain less total health gain for the money that we spend?

Dr Burns: Ian McKee is right. That effect has been observed in several conventional health promotion programmes. One big concern about conventional smoking cessation activity was that the people who needed smoking cessation activity least often benefited most from it and that heavy smokers tended not to avail themselves of the service, so targeting people who were in the greatest need was appropriate.

There are two explanations for the situation. One is the psychological observation that people in deprived areas tend to be less assertive about their health needs, but the position is more complicated than that. It comes back to resilience. When any societal change occurs, the better-off people, who are more resilient, will benefit from it. Members will have seen the coverage of the report by the Glasgow Centre for Population Health on post-industrial areas throughout Europe. The fascinating aspect is how, after the fall of communism, life expectancy in the eastern European areas that the report covered—Katowice, Moravia and Saxony—has rocketed, and is catching up with and will overtake life expectancy in Scotland. Those areas seem to have been more resilient to the change. The evidence is that if any major societal changes occur in Scotland, the better-off are likely to improve faster than the least well-off. That says something about the resilience, or lack of it, in highly deprived Scottish communities.

I am in no doubt that our approach should be to target services to meet need. Services need to be targeted where need is greatest, so a differential focus is needed. We need to level up. About 20 years ago, a debate took place in public health literature about whether to try to shift the mean or the worst. That debate has now been resolved—we try to tackle the most deprived areas. One reason is that that is most cost effective, because the worst health is in those areas and that is where more output will be achieved for the same level of investment in prevention. The health service has developed the keep well programme to tackle health inequalities, of which a critical part has been the development of a scoring system to target interventions to reduce cardiovascular disease at those who have the worst indicators. You are right: inequalities are best dealt with by targeting people with the greatest needs.

Ian McKee: Does giving the medical profession a large say in tackling health inequalities mean that there is a risk that we will do what we know best, such as prescribing, which would mean that loads of statins were prescribed for the people whom you just mentioned? Perhaps I am prejudging the task force, but is there a case for putting the responsibility for dealing with health inequalities solely in the hands of local authorities, which can contract us to participate in whatever way they think fit?

Dr Burns: It all matters—we must do everything. The health service must tackle need where it finds it. Local authorities must produce

their supported interventions. Housing and employment must be dealt with. The evidence makes it clear that a single approach will not work.

In the 1980s and 1990s, much money was invested in housing improvements in the Castlemilk area of Glasgow. While that happened, I, as the health board's director of public health, received representations from local people who said that the community networks were suffering because people were being decanted and that their old systems were being interfered with. After completion of the housing programme, we could find no improvement in the health status of people in Castlemilk. They were undoubtedly grateful for having better housing, but were their resilience to life in general and their capacity to gain employment, to accrue some wealth and to live a healthy life increased? The evidence is that taking action on one or two of those fronts may provide some benefit, but the best course of action is to tackle all those areas. I was keen that the health service should not be left out.

Many papers in the literature show that intervention rates for conditions such as angina are higher in affluent areas than they are in more deprived areas. The implication is that a more affluent person is more likely to seek help. The evidence is that that happens a bit in Scotland, but the health service here is probably better than the health service in other parts of the world—in countries that have an insurance-driven system, for example. However, health inequality is still an issue, so I am keen that we in Scotland apply an approach that involves the health service taking some responsibility for tackling it. All such action matters—we must take action across the board. Anyone who can contribute to tackling the problem must do so, if we are to make a difference.

10:30

Ian McKee: But you need grass-roots intervention, not just the top-down approach that has so often been adopted in the past.

Dr Burns: Oh yes—that is an article of faith with me. Policy can skate across the surface of what is happening in deprived communities. It is easy for policy makers to come up with a policy and think that they have addressed the problem. My predecessor used the phrase "fire-and-forget policy" to describe the approach of people who thought that simply by having a policy everything would be all right. I believe that we solve health inequalities individual by individual.

In the keep well programme, I was keen for us to adopt an approach that was not reactive, but which involved primary care workers knocking on doors rather than sitting in their surgeries. We have given primary care staff the tools to go out and knock on the doors of the people who never come in to see them.

The committee will be well aware of the work of Julian Tudor Hart, whose approach to primary care in a south Wales mining village was an inspiration. He and his wife, who was his practice nurse, would go round knocking on doors. He tells the story of the last man in Glyncorrwg to get his blood pressure measured. When he finally took the man's blood pressure, it was astronomically high, but once he had identified that that was the case, he worked with the man to tackle it. He said that the process took up 300 hours of practice contact time over the years, but as a result of his work the guy in question did not have a stroke or a myocardial infarction, did not suffer renal failure and never got diabetes. In fact, he lived a long and relatively trouble-free life, even though, given his initial blood pressure level, he had been on the verge of an extremely premature death.

The health service can make a difference by adopting such an approach. Our role is to be where the action is not, to go out and seek difficulties and to tackle them.

The Convener: How did people in the community react to that approach?

Dr Burns: By the end of Dr Tudor Hart's work, life expectancy in Glyncorrwg exceeded life expectancy in the adjacent villages of south Wales by several years so, at one level, everyone in the community did exceptionally well. When he was about to retire, the Medical Research Council set up a team to evaluate his approach, which found that people were extremely grateful. In our communities, that approach is unusual. The keep well programme is being evaluated and people's reaction to it will be discovered in the evaluation.

The Convener: I was asking about how people reacted right at the beginning of the process, rather than about the consequences of it. Were people quite happy about the adoption of such an approach?

Dr Burns: We are talking about a south Wales mining village in the 1960s. If one listens to Julian, one realises that there were problems. People found his approach unusual, but they saw him to be an active member of the community and responded appropriately.

The Convener: That is interesting.

Ross Finnie (West of Scotland) (LD): Many of us welcome the holistic approach that you have brought to your job and your recognition that health is interconnected with many aspects of society. I particularly welcome the fact that you have spent so much time improving the evidential base on which policy is determined, which allows politicians to come to more informed conclusions.

Like Ian McKee, I will concentrate on health inequalities. You made the point cogently that targeting is needed and said that you were talking about individuals, not a wide cohort. I want to tease that out a little with you. Targeting involves hard choices. Politicians must understand that, but I wonder why we do not quite do so. I do not in any way impugn Rhoda Grant's point when I say that politicians find it difficult to get their heads round Arbuthnott and the NHS Scotland resource allocation committee. I represent the West of Scotland, so I am outraged if anyone takes money away from the area, but Rhoda Grant and Mary Scanlon are similarly outraged if money is taken away from the Highlands. I do not criticise them for their outrage—it is a natural reaction, given that they know that there are pockets of deprivation and inequality in their area.

What is it about how information is currently presented that means that we cannot understand what is going on within the broad financial settlement? The issue is about much more than money; it is about people and resource. How can we present the information differently, so that I, as a member for the West of Scotland, and Ian McKee can be more comfortable that the deprivation element of the settlement is justifiable, and so that Rhoda Grant and Mary Scanlon—

The Convener: And the convener. Let us not forget the south.

Ross Finnie: Good heavens. I suspect that I will be reprimanded at the end of the meeting for omitting the convener—

The Convener: You omitted Fife, too.

Ross Finnie: You get my point. I subscribe to what Dr Burns said, but how can we present the information better, to persuade people that targeting has a genuine purpose and is not just an exercise in robbing Peter to pay Paul? We can theorise until the cows come home, but that will not make much difference if we cannot target.

Dr Burns: I talked about targeting based on need. The key is to deal with the greatest need first. The question is how we define the greatest need. For example, there are a number of scoring systems for cardiovascular disease. We can all go and get blood tests and blood pressure measurements and so on, and it is possible to come up with a number that purports to indicate our risk of having a myocardial infarction in the next X years.

If we have an effective scoring system—I can talk more about that, because conventional scoring systems have not served us well, particularly in Scotland—so that in the first instance we target people who are stone-wall certainties to have an MI in the near future and treat them and reduce the risk, we will do two things. First, we will do the individual a great service, which is what we are here for. Secondly, we will spend our money wisely, because in a high-risk group the number needed to treat—which is a measure used in assessing the effectiveness of a particular therapy—is not great. In other words, we do not have to treat many people in a high-risk group to prevent one of them dying from a heart attack.

When we have dealt with the people who are most at risk, we move up to the next decile and then the next one. At some point, the number needed to treat becomes very big. If we go to a more affluent area and say, "Our threshold for intervening will be very low in this area," we might have to treat 1,000 patients to avoid one MI, whereas in the most deprived area we might need to treat only 10 patients.

That brings us back to cost-effectiveness, which means that hard decisions must be made. I absolutely agree with members that the issue is priorities. Do we keep going up the social scale, spending more and more to get one good outcome? We are a good way away from that. We have a large number of people whom I will not describe as hard to reach, because people often say, "What do you mean by that? McDonald's can reach them very easily." They are not hard to reach—they are people to whom it is difficult to deliver services because they choose not to take them up.

If we are to get through to those who are in the greatest need, that brings on to the agenda the question of priority setting, not only between communities but between conditions. I have made it plain that we should invest a lot more in young people's mental health. We are pulling the evidence together on that. There has been a 44 per cent reduction in myocardial infarction mortality in Scotland in the past decade. Cardiovascular disease is becoming less of a problem in people under the age of 75. At what point do we decide that we may need to invest more in other areas? Such issues will always be with us, and this is the forum in which they need to be debated.

Ross Finnie: That is helpful, but when you talked about targeting you used the phrase "scoring systems".

Dr Burns: But—

Ross Finnie: Wait till I get to my question. I am not greatly into systems—I prefer to see individuals getting treatment. Nevertheless, there must be a recognisable, coherent basis upon which we allocate resource. Were you in any way implying that, although the work that NRAC has done on the Arbuthnott formula has advanced that thinking, to get a more refined view of how we

target we need to invest even more in the kind of work that NRAC has carried out?

Dr Burns: It is helpful that NRAC will be subject to continuing review as we develop more data on such matters. Programmes such as keep well are building up the database and building up a measure of risk and a measure of need. When the Arbuthnott and NRAC groups were both becoming involved, I spoke to them and said that in the allocation formulas they had to try to reflect an assessment of need. They have tried to do that as best they can, but they have said that it is very hard, and they are trying to do it with high-level data.

I am with you in your desire to focus on the individual. As a result of the GP contract, we are building up more information from data on the prevalence of high cholesterol, smoking and hypertension. Once we see the pattern in rural areas and urban areas, we will have much better data to enable allocation on the basis of need. It is important that we revisit those formulas as the data build up.

I will clarify what I meant by scoring systems. The conventional scoring methodology to assess someone's need for intervention for heart disease is based on data from the Massachusetts town of Framingham. I have only ever seen pictures of Framingham, but it has well-manicured front lawns, two cars in the driveways and typical American housing. It is not at all like some of our communities in Scotland. We have discovered that the Framingham-based scoring methodologies, which are based on cholesterol, smoking and hypertension, significantly underestimate risk in Scotland. Other factors are at play in Scotland. It is important that we refine our scoring systems so that we can assess need better. That is in the process of happening, and it is another first for public health in Scotland. I am delighted to say that we are quite good at it.

The Convener: On that more optimistic note, we move to questions from Richard Simpson.

10:45

Dr Simpson: I remind the committee of my declaration of interest: I am still involved in information-sharing work with NHS Lothian, which I want to ask about. I also wish to address the substance misuse chapter of the report.

I have been reading CMOs' reports for most of my professional life, and I have found the one before us today to be the most interesting and readable, because of its focus on young people and children, which I believe to be fundamental.

Let us take it that there are 54,000 to 55,000 births a year in Scotland. Your report indicates that there are between 41,000 and 59,000 children with at least one parent with a drug-using problem, and 70,000 with one adult with an alcohol problem. That effectively means that two years of our child cohort are in families where there is a parent with a drinking or drug-using problem. Would you like to make any comments, in addition to what is in your report, about how to integrate services to deal with that? The previous Government tried to implement various policies on drug services, primary care services, social work services, family centres, education centres, home start and sure start, but those services are all in silos.

Dr Burns: There is an issue with information sharing and the integration of information that is required to allow parents to be identified. Detective Chief Superintendent Carnochan has a graphic approach to explaining the life course of a typical young offender. It often starts with a pregnancy in which the mother has been drinking alcohol. There is then a succession of referrals to children's panels and child and adolescent mental health services. Often, the information about the social work, health and other concerns is not brought together. There is an information sharing need.

I wished to highlight exactly that issue in writing my report. We cannot just sit back and accept it. I am, however, heartened by the response of the Convention of Scottish Local Authorities. I spoke to COSLA chief executives recently about our understanding of the psychobiological impact of chaotic early life. I have had invitations to speak about that with senior officers and other representatives of many councils. I have a role in going out and spreading the gospel on that—it is underappreciated just how joined up the relevant services need to be.

I am also keen to bring together public services in a shared learning environment, where we can get people to cast off their institutional roles and simply talk about their experience, saying, for example, "It would have helped me if you had told me X." It is about grass-roots learning. I return to the point that policies are permissive, but unless people at the coalface get involved in shaping and implementing them, change will not happen.

I am not a management junkie—I do not read the books on management theory that are sold in airports—but I emphasise shared learning and the concept of a learning organisation. By "learning organisation" I am referring not to NHS boards, local authorities or voluntary organisations, but to all of them working together. The aim is to create a learning atmosphere.

An organisational response to the situation is required, and my public health roots tell me that it needs to be driven by information. My job has shown me that if a policy maker is shown scary

information, they react to it. If a doctor is shown scary information, they react to it. If we point out the hard facts and suggest a way to bring about action, that suggestion has to be taken away and people have to come up with an organisational response. I am getting all the support from local authorities and other agencies that I need. I would like my role in all this to be to help to catalyse shared learning and networking.

I will make a point about foetal alcohol spectrum disorders. You will have seen some debate about how much alcohol it is safe or unsafe to drink in pregnancy. There has been one major study into the prevalence of foetal alcohol syndrome in a community, which was carried out in Italy. We translate Italian data to Scotland, and I suspect that that significantly underestimates foetal alcohol syndrome in Scottish communities. I bet that its prevalence is very high in the young men and boys who are out on the streets committing violence. I want to examine the incidence of foetal alcohol syndrome in Scotland and I would welcome the committee's interest in that. If we can identify the risk factors, we can definitely intervene.

Dr Simpson: I could not agree more. One of my concerns is that we have not been good at corporate parenting. We talk about parents having problems and the consequences for the child. However, for us to step in as corporate parents results in St Mary's Kenmure and all the other residential care scandals that we have had. We have been very poor at supporting our foster parents. We do not have an adequate fostering system or support system.

My second question is about targets. All the targets that the health directorate sets—

Mary Scanlon: Excuse me—

The Convener: We will do this question first.

Mary Scanlon: I have a supplementary question.

Dr Simpson: I am happy to let Mary Scanlon in.

Mary Scanlon: I apologise for interrupting, but I want to ask this question before we move on. Dr Burns mentioned self-medication, but he has not said much about dual diagnosis with drugs or alcohol misuse. I am concerned that, in many cases, there is an underlying mental health problem that is not picked up and addressed. We waste a lot of money on detoxification and rehabilitation but do not get to the core of the matter. Will Dr Burns comment on that?

Dr Burns: Forensic psychiatrists tell me that many of the patients who end up in the state hospital and in medium-secure units have a long history of mental health issues from childhood that made them difficult to manage. Consequently, they were excluded from school, which was when alcohol and, subsequently, drugs supervened.

If you have a psychotic disorder, drugs and alcohol effectively stop you hearing the voices or help you to deal with bipolar disorder mania and so on. They are a way of keeping things under control. The mental health services often do not pick up those kids for a variety of reasons that may or may not be the fault of the system—the fault may be the parenting arrangements that ensure that they are not brought to appropriate attention.

We should try harder to avoid that kind of tragedy. If other school kids can see at age five that a boy has problems—I am sure that the situation is not unique—why can we not put in place preventive services that divert such children away from exposure to drugs and alcohol and help them to build a more resilient psychological state that allows them to cope with their underlying mental health problems? You are right that it is often not a case of one or the other but whatever they can get their hands on.

The Convener: From my experience in one of my previous existences as a school teacher, I know that, unfortunately, primary teachers can predict the route that some children will take, even at primary 1.

Dr Burns: We are back into the sensitivities of when we act and when the system should intervene.

Dr Simpson: My other question is on targets. In primary care, many targets require general practitioners to achieve certain levels, and GPs are paid for their work in achieving those targets. However, the problem group of people can be the group who are not reached. A target of 80 per cent for cervical smears might be achieved, and people might say how well we are doing, but—allowing for the people who do not need a cervical smear—there might still be 10 per cent who are not being reached. The situation is similar with breast screening. We are doing very well on breast screening but, even allowing for those who do not want the screening, there is a group of people who are not being reached. How can we encourage primary care services, in particular, to reach out sensitively to hard-to-reach groups and others? How can we develop new policies that go beyond the passive recipient stage or beyond the first letter stage of people being asked to come in for screening?

Dr Burns: I come back to ideas that underlie the keep well programme. Julian Tudor Hart achieved what he achieved because of huge personal commitment. He was a single-handed GP, and in the 1960s, when everything was different, he was driven to achieve what he achieved.

The difficulty for primary care services in reaching the groups who do not come forward for screening is time. People are working hard. The idea behind the keep well programme is to give practices additional resources to create space so that they can tackle such issues. The extra money is not necessarily to buy more GP time, although GPs are perfectly free to use it in that way if they feel that that is best. The extra money might be used to buy additional practice nurse time, so that services can be delivered more sensitively or during extended hours. Nurses can go out to women who are not presenting for cervical screening and talk through some of their reservations.

In my experience, GPs know their patch exceptionally well. We should let them develop their practices in a way that responds best to need. I can understand that, for governance reasons, health boards want a system for negotiating how services will be provided. The new contract allows for locally negotiated service provision.

I am a great champion of primary care services—but then I would say that, because I am married to a primary care practitioner. I believe strongly in a highly motivated primary care service and a primary care team approach that offers a range of disciplines under one roof. Practitioners must have enough time to develop strategies to reach the families that they know very well. The district nurse and the health visitor know the streets where those families live and what people are doing. They should be given the support, the time and the resources to pursue their work.

I am a fan of letting things emerge; I do not like the micromanagement of processes. Give the coalface workers the resources and have faith in them. Very few of them will let you down.

The Convener: I will bring in Michael Matheson and then another coalface worker, Ian McKee.

11:00

Michael Matheson (Falkirk West) (SNP): I was intrigued by your opening comments, Dr Burns, about early intervention, which clearly forms an important part of your report this year. You also spoke about your son's experiences. I can think of three or four people who were in school when I was and who are now dead, either through being murdered or through intravenous drug use. I was schooled in the Gorbals.

When early intervention programmes are being developed, agencies that could help in resetting someone's direction very often fail to pick up on problems and revert simply to their normal statutory responsibilities. If it is housing, it is a housing matter; if it is in the classroom, the teacher just finds a way to manage pupils' bad behaviour; if it is health, the doctor just treats what is presented to them; and if it is social work, they ask whether there is a statutory responsibility to intervene in a child protection case. If there is no statutory responsibility to intervene, those agencies do not come together to address the warning signs that you highlighted.

I know that you are not a management guru, but it strikes me that one of the biggest barriers to creating the type of early intervention programmes that you think are necessary is the culture in many of those agencies. How can we change that culture, even with your evangelical approach of going round local authorities and arguing the case? The body that I find the most difficult to persuade to get involved in an early intervention programme is the local health board. It has to recognise that it should support organisations that are involved in early intervention. To return to Ross Finnie's point, we can theorise for a long time, but we have to create a grass-roots change that will deliver results. Who should take the lead responsibility for that? In the end, someone will have to take that lead responsibility to make sure that the change happens.

Dr Burns: We should not beat ourselves up too much about this. A lot of insights are emerging, for example about the importance of the early years in predicting adult health. Although that might be self-evident at a certain level to some of us who have had such experiences, the data and processes that prove that there is a chain of events linking all those areas evolved only relatively recently. Therefore, we have not had time to have any major organisational response. That is developing.

Someone has to take overall responsibility for such change and I suspect that it is the local authority—I suspect that that is where most of the different areas come together. However, that does not let any of the other groups off the hook. We have community health partnerships where local authority and health board come together. I listen to GP colleagues talk about their experience of the community health partnerships. Some work well and others appear not to work so well. I would like to understand why some of them are not working. I suspect that it is because of micromanagement behaviour. I do not mean to use jargon, but we need to have much more of a patient or people focus.

We are here to try to make communities work better; we are not necessarily here to please our bosses in the sense of managing up a series of objectives. The objective should be, "Can we make this community function better? Can we help this community look after its children better? Can we help this community educate its children

better? Can we help this school, which has low attainment rates, improve?" Some schools in very deprived areas have had superb results. It is about having common objectives for all the different organisations and helping them to understand how they contribute to those common objectives rather than meeting their boss's objective or their statutory responsibility—although that is really important and I will get into all sorts of trouble if I say that it is not important; statute is a bottom-line issue. It is about how we practise and how we view the community. That comes back to the local authority having the lead responsibility.

It is about a different attitude of mind, and I can foster that attitude of mind through data. I can pull together and synthesise the evidence and confront people with what is happening in their communities. Some of the community profiles that are produced by NHS Health Scotland, the Glasgow Centre for Population Health and so on make stark reading, and I can help people to interpret them.

Michael Matheson: I was intrigued by what you said about the need to improve the mental health and resilience of some of our young people at an earlier stage. You suggested that there are psychological theories that could be used to deal with that issue.

I am aware that individualising the approach to that extent is extremely resource intensive. I do not mean that in purely monetary terms; I am also talking about staff commitment. I am aware that the collection of some of the data that you are referring to is at an early stage, but I would be interested to know whether there are any models in operation in Scotland or elsewhere that specifically centre on early intervention with children who are showing early signs of mental health problems.

Dr Burns: The first thing to understand is that theories about how our behaviour develops and how we form attachments to adults in the first six months of life have taken a great leap forward with the advent of new technology for imaging what is going on in the brain. When I was a medical student, we were told that people were born with all the brain cells that they were ever going to have and that it was all downhill from then on, but the evidence now shows that what is going on in the brain can be refashioned quite extensively over a prolonged period—well into adulthood. However, the first few months of life are critical.

We are working with a lot of groups in the United States of America to get an understanding of this issue. The Harvard centre on the developing child, where a lot of the evidence is emerging, uses a tennis analogy to describe the process of the development of a healthy psychology: it talks about "serve and return". If a baby is in some discomfort, he serves something into the relationship with his carer—which is to say, he cries. A baby is genetically programmed to cry if he is hungry, so he cries. If the parenting is responsive, he gets a return: he gets fed, he gets his nappy changed, he gets comforted or whatever. Through that process, the baby learns that he has some control over his environment, and that that control extends to a carer—usually the mother. The next level involves smiling, which gets a response. After that, there is speech, which gets a response. That is how the brain builds up capacity.

If the baby cries, as it is programmed to do, and the mother is under the influence of heroin, there will be no response from the mother. If the mother has not learned the empathetic response, she will simply think, "The baby's crying is annoying me," and the baby will be hit, shaken or abused in some other way. In those situations, the baby learns that it has no control over its environment and it does not build up the next level of empathetic response. Colleagues in Harvard and elsewhere have used various imaging techniques to show that different centres of the brain build at different times.

We are interested in how, at an early age, we can support new mothers into developing those responses. A series of parenting programmes has been developed in the USA that often involve nursing support, such as the nurse-family partnership programme, in which a nurse is supplied to an at-risk home and explains to the mother that, when a baby cries, the correct response is to go and comfort him. That is the kind of support that is needed. The difficulty with many of those programmes, many of which we have investigated, is that they are very culture and context sensitive. What happens in Denver, Colorado, does not necessarily work in inner-city Detroit or in Edinburgh, Glasgow or Dundee. Therefore, we will have to take elements of the programmes and see which of them work in other places. In that regard, the valuable lessons that were learned over a few years by the starting well programme in Glasgow will be incorporated into any new programmes that are designed.

Those programmes involve the very early years. There is powerful evidence that, if children are encouraged to socialise in pre-school education—such as in kindergartens for children aged three and older—their employability, educational attainment and health status will be improved in later life.

The most famous programme, which was carried out in Detroit, followed participants in an early school programme in a highly deprived area for 40 years. It found that, over that period, about $50 was returned into the community for every dollar that was spent on education, which shows

that the programme was highly cost effective. Again, however, we must think about what can be done in a Scottish context.

It has been suggested that things such as cognitive behaviour therapy can be used with adults who have experienced problems. For example, group therapy can be used to teach young mothers how to form an emotional attachment with their babies and so on. The Scottish Association for Mental Health is interested in a concept called mindfulness, which is about teaching people to be more aware of what is going on and how they interact with other people. All those programmes have been suggested in different contexts but, before I advise ministers which way to go, I need more evidence that they work and about the circumstances in which they work.

We are thinking broadly and holistically about this matter. We are not thinking about only one group in society; we think that many or all of those interventions might be appropriate for different individuals. It is critically important that we get this right.

Ian McKee: I was interested about what you said about Dr Julian Tudor Hart, because I, too, admire his work. Shortly after the time you were talking about, my colleagues and I visited everyone in our area who did not come for an antenatal appointment and, if necessary, gave them treatment at home. That resulted in a reduction in the perinatal mortality from about 26 per thousand to eight per thousand over the period. However, that sort of thing is extremely time intensive.

When Professor Watt gave evidence to the committee on 12 March, he told us that, using whatever measure of health you wish, the prevalence of health problems is two and a half to three times higher among the most deprived people but there is a flat distribution of general practitioners across the country. Throughout the time in which I have been in practice, it has been much more rewarding—except, perhaps, in a spiritual way—to work in a leafy suburb with pleasant patients, long consultation times and simple problems that can be sorted out fairly quickly than to work elsewhere. What are you going to do to make it more desirable for doctors and nurses in the health service to work in areas that have the greatest need?

11:15

Dr Burns: The keep well programme has brought additional resources into those deprived areas, outwith NRAC and the Arbuthnott formula. That has been a way of skewing investment. The answer might be to have more general practitioners, or it might be to have an enhanced primary care team, or it might be a mixture of both approaches.

As I have said, I am a fan of letting the people who know the patch decide how the resources would be best used and of having an overall outcome to which we want them to work. Once we have seen the evaluation of the keep well programme and found out the model that has had the most effect in the different areas in which the programme has been implemented, there can be discussions with primary care colleagues about how they can best apply the information. The case for extending the programme can then be made to ministers. Management colleagues get frustrated with public health doctors such as me, but I think that the best approach is to allow solutions to emerge from the people who know the coalface problems. We are heading in that direction, but I do not want things to be stalled by the renegotiation of contracts. I want health inequalities money to follow health inequalities and support primary care in doing so.

Ian McKee: Is that a sticking-plaster solution? There will be practices and areas that will not take part in the keep well programme or the programme might not continue. Is systemic change in the set-up needed?

Dr Burns: The best way to convince people to spend more money is to give them data that show that the money will be well spent. The keep well programme will generate such data.

Mary Scanlon: You have mentioned several times the excellent data in Scotland. Page 13 of your report mentions children with complex developmental problems. Others have talked about their school days. I do not remember anyone in my class or anyone throughout my school years who may have had an autistic spectrum disorder. Are we simply better at diagnosing? What are you taking from the information that we have? Is there an increasing year-on-year prevalence of ASDs? Are there any preventive measures that we can or should take? Do we understand ASDs any better than we did a couple of decades ago?

Dr Burns: I do not have special expertise in the area, but I believe that there is increasing awareness of the problem. The increasing incidence of ASDs is probably largely explained by increasing awareness of their diagnosis, particularly of Asperger's syndrome. The imaging technology that we have is bringing new insights. I have read focused studies in *Nature,* for example, that discuss genetic predispositions and abnormalities in certain bits of the brain on functional imaging, but that is high-level stuff that has not yet come close to allowing us to say that something is the cause of ASDs and therefore

how we can prevent them. The problem is hugely tragic. I have seen families that have had to cope with very difficult children who are at the extreme end of the spectrum. We need to get to grips with the problem, but I do not think that we are any closer to doing so.

Mary Scanlon: Is the incidence of ASDs higher in Scotland than elsewhere in the UK?

Dr Burns: I am not aware that that is the case. Where one thinks that things are being diagnosed more aggressively, one must be cautious about saying things without having a precise test. If a blood test can be done, a survey can be done and there will be hard data, but it is harder to make a diagnosis where a clinical judgment must be brought to bear on whether someone is somewhere on the spectrum.

Mary Scanlon: What research is being done on the issue?

Dr Burns: A number of centres are doing research, but I do not know of any national survey that is being done.

The Convener: Before I bring the evidence session to a conclusion and thank Dr Burns for an informative, useful and quite intense session, on behalf of the committee I would like to ask for his views on a couple of matters on which the committee will then take a decision.

You mentioned the keep well programme frequently in your evidence. Would you view it as worth while—the committee will consider whether to do so at a later stage—for us to take evidence on the keep well programme?

Dr Burns: I think that it would be. An active process of evaluation is under way. I do not know off the top of my head when it will be complete, but I can certainly find that out. It might be of most use to you to come back to the matter once the evaluation has been completed.

The Convener: I will ask about a second issue that you have raised. I am sure that the committee will have other matters that it wants to consider following your evidence, but if I am right, you made a suggestion to the committee about foetal alcohol syndrome being linked to the incidence of violence among young men. Subject to the committee taking the view that we want to commission research on that, would it be worth while for us to review the matter?

Dr Burns: I would like to commission research into the prevalence of the disorder. We need to know exactly what the impact is, because there has been some debate on the issue. My view is that the evidence is that there is no safe level of alcohol consumption during pregnancy, whereas the Royal College of Obstetricians and Gynaecologists says, “Do not drink very much.” Where there is inconsistency in the public mind, we need to bottom it out—particularly when the outcomes could be so significant.

The Convener: So your view is that at the moment there is not a role for the committee on the matter.

Dr Burns: I do not think that there is a role for the committee.

The Convener: I picked you up wrong. I thought that you wanted the committee to investigate the issue.

Dr Burns: It is an issue that I feel strongly about and I think that some colleagues also feel strongly about it. It is useful to have that support.

The Convener: Among all the issues that you have raised, is there anything that you would like us to consider as hot spots in what you have done? We have heard about early intervention, antenatal care and the importance of relationship building. Given that there is still space in our work programme to do other things, is there anything in particular that you might wish us to consider?

Dr Burns: As I have said, this is a developing area. I am keen that it gathers momentum and enters the local authority mindset so that we can build up a new way of working to cut through the silos.

We should wait and see what momentum we can build up through the task force report. It may be that later in the year or next year we come back to the issue and see how far it has got, how pervasive the ideas have been and how people are responding to the task force report, particularly in the early years.

The Convener: We might have you back at some point to reappraise the situation.

Dr Burns: Yes.

The Convener: That would be very useful. Thank you very much.

That was a very long session, so I will suspend the meeting for five minutes.

11:23

Meeting suspended.

11:33

On resuming—

Subordinate Legislation

National Health Service (Superannuation Scheme, Injury Benefits, Additional Voluntary Contributions and Compensation for Premature Retirement) (Scotland) Amendment Regulations 2008 (SSI 2008/92)

Meat (Official Controls Charges) (Scotland) Regulations 2008 (SSI 2008/98)

National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2008 (SSI 2008/105)

National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2008 (SSI 2008/106)

The Convener: Item 2 is subordinate legislation. We have before us today four Scottish statutory instruments for consideration under the negative procedure.

SSI 2008/92 makes a range of amendments to a number of other instruments pertaining to the NHS superannuation scheme, injury benefits, additional voluntary contributions and compensation for premature retirement. The Subordinate Legislation Committee drew the regulations to the attention of the committee on the basis that it had sought clarification from the Scottish Government on the intended effect of the provisions introduced by the regulations and was satisfied with the Scottish Government's response. The relevant extract of the Subordinate Legislation Committee's report is included in members' papers.

SSI 2008/98 provides for the collection of meat hygiene official controls charges in Scotland, as required by European Community regulation 882/2004.

SSI 2008/105 amends the National Health Service (Charges for Drugs and Appliances) (Scotland) Regulations 2008 to correct various errors identified by the Subordinate Legislation Committee during its scrutiny.

SSI 2008/106 amends the National Health Service (Optical Charges and Payments) (Scotland) Regulations 1998 to increase the optical voucher values and supplements.

The Subordinate Legislation Committee made no comments on SSI 2008/98, SSI 2008/105 and SSI 2008/106. No other comments have been received from members and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendations in relation to the instruments?

Members *indicated agreement*.

Mainstreaming Equal Opportunities

11:35

The Convener: Members have in their papers a letter from the convener of the Standards, Procedures and Public Appointments Committee. The letter is about a proposal from the Equal Opportunities Committee to change the standing orders to require committees to report on the work that they have undertaken to mainstream equality issues at least once per parliamentary session, perhaps in annual reports. The letter seeks our collective view on whether we support the principle of reporting on mainstreaming equal opportunities near the end of the session in our annual reports and, if so, whether we believe that a rule change would help to secure that it happens.

We are also asked whether we plan to include in our next annual report any information about how we have mainstreamed equal opportunities. May I have members' comments?

Helen Eadie (Dunfermline East) (Lab): I support strongly the notion of including such reports in our annual reports in the way that is set out in the paper. The only question that I have is whether a rule change is necessary. I do not know because I am not an expert in the area and I am open to receiving advice.

The Convener: Sorry, I missed that last bit—was it to do with whether changing the standing orders is necessary?

Helen Eadie: Yes. I do not know whether such a change is necessary, so I seek further guidance from others who might be more knowledgeable on such matters.

The Convener: Yes, I am a bit like you in that regard. Does anyone else wish to comment?

Rhoda Grant: I agree with Helen Eadie. The only benefit of changing the rules is to make sure that the reporting happens. Most committees would be happy to include such a report voluntarily. However, we need to look to the future because things can change. A rule change would enshrine reporting on mainstreaming equal opportunities in the Parliament's ethos and send out a signal, which might be useful.

The Convener: I have no fixed view either way. I concur with the members who have spoken. Ours is one of the committees that tries to mainstream equality because it is at the root of everything that we try to do in prevention, intervention and treatment in the health and sport portfolios. It is probably one of the main thrusts of our agenda. However, I am not convinced about a change to the standing orders, simply because I do not know whether committees will comply voluntarily. It is pretty radical to change the standing orders. I do not want to put words in members' mouths, but would it be appropriate for us to respond that we have no conclusive view whether the reporting of mainstreaming equal opportunities should be part of the standing orders and that we should see whether it works on a voluntary basis?

Helen Eadie: That is fine.

Mary Scanlon: I would prefer for it to happen voluntarily rather than being overly bureaucratic.

Ross Finnie: If we are all signing up to including such a report in our annual report, as this committee is, the next time that we get a set of reports, we will have an evidence base on which we could judge whether it is necessary to make a change to the rules to make such reporting mandatory.

The Convener: Our annual report will be before us in June for consideration so we can judge the situation then. In the meantime, does the committee agree to delegate to me the response to the letter? I will send it round to you all and take silence to be affirmation after how long?

Ian McKee: An hour.

The Convener: I will give you more than an hour, Dr McKee. We do not have to respond until 1 May, but I will send the response to members and include a deadline for saying whether you are not content with it. However, the matter does not seem at all contentious.

That concludes our formal business in public.

11:39

Meeting continued in private until 12:04.

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