The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 22 January 2013

Session 4

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HEALTH AND SPORT COMMITTEE
2nd Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Gareth Brown (Scottish Government)
Sir Harry Burns (Scottish Government)
Nicky Coia (NHS Greater Glasgow and Clyde)
Ann Eriksen (NHS Tayside)
Derek Feeley (Scottish Government)
Felicity Sung (Scottish Government)
Dr Lorna Watson (NHS Fife)
Dr Maggie Watts (NHS Ayrshire and Arran)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 22 January 2013

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

Health Inequalities

The Convener (Duncan McNeil): Good morning and welcome to the second meeting in 2013 of the Health and Sport Committee. I remind those present to switch off mobile phones, BlackBerrys and other wireless devices as they can interfere with the sound system.

The first item on our agenda is evidence from the Scottish Government to begin our scoping exercise ahead of our inquiry into health inequalities. I give a warm welcome to Derek Feeley, director general of health and social care, and Sir Harry Burns, chief medical officer, Scottish Government, and I invite them to make opening remarks. I assume that you have agreed who will proceed first.

Derek Feeley (Scottish Government): I will start, convener. As we go through the evidence session, you will probably find that I will defer to Harry Burns on this subject more than I would on virtually any other. When you have someone with his expertise sitting alongside you, it is often best to bow to that.

We welcome the committee's interest in this issue, which is one of the most significant that we face. The recent Audit Scotland report on health inequalities in Scotland started by stating:

"Tackling health inequalities is challenging."

That is an understatement. The problem is probably the most complex that we face and there is no simple solution.

When Harry Burns and I went to the Public Audit Committee to give evidence on the Audit Scotland report, we did two things. First, we welcomed the spotlight that Audit Scotland was shining on the issue. Secondly, we were keen to make the point that, although the Auditor General for Scotland's report and its analysis of the challenge were helpful, we believed that its recommendations were too narrowly drawn and that a broader response was required.

There have been numerous reviews of the evidence on what policies and interventions should be pursued to reduce health inequalities, the best summary of which is in "Inequalities in health in Scotland: what are they and what can we do about them?", which was written in 2007 by Sally Macintyre from the University of Glasgow to inform the Scottish Government's task force on health inequalities. I will leave a copy of it for the clerks.

Although the paper was published in 2007, many of its recommendations remain valid. They were reinforced by a recent World Health Organization report that looked at the social determinants of health and made three broad recommendations: measure and understand the problem, improve people's daily living conditions and tackle the inequitable distribution of money, power and resources. Scotland is well placed on the first of those recommendations. We have a range of indicators with which to monitor progress on reducing health inequalities, which we publish annually. We published the latest suite in October 2012.

There is no doubt that health services must play an important role in tackling health inequalities, which is why the work that we have done on some of the big public health challenges—such as the ban on smoking in public places and the work that we are trying to do on alcohol—is really important. Initiatives such as keep well, our targeted smoking cessation services and the new detect cancer early programme are all important contributions to tackling the problem. The conclusion that Harry Burns and I have reached—he will speak for himself in a moment—is that those measures are all necessary but unlikely to be sufficient. On its own, the national health service cannot tackle the range of daily living conditions that the WHO talks about or the broader social inequities.

To try to recognise the breadth of the challenge, we have been working with the Convention of Scottish Local Authorities to try to enhance the contribution that community planning can make. We are about to start a significant piece of collaborative work around the early years, which will go right across the public services and is aimed at reducing infant mortality and improving attachment and readiness to learn. That is an important piece of work that has the potential to make a big contribution in the health inequalities area.

As the committee will know, we recently reconstituted the ministerial task force on health inequalities. It has had one meeting and it will meet again in early February. It plans to publish a report in the summer.

I hand over to Harry Burns to add anything that he wishes to add.

Sir Harry Burns (Scottish Government): It is very important not to see inequalities in health as an isolated phenomenon. If we look at the map of Scotland and shade in the areas that have the worst inequalities in health, we might be looking at the areas with the worst crime rates, the poorest

educational attainment rates, the poorest environmental conditions and so on. Inequalities in health are just a manifestation of inequality across the whole of society. To target inequalities in health without trying to understand what the drivers are for adverse outcomes across all those domains is to miss the point.

The same kind of things that cause poor educational attainment in children cause an increased propensity to offend and an increased propensity to addictive behaviour in later life, and ultimately they lead to failure in the jobs market and increased poverty. In that way, the cycle of intergenerational failure begins again. Twenty-five years of interest on my part, starting as a surgeon in the east end of Glasgow, led me to the conclusion that the basic problem lies in the early years. That is not the only explanation by any means, but we will not fix the problem without changing the conditions in which very young children are nurtured and grow.

All the evidence shows that adverse and chaotic environments in childhood lead to a number of problems later in life. Children who experience adverse environments face a whole range of biological consequences that lead on to behavioural consequences. Children who experience adverse events in early life are far more likely to have mental health problems and are far less likely to succeed at school. That creates a generational cycle of failure in a number of domains of living.

There are things that we can do, not just for children but later on in life, that can ameliorate the problems of early life, but unless we break the intergenerational cycle by radically changing conditions of nurture, attachment and support for babies and their families, we will not be as effective as we can be. That is why we have started off with the major effort in the early years collaborative.

There is a range of other things that we can do. As Derek Feeley said, we have started work with COSLA and local authorities on trying to change life in ways that reduce offending and reoffending and improve educational attainment. There are active labour market programmes that are not just aimed at getting young people out of unemployment but are actively concerned with enhancing their skills for living and participating more effectively in the social environment. There are also interventions that are aimed at supporting the elderly to be independent. All those things will help to reduce both inequalities in health and other types of inequality that we see in society.

It would be a mistake for any part of society to think that inequalities in health are just an issue for the health service. They are an issue for the whole of society, just as inequalities in relation to offending, work and so on are issues for the whole of society. Unless we understand that, we will carry on experiencing problems.

The graph that shows how inequalities in health have been widening uses life expectancy as a measure. We have looked at trends in life expectancy in 16 western European countries going back 160 years. For most of that time, Scotland had pretty much the average life expectancy in western Europe. It has only fallen behind in the past 40 or 50 years. Scotland has fallen behind in that period because the gap between rich and poor has widened. Affluent people in Scotland have a life expectancy that is better than the western European average, but the gap in life expectancy between the extremes of rich and poor in our society is 14 or 15 years. If poor people's life expectancy had improved at the same rate as it did until the 1950s or 1960s, our average life expectancy would be what it was for most of the past 150 years—the western European average or slightly better than that.

There is nothing intrinsically unhealthy about Scotland or the Scots. What has happened in the past 40 or 50 years is that a large part of our population has failed to improve its health at the same rate as the more affluent in the population have. Understanding that is the key to doing something about it.

Gil Paterson (Clydebank and Milngavie) (SNP): Good morning, panel. What you describe is poverty, and most informed people accept that poverty and health inequality are bedfellows—they go hand in glove with each other. Given the prospect that the income of the working poor and the non-working poor will be cut soon, what planning is being done? What is the reaction of the Government in Scotland to that prospect?

Sir Harry Burns: It would be a mistake to assume that poverty is the cause. I bet that, if we went back a generation or two, we would find that the family of just about everyone in this room was very poor—that was certainly the case for my grandfather. He was a miner in west Fife and, as he had bad lung disease, he did not work much. However, from very poor communities, people emerge and succeed. What allows some people to succeed when many people fail? That question is why we are focused on the early years.

The first time that I met a well-known and very affluent Scot—I will not name him—who emerged from humble beginnings, built up a big business empire and is now actively engaged in philanthropy, I asked him what made him succeed when all his friends probably did not. He instantly said, "I had a really good family." The notion of family support and consistent parenting that allows young people to develop a sense of being in control of their lives and allows them to make

choices—not to get involved in difficult behaviour but to succeed at school and see that as a way of emerging—is the key to all this.

Poverty is a consequence of much of what we are discussing, and we must tackle it. It is not for me to come up with the economic solutions to poverty. However, if we get young people attaining at school and involved in successful activity in the jobs market, we will ultimately deal with poverty and begin to break the cycle. However, the key first and foremost is the early years.

Gil Paterson: I appreciate your point and I have experience of the issue from where I was born and raised. However, my worry relates to what we know is about to happen. We know, without doubt, that the working poor will be affected. The interventions that you wish to make for the children you talk about need to be resourced. At the same time as there will be more clientele—if I can use that word—we will see the resources that are available to the Government to tackle the issue being cut. Are we in a position to mitigate the situation or are we—to be frank—kidding ourselves on? Can we square the circle with resource? Given the cuts in income that are about to be made, the impact on ordinary people will be dramatic and I can only see things deteriorating and more families being pushed below the poverty line. Therefore, more intervention will be needed.

10:00

Derek Feeley: I think that the first thing that you are looking for is an assurance that we are building some of what you are talking about into our planning. I can give you that assurance. The task force on health inequalities will have regard to welfare reform and the broader economic situation.

Harry Burns made an important point. It is easy to get into a slough of despair as we ask ourselves how we can deal with the issue. We do not have a choice; we must tackle health inequalities. We must do the best that we can with the resources that we have.

There is a cycle that we need to break into and I agree with Harry Burns that the early years are the right place to try to do that. Much of what we are trying to do through the early years collaborative is not hugely expensive. It is about doing the evidence-based things reliably well and bringing improvement science to the will and the enthusiasm that are out there in the early years community. The environment in which we are trying to make a difference is very tough indeed, but that does not mean that we can just take a step back and not try.

Gil Paterson: We have very deprived areas and very wealthy areas, and the differential between the two is massive. If we could concentrate on one area and leave everything else alone, that would be fine, but my concern is for people who are elsewhere in the framework that I am trying to describe. If we exclusively target the neediest areas, is it likely that people in neighbouring communities who are in a slightly better position will be adversely affected, so that the tables are turned in the communities? I know well and can take you to areas where the community is in dire need but just up the road there is a slightly better area, where people are just managing. I suppose that I am asking about universality. Is there a danger that we can overtarget and create problems in areas that are performing relatively well, compared with the poorest areas?

Sir Harry Burns: The answer to that is yes. Statistically, there is no question but that the best way to deal with the problem is by levelling up. We classically describe five quintiles in the population, based on socioeconomic classifications and so on. The aim is not to take the best and the worst and make them look the same, because people in other areas would suffer significantly; the aim is to level up. That is what will bring the overall picture of Scotland's health back in line with where it should be.

Families in difficulty need support, regardless of where they live. The aim of the early years collaborative, plus all the other interventions that we will bring on stream in time, is to help people in difficulty, irrespective of their postcode.

The Convener: You referred in your introductory remarks to the response of Governments and the Parliament over time, and health inequalities have always been a top priority. What has gone wrong and why are we in the current position? Why have we not identified the problems? We have introduced policy and monitored it, and have had task forces. Why have we not delivered better?

Derek Feeley: It is quite difficult to make an assumption about what would have happened had successive Governments not done what they did. If they had not done that, would we be in a significantly worse position than we are in today? There are signs that some of the things that a range of Governments have done have made a difference. From the big public health measures through to the targeted things that the NHS has been doing, there have been successes along the way. However, the problem is huge.

Harry Burns might come back to this, but I think that one of the things that we must do and that we ask the committee to help us with is to make some of what has been done stick for the long term. If we could get to a position whereby the whole of Scottish civic society had a clear idea about what we will try to do about health inequalities and we

committed to sticking with those things for the long term, that would make the step change that we need to make.

Sir Harry Burns: The fundamental problem is, as Derek Feeley said, the fact that we have not stuck at it. We have tended to introduce interventions with three years' worth of funding and to implement them across too small an area, which means that they will not get a big enough change and enough people to be able to demonstrate a statistically significant improvement. At the end of the three years, somebody from the local university comes along and says that the intervention has not made any difference, so we stop it.

The keep well project targeted people on the basis of their postcodes and was run around general practitioner practices. It is only now, after six or seven years of the project running, that some health boards are coming to me to say, "Hey, wait a minute, we're beginning to see some differences here." The critical thing about areas that are beginning to report those differences is that they have gone beyond the bounds of the original project. They have said, "Well, instead of just treating people with signs of heart-disease risk, why don't we help them with advice on their social problems? Why don't we help change their local environment? Why don't we do a whole range of other things to connect them more successfully with society? We'll organise things like social events for elderly people who feel isolated." Suddenly, by doing a whole range of things, they are beginning to see differences.

As Derek Feeley said, the problem is that we have not stuck at things for long enough and we have not done them on a big enough scale. The changes that come in from the early years task force must be done at scale and we have to stick at it until we see things happening. We should see things happening quite quickly.

The Convener: This has been the Government's top priority for the past six years and there has been monitoring. There has also been the failure of local government and health to work effectively. The need for early intervention with children has been recognised for some considerable time. What was the health department's response to the Christie commission when it reported? What actions has the health department taken in respect of that in, say, the past couple of years?

Derek Feeley: I will come back to your point about the Christie commission, if that is okay, because I just want to go back a step. Health was already doing a lot of work around targeted and general prevention even before Christie. What we have tried to do with the Christie report through things such as the change funds is to raise our game on prevention.

As I said in response to your earlier question, this area is not completely without success. We have been making progress in some areas. Sir Harry Burns mentioned the keep well programme; according to the most recent statistics, the improvement in cardiovascular outcomes in the most deprived areas has been better than that in the richest. To my knowledge, that is the first time that that has happened. There is not a complete absence of success in this area.

However, as Harry Burns has pointed out, it has taken us 50 years to get to this position and I am not sure that it is realistic to expect 50 years of decline to be turned around rapidly in a relatively short time. It will take us a long time to recover, and getting us to that better position will require a sustained cross-government and cross-civic society response.

The Convener: We have known that for some time now. Who put the light on here?

I presume that, when you make something your top priority, you discuss the possibilities and risks involved, the objectives that can be achieved and how everything will be measured. This morning, you have conceded that, on your own measurements, the approach over that time has failed. Now we have another task force coming up. What is going to radically change, how are we going to push on and how are you going to make this a genuinely top priority for the Government?

Sir Harry Burns: I dispute the fact that we have known this for some time. When I started looking at this issue, the answer was to get people to stop smoking. However, we then discovered that Scottish smokers actually figure quite low in the European league tables. The answer, then, was to focus on diet, which might or might not be the issue. The fall in cardiovascular death rates in Finland, where diets were radically changed, is identical to the fall in cardiovascular death rates in Scotland, where the diet has not been changed.

The issue is much more complex than you think, and the whole story has been bedevilled by people who knew the answer. It is much more complicated than anyone ever assumed. Given the number of European conferences I get invited to, someone obviously thinks that I know something about this, but I do not know whether we are at the end-point of knowing the answer. In just the past few months, a whole range of scientific publications has suggested that an even more complicated layer of causation underpins all this. We are not there yet, but we know that, if we make these early years interventions at scale and in a consistent way, we will begin to make a

significant difference in the health and wellbeing of the upcoming generation.

My question, however, is whether civic society has the appetite to adopt the kind of evidence-based interventions that prevent young people from going off the rails and ending up in jail or that deal with them when they come out. I recently spoke to an MSP who, on a recent visit to Barlinnie, was told that people leaving the jail were given three nights' accommodation in a hostel for the homeless and then were on their own. Do we seriously think that that will help those people get back into society? We are just not joined up—and that is an issue not just for the health department but for everyone. The issue is much more complicated than people think and will continue to get more complicated the more we get into it.

The Convener: We on this committee and indeed other committees understand that and I hope that we will take up some of those themes. However, I do not know whether that answers my question. We spent a lot of time and put a lot of focus first on smoking and then on alcohol, but it appears that our interventions in that respect will not be the significant ones. However, the issue of health inequalities has not had the same exposure and the local government outcome agreement strategy has not moved the issue on. If you are to move on and get the committee and others behind you, there needs to be a recognition that up to now policy and delivery have failed. Why is there such a reluctance to say that?

Derek Feeley: When we published "Equally Well" in 2008, I did not hear anyone saying that that was the wrong policy.

The Convener: No. That is the problem.

Derek Feeley: I did not hear anyone saying that in the Parliament, either. I heard no one saying that it was the wrong policy. "Equally Well" contains around 78 recommendations, and we are delivering reasonably well on most of them.

10:15

The Convener: The message that we are getting from the figures is that we are not achieving our objective. Our top objective was to reduce health inequalities. What was the response to the Christie report when it came out? What actions did the health department take in response to that report?

Derek Feeley: The Christie report talks about prevention in the broadest terms, so we have been upping our game in relation to prevention, working in collaboration with our local authority partners. That is why we have change funds for older people and so on. We have been doing a raft of things. The stuff that you have seen most recently in the GP contract about anticipatory care is directly—

The Convener: If the issue of early years is at the heart of the matter, why are we only now getting to it?

Derek Feeley: Harry Burns is desperate to say something.

Sir Harry Burns: I have a couple of points. First, we had an input into the Christie commission's recommendations. The need to focus on preventative spend in part came from the recognition that a lot of health service spend has been on screening, health promotion and so on.

Secondly, I dispute the assertion that previous things failed. If you do not see a change, either a change has not occurred or you have not collected enough data to show that there is a change. I can take you around places that have participated in the equally well process and where lives have been transformed. The problem is that we do not do things at scale. We take things that have a good evidence base and do them at a small scale, then we say, "Oh, this hasn't worked, so we'd better throw it out and start again."

We need to build on the things that have worked and do them across the whole system. To say that the answer is to do with early years is incorrect. Taking action on the early years is the way to break the cycle, but there is a range of other things that we need to do as well. I am looking for consistency and cross-societal action.

The Convener: You say that tackling health inequalities was a top priority, but did you know that screening and public health messages have not narrowed that health gap? They have widened it.

Sir Harry Burns: No, they have not. The gap has widened despite a number of things that have happened. It might have widened more if those things had not happened.

Bob Doris (Glasgow) (SNP): I was struck by your comment that, over much of the past 160 years, Scotland had pretty much the average life expectancy in western Europe and that it is only in the past 40 or 50 years, as economic inequalities have widened, that health inequality in Scotland has increased.

I want to put two points on the record before I ask about early years. First, economic inequalities are solved by using the economic levers of power, and this Parliament does not have those levers of power. Secondly, it has been widely accepted that welfare reforms have increased economic inequalities in society and, once again, this Parliament does not have the power to prevent those damaging welfare reforms.

We have heard that addressing health inequalities has been a priority for the past six years. In the hope of getting some cross-party consensus, I damn well hope that it has been a priority for more than the past six years, and that the previous Scottish Executive also had it as a priority. My concern is that, when politicians who are not in government seek to criticise other parties' schemes, it feeds into a short-term approach, with one Government's scheme being ditched when the next Government comes in. We have heard today that that chopping and changing is one of the significant issues in relation to what we should be doing to mainstream the pilots that work at a local level. It is important to put that on the record in order to balance the debate that we have had this morning.

I was surprised to see that, out of a total of £607 million that has been spent on health inequalities in the previous three years, the portion that was spent on early years was only £26.8 million. Is that an accurate figure?

Derek Feeley: Are those the figures from the Audit Scotland report?

Bob Doris: Yes.

Derek Feeley: Audit Scotland derived those numbers from work that we did back in 2008 when we published "Equally Well". To get a snapshot of where we were at the time, we asked people to make assumptions about what parts of the budget they spent on health inequalities. Therefore, the figures are illustrative, rather than definitive. Of course, there was huge expenditure on things such as education, which might not be reflected fully in the figures. The figures give a sense of where we were in 2008. In 2008, some things for 2009-10 and 2010-11 were not known about, so they are excluded from the numbers. The overall number should be treated with caution. It is intended to give a sense of the spend, rather than to be a definitive statement of it.

Sir Harry Burns: It is difficult to apportion time in primary care, for example, and say how much of the primary care spend is targeted at supporting children. It is almost impossible to make a judgment on that. There is a lot of activity on the early years. Derek Feeley mentioned other sectors: local authority nurseries and playgroups all contribute to the early years effort, for example. We are concerned about consistency of application and doing the things that work at scale to level up the opportunities for families and to ensure that they are supported. Families will be feeling stresses as a result of welfare changes, so we need to find ways of supporting them through that period. The children tend to suffer when the parents are stressed. It is important that we ensure that the stresses that parents feel are not visited on the children. It is hard to quantify spend in those areas.

Bob Doris: You will appreciate that I do not want to create an audit trail just for the sake of it or to wrap up the system in bureaucracy, but Audit Scotland can audit only the figures that are collected. I must say that, as a proportion of £607 million, £26.8 million seems low, given the Parliament's and the Government's early intervention agenda. What is not captured in the figure that should be captured? If the figure is an underrepresentation, what figures should be added, in cash terms, so that we can see the global spend? When I look at the figures, I think that £26.8 million seems a small amount compared with the total of £607 million that is being spent on health inequalities.

Derek Feeley: The figure will be made up of particular ring-fenced allocations of money, so it will not include anything that is taken from more general allocations. A lot of the money that goes towards funding health inequalities work in, for example, the local authority sector would be difficult to split out. The Public Audit Committee has asked us to do further analysis of the work, which we will certainly have to do. I do not think that we will ever be able to say definitively exactly what we spend from every budget, because some of it is almost impossible to split out. How do we allocate the time that a health visitor spends with people in deprived communities compared with the time spent in other communities? The same applies to social workers and teachers, for example. We can do the best that we can to get the most up-to-date picture, but it will never be perfect, I am sorry to say.

Bob Doris: In your initial comments, you moved towards saying that health work is wider than addressing the manifestation of health inequalities and is about preventing them from occurring in the first place. It is up to you what answers you give, but my reason for asking the question was that I hoped that you would make that point. You mentioned social workers. A variety of projects in our communities that address early years issues are funded by local authorities and partnerships. Are those captured in the figure of £26.8 million?

Derek Feeley: No, I would not think that they are.

Bob Doris: Should they be?

Derek Feeley: If we sat down today and did the analysis that was done in 2008, we would try to do it differently. There is a choice for us as we think about how to respond to the committee's request for greater clarity on the numbers and the similar requests that we have had from the Public Audit Committee. We can either try to update the numbers or try to have a more fundamental

assessment of exactly where we are. My preference is to do the latter rather than the former, because I am not sure that the former would tell us the full story.

Bob Doris: Should there be a combined health and social care integration budget to address health inequalities in the early years? Would that allow us to get towards what the overall spend is in that area?

Derek Feeley: You can expect one product of health and social care integration to be a more targeted effort around health inequalities. Bringing together the two types of organisation ought to help us to make some progress on the early years and beyond. However, that will not necessarily help us to get beneath the surface of every penny that is spent, because a lot of money will still be spent on general allocations and staff. A lot of work would have to be done to understand how staff were being deployed in order to get an accurate, to-the-pound assessment of exactly what has been spent.

Bob Doris: I have a final question for Harry Burns. You mentioned that there have been a number of pilots and good schemes at the local level that started to show evidence, but which we have axed or changed. That has happened under successive Governments. Can you pick a current early years scheme that should be embedded for the long term—a scheme that you would not like to see wither on the vine, and which should be invested in and mainstreamed across the board?

Sir Harry Burns: Very early on in the introduction of the equally well programme, a project was begun in East Lothian to look at poorer areas in the local authority area. A whole series of interventions and joined-upness began to be designed. Social workers and voluntary agencies, for example, began to offer integrated support to families and young children, and the learning from that has spread to other areas.

I could also point to Fife. In Kirkcaldy, a project looking at young people's alcohol consumption has shown amazing collaboration among the police and education, social work and health services to see that not as a criminal justice issue, but as a need for some support.

There are projects across the Lothian NHS Board area, such as the family nurse partnership intervention. I probably should not go into the details of individual cases, but there is no doubt in my mind that supporting pregnant teenage girls through their pregnancy and the first year or two of the baby's life transforms the lives of both the baby and the mother. Mothers who would have drifted into alcohol abuse and all sorts of things in the past carry on at school, get highers, and move on into careers as a result of the support that they get from the family nurse.

There are a lot of things that are happening out there that we need to join up and learn from, and we need to share and spread the learning. That is happening, but only in pockets.

Bob Doris: That was a really helpful answer.

I have no further questions, but I leave sitting the fact that much of what Sir Harry Burns mentioned would not be included in the £26.8 million. We must get a bit cleverer at quantifying the money that is invested across a range of public bodies to tackle health inequalities in the early years.

Thank you for your answers.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I entirely agree with the chief medical officer that we are dealing with an extremely complex problem, and it is not because of a lack of effort by successive Governments that we still have a widening gap. When Labour came in, we revisited the Black report and considered the early years. At that time, the early years were a priority for the United Kingdom Government and the Scottish Government.

We reduced absolute child poverty by a third and introduced home start, sure start, family centres and community schools. All those measures were designed to deal with the three-plus group. I think that the new thing that the chief medical officer is pointing to is the zero to three group, given the importance of the very early stages of attachment and the fact that the damage is done in the first three years. I think that that concentration, which was only reflected in home start, sure start and family centres, is perhaps the new thing.

10:30

When the chief medical officer last came in front of us, he said that, if we are successful in the early years work—if we are on the right track and are getting there—one of the things that we should see is a pretty rapid reduction in infant mortality. However, in the past couple of years, we have seen a reduction in the number of midwives and a 40 per cent reduction in recruitment of midwives. We have seen a focus on family nurse partnerships that will take 350 health visitors off to look at a very small number of families, rather than the second, slightly broader group that Gil Paterson referred to. We have seen the case load of health visitors rise and the case load of social workers become almost overwhelming.

We say that we are trying to address the problem and that we are going to make a difference to the zero to three group, but what has

happened not just in the squeeze that we are now facing but in the past three to four years has actually undermined the very thing that we are talking about.

I accept that family nurse partnerships are being rolled out, and I value that. The family nurse partnership is actually a Scottish health visitor programme updated by an American who came to see it. Nevertheless, it is interesting and useful, but it is expensive. Apart from that, how are we going to tackle the problem and what outcomes will we see in a reasonably short time, as opposed to the long time that I accept is needed to see the generational change that we need?

Sir Harry Burns: It is actually not zero to three that we are focusing on, but minus nine months to three. We might even need to focus on what happens before conception, as we think about young girls who move on quite quickly into the potential for becoming pregnant. We need to begin to get them to understand a bit more about what pregnancy involves.

We will see some significant changes early on. Paying attention to diet, smoking and alcohol during pregnancy—actually, there should be no attention to alcohol whatsoever; I am a proponent of women not drinking at all during pregnancy—will reduce the number of stillbirths and the number of low birth-weight babies, and in turn that will have an impact on infant mortality, which is of course measured up to the first year of life.

We have already seen falling numbers of low birth-weight babies in the most deprived areas, which shows that the message is out there in the midwives and support systems for women in deprived areas, and that it is working. We cannot do this work without the support of midwives and health visitors. As we move through it, part of the exercise that is developed by the early years collaborative will be to look at the workforce implications and ensure that an appropriately trained workforce is in place to deliver that message.

A significant reduction in infant mortality is not entirely straightforward to achieve, because most deaths in the first year of life are associated with congenital malformations, which are unlikely to be significantly influenced in all of this. However, the fact is that Scotland already has the lowest infant mortality of the four UK Administrations. We think that the early years collaborative, at the end of this week, will set itself a target of a significant reduction in infant mortality, bringing us much more closely in line with Scandinavia.

We are already seeing changes. The effort that has gone into the early years work in relation to low birth-weight babies and so on has paid off a bit with the existing workforce. However, you are absolutely correct: we need to ensure that an appropriately trained workforce is in place. As we begin to see the load, I am hopeful that investment will be made from the preventative spend fund.

When it comes to social workers and so on, it will be important to change the engagement with individuals and communities. At the moment, public sector engagement is all about case load, risk management, protocols and guidelines, but the issue is actually families in trouble. I have spent a lot of time with substance misusing parents who are trying to do the right thing and move on. The best results often come from the third sector, which sits down and engages with people on a different basis from social workers. The third sector cannot take your children away. It is there to help and support you and therefore the trust that builds up is much greater.

That said, in my home town there is a very effective public sector project that is looking at substance misusing parents. The critical thing is that the health visitors and social workers who work there are friends of the families. A key part of this is a different dynamic, with public sector workers, third sector workers, individuals, parents and communities engaging differently to co-produce different outcomes. It is not us telling them what to do but working with people to change their lives. Too often, it has been top-down—"You will do X, Y and Z". Engagement with people to help them to create positive futures for themselves requires a very different way of working. It is not just about the workforce but about how the workforce engages.

Dr Simpson: My experience matches that. When I worked in West Lothian for three years as an addiction specialist, it was the voluntary sector organisation that was able to intervene positively within families. However, the voluntary sector is subject to the short-term funding that you referred to earlier. I do not know whether you agree, but we have to find a way to ensure that the programmes that work in the third sector get long-term, core funding so that the third sector does not spend all its time repeatedly tendering. According to my third sector colleagues, the tendering process was one of the most damaging things that they had to deal with. At the time, we in the public sector—in health—had no retendering. We are beginning to have it and I am not sure that it is positive.

We had very helpful answers on the minus nine months to three group; the second group is three to 16. Are we sufficiently identifying those with conduct disorders and those who are being excluded from school, and are we picking them up in a way that provides the wraparound support that you just referred to in relation to the zero to three group? Exclusions seem to be rising again slightly.

That is not a criticism of the current Government; circumstances are difficult.

On where we are, the most striking thing—I keep referring to this in the committee and in the chamber—is the finding in a paper by Professor O'Connor that in a study conducted in Stirling and Glasgow, 14 per cent of 15 and 16-year-olds self-harmed, and a further 14 per cent had seriously thought about doing so. Something fundamentally wrong is going on with the three to 16 group if we have a society in which one in three youngsters say that they are thinking about self-harming.

Sir Harry Burns: That is more work for the health visitors. We are introducing the 27 to 30-month health visitor assessment of developmental delay. As you rightly say, developmental delay is a sign that the previous years have not gone as well as possible. Therefore, at that stage—well before school—we hope to be able to institute evidence-based programmes to put things right, with the aim that the children will arrive at school ready to learn, socialised and able to integrate positively in school.

School exclusions are a particular irritation—I do not know whether that is the right word. If a child needs to be excluded from school because of their behaviour, that is a sign that there is a problem at home. What do we do? We take the child out of school and send them back to the environment that created the problem in the first place—daftness.

We need to rethink our systems in that regard. I have a particular interest in one way of dealing with the issue: the nurture group process, whereby children with conduct disorders are taken into a special environment in school and helped to socialise. However, the best thing to do is to stop the behaviour occurring by intervening early.

Again, across the whole education sector and indeed the whole of society we must think differently and join up. We need to see a life as a course, not just as a series of snapshots. Instead of saying, "This bit's failing, so we need to turf the child out", we need to stop the child failing, and if they fall through the net we need to institute appropriate measures. I expect the early years collaborative to have something to say about things such as enhancing play, enhancing parents' reading with their children and building up attachment in the three to five age range.

When children in their teens suffer significant mental problems, the origin is very often in the first few months and years of life. I hope that as the cohort comes through from the early years interventions, we will begin to see reductions in things such as self-harm. When there are such signs of stress, lack of self-esteem and so on, we need to think more clearly about intervening at school age.

Dr Simpson: I will not tackle the third group; I will leave that to other members.

In a previous session of Parliament we heard evidence on speech and language therapy from a professor who I think was from Queen Margaret University. He said that the gap between problems starting and referrals had got longer, not shorter, because of the health visitor issue, so I welcome the introduction of the 27-month check for language delay. Early speech and language therapy prevents a child from going to school with a difficulty that will create further problems.

I have been working with the charity Place2Be, which has been working with 10 schools, including in Niddrie, to do exactly the sort of in-school nurturing that you are talking about. There is a lower rate of exclusions in those schools. The programme is being expanded to East Lothian, although the expansion is under threat because of finance—the NHS is not playing its part in funding the programme. I put that on the record, and I hope that the NHS will fund the programme in East Lothian as it does in Niddrie. A pilot in Glasgow is being looked at, too.

Place2Be's programme is not the only such initiative, but programmes that work need to be expanded. It is not an expensive programme and it has a huge effect. Some 70 per cent of the children in the schools go to counsellors to talk. Families' ability to talk about problems is being augmented through in-house charitable support, which is separate from the education system. I will return to the issue in the parliamentary debate on mental health later in the week.

Mark McDonald (North East Scotland) (SNP): The point was well made by Bob Doris that if we are talking about 50 years of increasing inequality, year zero goes back some way and predates the setting up of the Scottish Parliament. I appreciate that the witnesses are not in a position to talk about wider policy approaches, but the implication of what has been said is that the response is hampered by the Parliament's lack of control in some areas.

It is clear from the discussion that politics does not do the long term very well and never has done. The electoral cycle tends to get in the way. There is a difficulty with the message that it will be years before significant improvements are manifested as a result of an intervention. Unless there is complete buy-in and an acceptance that it will take a long time for the results to show, Governments or politicians of whatever colour will be hectored for a lack of progress and we will always be in a position in which—for want of a better analogy—the baby is thrown out with the bath water.

What can we do to ensure there is an acceptance that some of the measures that you are talking about will, by their nature, take a long time to show the dramatic improvements that people want to see?

10:45

Derek Feeley: The strength of the early years collaborative approach has the potential to offer us that. We are bringing to the early years agenda the methodology that we applied to, for example, the patient safety programme, which demonstrated a clear understanding of what it takes to improve.

The early years collaborative is a much more complex agenda that, as far as we can establish, no one else in the world has tried to do at the scale that we are doing. The power of the methodology is that the data is collected as we go along.

We are getting together every community planning partnership in Scotland on Thursday and Friday this week. We will send them off to do some stuff from next week to start counting the impact of the changes that we are making. The power of the data in our approach is not that it is a big, multi-year evaluation; rather, it is the fact that data is counted every day. With that approach, at least there is the prospect of getting a sense of progress as the programme is worked on. That progress would not stand up to randomised control trials or necessarily be accepted in peer-reviewed journals, but it ought to give us a sense of whether we are heading in the right direction.

It is early days. We are just about to start the work but, we hope that, by going through the plan-do-study-act cycles that are part of the programme, the data will be collected as we go along.

Sir Harry Burns: On the long-term nature of the issue, I have come to this through science, not through opinion or my own political views. My background is that I was a surgeon who got interested in health inequalities. Over the years, the scientific evidence on the importance of positive and nurturing early years has become utterly compelling. I can show biochemical and neurological changes and all sorts of precise linkages between something that happens in the early years and the subsequent risk of heart disease, stroke, cancer and a range of mental health outcomes.

Politicians, on the whole, are rational people. When they are presented with scientific evidence that says that certain policies are causing neurological or biochemical abnormalities, but that certain interventions are changing the situation, they tend to accept that. Since I have been involved in policy, I have worked closely with every health minister since Sam Galbraith. They all want to do the right thing, even if they may differ slightly on how they want to achieve that. I earnestly hope that that will continue, no matter what happens.

There is very strong evidence that we will break the cycle, but there are other evidence-based actions that people can take later on in life that will change the biochemical predictors of pure outcome, the neurology and the DNA changes that we have observed taking place among affluent and deprived citizens in west central Scotland.

Clever scientists are on the case. All the evidence suggests that if we do what we are going to do on Thursday and Friday, we will see significant improvements in a new cohort of Scots, which will lead to a great reduction in the differences between affluent and deprived Scots.

Mark McDonald: Sure. There was some discussion earlier around whether the public health messages and campaigns have succeeded or failed. I guess that the only way we could have assessed that definitively would have been to establish a control group on, say, St Kilda, but that would possibly have been a little inhumane.

However, I agree that the early years are absolutely crucial. Obviously, beyond the early years, a great number of Scots have left that cohort and are part of the figures that we see on health inequalities. The worry is about how we ensure that we do not take our eye off the ball on that. We obviously do not want to write off a whole generation, or generations, of Scots by saying that they are beyond rescuing from the situation in which they find themselves. What, in a nutshell, is the answer? Where do we go from there?

Sir Harry Burns: It gets harder, the older you become, to make changes in your life. We think that we can do a lot on reducing offending and reoffending, and we are discussing with colleagues specific interventions on that.

One of the reasons why behaviour-change interventions are less likely to work is to do with the notion of locus of control. As a surgeon, I used to tell people to stop smoking and to eat a healthy diet. I very often got the response, “Ach, if you’re gonna die of cancer, you’re gonna die of cancer”; it was seen as being not within their control to make changes that would reduce their risk of dying of cancer, and that some kind of external focus was determining their future.

Psychologists talk about an “external locus of control”. We know from psychologists that the sense of control is built in the early years, but it can still be developed later on in life. It comes down partly to the business of engagement and it involves the notion of individuals participating in

decisions about their environment, community and so on.

The classic word is “empowerment”. Have we really tried to apply that in deprived areas? I have been working in one or two deprived areas, trying to get people engaged who have become very much dislocated from society in general and who live very solitary and damaged lives. When we get them involved, they change their decisions about their health and wellbeing and about participating in society more generally.

It is invidious to talk about individuals, but I know of one individual who was housebound for seven years after the death of their spouse, but who was changed by an empowerment type of intervention. That individual is now the focus of a huge amount of community work in that area. It comes back to my point about the changing nature of how we engage with society and how we should do things with people and not to them, and how we should get them engaged, which will begin to suck in middle-aged and older people.

I cannot talk about middle-aged and older people without making a plea for them to do physical activity. If everyone did two and a half hours of physical activity a week, life expectancy in Scotland would increase by a year. It is a very significant intervention. However, why would folk who are isolated go out to take exercise? They need to feel that they are part of a group and need to become engaged.

Mark McDonald: I have a final question. I accept entirely the point about inequality being a huge factor. In that regard, we can consider the Scottish index of multiple deprivation as a guide to where intervention is most likely required. However, beyond that, Gil Paterson talked about communities to which he could take you. I could take you to what we might call middle-class suburbia and, even there, I could point to people in my school yearbook who became teenage mothers or who became addicted to drugs. Those people come from communities that would not come close to touching the “most deprived” rating in Scottish index of multiple deprivation figures, but there were people in those communities who were at risk and who could have been identified as being at risk. Do we need to get smarter even than using the index of multiple deprivation in identifying at-risk individuals, never mind at-risk communities?

Sir Harry Burns: We absolutely do. We should not draw circles on a map and put all our effort in those circles; we should find more sensitive ways of finding people who need help. Support and engagement should be available to people on the basis of need, not postcode.

Derek Feeley: Data from the Scottish household survey—it is a little bit out of date, but we can draw some conclusions from it—showed that about 34 per cent of low-income households lived in the 20 per cent most deprived areas. That surprised me—I do not know about the committee. I would have expected the figure to be significantly higher than 34 per cent because it means that 66 per cent of low-income households are not in the 20 per cent most deprived areas.

The Convener: Are we talking about universalism-plus?

Derek Feeley: We are talking about everything. Do everything.

The Convener: How does health policy reflect that in considering areas and ensuring that resources are adequate in those areas?

Sir Harry Burns: The family nurse partnership provides an example. In the areas where it operates—and when it is rolled out across Scotland—any teenage girl who becomes pregnant will be offered a family nurse, irrespective of where she lives. Those people are relatively easy to identify, but other things are harder to identify. We are constantly looking at ways of identifying situations and we will use community planning as a major part of that effort.

The Convener: We have discussed access to GPs and time with them since I was a member of the then Health Committee. I do not know for how many years the deep-end initiative has been going. Is that another area that needs to be addressed?

Derek Feeley: We are in active discussions with the deep-end practices, and Stewart Mercer is doing a piece of work on the impact of GPs having more time with patients. The Audit Scotland report has an interesting analysis of where GP practices are. The correlation is not direct, but there are still significantly more GPs in the most deprived areas than there are in the least deprived areas.

Another part of the response to your question comes from some of what we have tried to do recently in relation to the health improvement, efficiency and governance, access and treatment—HEAT—targets. We set a universal target for smoking cessation services, but we made it particularly challenging for boards to achieve in deprived areas; we expect them to do more in deprived areas than they do in the country as a whole. We have done the same on measures such as fluoride varnishing—we have tried to emphasise boards upping their performance in deprived communities. We must do both.

The Convener: We have spoken briefly about the role of the Convention of Scottish Local Authorities and of local government in wider

delivery. What are we doing to improve the performance of community health partnerships and the relationships with local authorities?

Derek Feeley: The committee will be aware of the statement of ambition—the revised guidance to community planning partnerships—that was published recently. In that, reducing inequalities is a key priority and is one of six big priorities for community planning.

We have deliberately taken the community planning partnership as the collaborative home for the early years collaborative. On Thursday and Friday, people from local authorities and the health board will sit round the same table to produce a joint plan for the changes that they will make in their community planning partnerships. We have a strong signal in the community planning guidance that reducing inequalities is a priority and we will have people coming round the table to work together locally, which is where the improvement will happen.

Drew Smith (Glasgow) (Lab): I want to go back to the Audit Scotland report and to pick up the point about primary care. Mr Feeley said that there are more GPs in deprived areas than there are in less deprived areas, but one of the key messages in the Audit Scotland report is that

"The distribution of primary care services across Scotland does not fully reflect the higher levels of ill health and wider needs found in deprived areas".

The report's second key recommendation is that you should

"review the distribution of primary care services to ensure that needs associated with higher levels of deprivation are adequately resourced".

Are you going to do that?

11:00

Derek Feeley: Harry Burns will want to say something about that, in due course.

We should keep that situation under constant review, although I have a few points to make. First, there are more GPs per head of population in Scotland than there are in any of the other countries in the UK; we have more GPs, full stop. Secondly, although Audit Scotland is right to say that there is no direct correlation between the level of ill health and the number of GPs in an area, the gap that exists in Scotland between the most deprived areas and the least deprived areas does not exist in other parts of the UK, so it is not as if there is no correlation at all. There is a significant difference between the most deprived and the least deprived areas when it comes to the number of GPs.

We have a limited number of levers that we can use to get GPs to set up in particular locations. Among the things that we can do is ensure that there are better premises in deprived communities. For example, a new state-of-the-art health centre is to be funded in Possilpark, which is one of the most deprived areas in Glasgow. It will be an outstanding primary care facility. It is possible to invest in such initiatives, but there is very little that I can do to force a general practitioner to set up in a particular location.

Another issue is what the GPs are doing in such areas. The work of the deep-end GPs is extremely interesting from the point of view of adapting the practice of GPs in those areas to better reflect the needs of their customers and clients. We have started to take some steps in the GP contract. The failure to agree a GP contract at UK level has given us an opportunity to agree a more Scottish contract, within which we have prioritised work on anticipatory care—that picks up the convener's question about what we have been doing on prevention and anticipation—so we are trying to pick that up in the GP contract. We are also doing work on multimorbidity, which is a particular challenge in deprived communities.

We should always keep the distribution of GPs under review, but that is probably not enough. We need to think more holistically about how we use GPs, the nature of practices and how we can incentivise the right kind of care for people in deprived communities.

Harry is more eloquent than I am in making a point about where people are distributed, so I will let him do that.

Sir Harry Burns: Just because someone lives in an area does not mean that they are registered with a GP in that area. A few years ago, we looked at the situation in, I think, Drumchapel. We found that residents there were signed up with about 100 different practices that were spread all over Glasgow. We cannot just plonk a GP in an area and say that, suddenly, there will be more GP time available to people in that area because a lot of them will sign up with that GP. It is very difficult to estimate the amount of GP time that is available to residents of an area, because many people sign up with practices outwith the area.

Another point to make is that primary care is about a lot more than GP time. Mention has been made of health visitors, whom I consider to be an essential part of what we are trying to do. Increasingly, I see primary care expanding into a whole load of other disciplines. That has already happened in some parts of Scotland. Some of that is about supporting families in different ways; for example, there are health centres in which there are welfare rights people. We are talking about generally expanding our ability to support people who are in difficulty.

I want to see us working more closely with local authorities on such things as signposting for people who need help in specific ways that might not come from the health service. I have already spoken about physical activity; we will have to develop a way of ensuring that GPs hand on to another layer of intervention people who need help with physical fitness. The best way to do that is to get physical activity co-ordinators and so on working in primary care settings.

We will see primary care expanding into many other areas beyond general practice, which I think is absolutely right and reflects the whole-society nature of the problem that we face.

Drew Smith: To be fair, I did ask about primary care—I did not ask specifically about GPs. I accept the point, however.

There is a challenge for us, because every question can be answered with, "It's very complicated." Of course it is very complicated; we all, round the table, accept that. Audit Scotland has put a report before us, so I am trying to get a sense of where you think the report is fair and where you will make changes because the report has been useful.

The chief medical officer has said that he absolutely accepts that short-term and small-scale interventions are disruptive and are not the way to do things and he went further than just accepting the point: he advocated it.

Audit Scotland also says the NHS boards are failing to allocate resources to target needs within their areas. What is the response to that? What action should we take when someone tells us that? Audit Scotland says that there is at local level a "lack of shared understanding" of what health inequalities are. You are concerned about the complex causes of health inequalities and you are concerned that we do not have a definition of those causes, but locally there is not even understanding of what the symptoms are and what the cures might be.

Sir Harry Burns: We have already pointed to the fact that some of the arithmetic around the expenditure has left out a lot because, of necessity, a lot of expenditure on health inequalities will come from areas other than health. Therefore, we are moving in the right direction by strengthening community planning and community planning partnerships to bring funding together.

We forget that all the funding for healthcare is skewed towards health inequalities. The reality is that people who live in deprived areas are more likely to get cancers and heart disease and have strokes, so they get treatment for those things. When I had a specific interest in cancer as a surgeon, I looked closely at the pattern of treatment, because the outcomes from some cancers—from most cancers, actually—vary by socioeconomic status; the lower down the social scale you are, the less likely you are to survive. One of the obvious reasons for that could have been that less treatment is available for people in deprived areas, but I could find no evidence of that. I did, however, find more aggressive cancers and more aggressive physiological responses to those cancers. I found a biological explanation for it, which has been shown elsewhere in other countries.

Most of the health service's spend on healthcare actually goes on dealing with the health service's response to socioeconomic deprivation; it is tackling it in real terms.

Drew Smith: One of the purposes of our inquiry is to ask these questions. We will have to have other panels before us, but when we have the chief executive of the NHS in Scotland and the chief medical officer here it is not unreasonable that we concentrate on the NHS.

Does the NHS currently do anything that increases inequality?

Sir Harry Burns: The obvious one is anti-smoking campaigns. Historically, in campaigns on unhealthy behaviours, the people who have a stronger sense of control over their lives respond and those who do not do not respond. Traditional health improvement projects widen health inequalities, which is one of the reasons why I believe we must move beyond that approach.

Drew Smith: I presume that that is also the case with regard to our thinking on physical activity. We need to ensure that we shape campaigns that do not make the same mistakes.

Sir Harry Burns: Absolutely. When I discussed that issue recently, I got the response, "Well, poor people don't take physical activity". If we keep telling them that they do not take physical activity, they ain't going to start. We have to find other ways of dealing with the problem.

I live in a relatively deprived area, where the efforts of my local authority to establish running groups and so on are really very striking, and you can see the evidence on the streets of the town. We can do it, but it is a question of attitude and culture. Do we really want to make a difference? If we do, we need to find ways of delivering the intervention.

Drew Smith: I still have to wonder whether—apart from those public health campaigns—the national health service and the Government's health directorate are doing things that increase health inequalities. The big challenge in this is, as Mr Feeley pointed out earlier, how we redistribute power, income and resources. The chief medical

officer talked about small-scale projects, but we need big budgetary changes to deal with this matter. Of course, that means having to divest something else of money. I presume that you are asking yourselves that very question; surely if you know that you need to move more money into tackling inequalities, you will have to start by looking at the things that you know do not work to reduce inequality and, indeed, might even make it worse.

Derek Feeley: There should not be a litany of such projects. For a start, we inequalities proof our policy making as we go along; in other words, as we develop policy, we ask ourselves whether we are clear about its impact not just on income or socially generated inequalities, but on all inequalities. As a result, there should not be a large number of policies that increase inequalities.

The real question that we should be asking ourselves is whether we have the balance right between the policies that improve health for all and those that—to use Harry Burns's phrase—level up. That issue is still open, but I hope that I gave members some assurance when I listed some of our recent moves to influence behaviours through the HEAT targets. Moreover, the detect cancer early programme explicitly recognises that some of the issues with regard to cancer outcomes come down to the fact that people in deprived communities tend to present later with cancer, so we are deliberately going after that segment of the population.

Of course, we have a duty to improve everyone's health, but one of our particular duties is to improve the health of those who are currently health-deprived, and we need to get that balance right.

Drew Smith: In its report, Audit Scotland's first recommendation is:

"The Scottish Government should introduce national indicators to specifically monitor progress ... and report on progress."

As the chief medical officer has pointed out, many people have been looking at the issues for a long time now, so how can we reassure ourselves that 10 years after our report is published another chief medical officer, another head of the NHS in Scotland and another health minister—there might well have been a good few health ministers by then—will not be sitting before the health committee then, saying, "The issue's complicated and it's difficult to measure progress, so we don't"?

Sir Harry Burns: How do you know that I will not still be here in 10 years?

Derek Feeley: I am pretty sure that I will not be. [*Laughter*.]

I was puzzled by that recommendation in the Audit Scotland report and, indeed, said as much to the Public Audit Committee. I point out that footnote 22 at the bottom of page 10 of the report refers to

"*Long-Term Monitoring of Health Inequalities*, Scottish Government, October 2012",

which is the only reference to the fact that we are one of the few countries to report annually on progress in these areas. Every year, we report progress on healthy life expectancy at birth, premature mortality, mental wellbeing, low birth weight, hospital admissions for heart attack, heart disease, cancer incidence, cancer deaths, alcohol admissions, alcohol deaths and all-cause mortality by socioeconomic status. Such evidence means that the suggestion that there is no monitoring of such matters is not supported.

11:15

If the committee wanted to offer some advice about whether those are the right areas to monitor, that would be incredibly helpful. If we should measure other things by substituting some of, or adding to, the measures that I mentioned, I am open to hearing about that. However, there is regular monitoring of health status in those areas.

The Convener: The fact that poor people get more than their fair share of treatment is a negative thing, I presume, in that they have left it too late and find themselves in hospital. Who gets the biggest share of, or the biggest benefit from, the preventative measures; is it the rich, the middle classes or the poor?

Sir Harry Burns: Preventative measures include things like cervical screening and breast screening. Everyone is invited for screening, but uptake is lower in poorer areas.

The Convener: Is there evidence for that?

Sir Harry Burns: There is evidence for it, but there is also evidence that primary care staff, for example, make an extra effort to encourage folk. However, it comes back to my point about whether people feel in control of their lives.

The Convener: I was just trying to get some clarity about treatment and preventative measures. Such measures are important; they are where we want to get to.

Sir Harry Burns: Increasingly, they are absolutely where we want to get to.

The Convener: The other point that has come out is about what is important for politicians—we all plead guilty to this—in the outcomes. Outcomes are at the heart of what needs to change to implement the preventative agenda and deal with health inequalities. We measure success by

whether hospitals are kept open, or by the impact of the smoking ban. Indeed, the Cabinet Secretary for Health and Wellbeing was measuring success in such a way in an article on Sunday.

Do we need to make a journey? Why are we not listening? Why have your interventions on the policy makers over time not been more successful in encouraging us to measure health outcomes differently, rather than by free prescriptions, hospitals or access?

The committee has spent a lot of time on end-of-life care and on regulation and delivery of care for older people. However, the key is clearly—as you said today and have said for a number of years—that we need a different direction and different priorities that can unlock the health inequalities; that is, early years intervention. We are just not getting there, are we?

Derek Feeley: The challenge for policy makers and parliamentarians alike is that all those things matter to people. We all spend some of our time doing what is urgent and some of it doing what is really important.

I take you back to the first words that I said: I very much welcome the inquiry. It has the potential to put us on a course that carries a sense of consensus and shared purpose. It is recognised that Administrations over a number of years have done their best to resolve some of the big complex issues, but agreement about the core issues that we will prioritise over the next 10 to 15 years would be a significant step forward. Then, there would be a legitimate challenge to us to get on and deliver improvements.

The Convener: Is it the case, as I think Sir Harry Burns alluded to earlier, that the poor are less likely to vote and that the worried well vote in large numbers? Do we as politicians need to overcome that to deal with some of these issues?

Sir Harry Burns: Thankfully, voting habits are not my area of expertise.

The Convener: You suggested earlier that, given the effects on the courts, we need early interventions for young people who are in trouble, so we need to overcome society's feelings about the issue. Does that not come down to politics and voting? Does that not affect whether a hospital stays open?

Sir Harry Burns: We need a real cultural change. Instead of blaming people, we need to see people as being in need of help and support, no matter what position they are in.

When I took on this job, one of the first things that I did was to go down to Carstairs. Over the years, I have met probably a dozen mentally disordered murderers, every one of whom has a history going back before the age of three. Their lives have been blighted very early on. They have been excluded from school, they have taken refuge in drink and drugs in their teens and later they have wandered about town with a knife in their pocket with the result that somebody got stabbed. The mental ill health that comes from abuse and neglect in the early years is hugely dominant in the lives of those individuals. We need to get away from the attitude that the answer is to lock them up for ever. Thankfully, we have places such as Carstairs that try to work with those people on their mental disorders.

To a greater or lesser extent, you can see that with folk in Barlinnie and other prisons. Failure in life has its origins at that early stage. People who are neglected in early life have not learned to attach, so they do not nurture their own children in turn and therefore the cycle is perpetuated. To a large extent, that perhaps accounts for the gradual widening and the accumulation of that adversity in our society.

I am really looking forward to the results of the 27 to 30-month health visitor assessments on developmental delay. When we see those results change, we will see real evidence of a shift in the way that pregnancy and the first couple of years of life are nurtured. The fewer developmental-delay kids that we see, and the fewer children that are put on the risk register, the more we will see real change in our society. We can then look forward to closing a few prisons in future.

The Convener: Should health inequality be measured differently from how we measure it now, or does that not matter?

Sir Harry Burns: The measurements that we have more or less come from routine statistics. As Derek Feeley said, the early years collaborative will identify, almost on a day-to-day basis, the number of women attending antenatal clinics who smoke, the number who have been given smoking cessation advice, the number who have taken that advice and the number who continue to drink alcohol during pregnancy. That will be on a chart on the wall, and we will see the figures coming down or remaining flat or whatever. If they flatline, we will need to redouble our efforts. We will move into an era when we measure a lot more about the growth and development of children. From that, we will determine the most sensitive measures.

I come back to the point that it is human nature to look for a magic bullet to solve complex problems. The magic bullet does not exist here. We need to pull together a lot of hard work across the whole of the life course. If we get that realisation out there so that people have the sense that the whole system needs to work together on the problem, that will be a mighty leap forward.

Gil Paterson: I have a quick question on the issue of people presenting, which I think Sir Harry Burns spoke about. An associated issue is that, in our most deprived areas, when people have made an appointment with the doctor, the prospect that they will turn up is not great. Are any schemes in place to help people with presenting and keeping appointments, which might have the effect of changing the situation for them?

Sir Harry Burns: There are successful interventions. Most folk have a mobile phone, and there are systems by which people get text reminders of when their appointment is and so on. That kind of thing has a significant effect. Again, it is about doing at scale interventions that work and ensuring that everyone participates in them. Things are happening that are having an impact.

Gil Paterson: Good. Thank you for that.

Nanette Milne (North East Scotland) (Con): I apologise for being so late getting here, which was thanks to a broken-down ScotRail train. I therefore missed a lot of what was said at the beginning of the meeting.

I have been around long enough to have seen a lot of changes in the health service come and go, then come again. I have never been in general practice myself, but my husband was a GP for most of his working life in a practice that covered most of Aberdeen. This is perhaps going back to the future, but the way things went there was that they had a practice nurse, a health visitor and a social worker who were all pretty well attached to the practice and who met several times a week. It strikes me that that approach got to the root of the problems for families in practice areas. For example, a situation could be dealt with before a baby was born if it was anticipated that there might be an issue with a particular family.

I think that that kind of local collaboration was what Sir Harry Burns was getting at. As I said, we are perhaps talking about going back to the future, but it strikes me that that might be the way ahead. That is a comment rather than a question. However, do you think that we should go back to having practice-based health visitors where possible?

Sir Harry Burns: We need to go a lot further than that, and not just with practices. We mentioned the fact that people sign up with practices all over the place and not just in their own area. From what I can see, we need a much more widely co-ordinated effort that brings social care, educational interventions and pre-school interventions together in a co-ordinated way across the life course. Obviously, we are focusing a bit on the early years, but the intervention must continue even as children move into secondary school. The transition from primary to secondary can be stressful and can knock kids off track. Organisations such as Place2Be, which Richard Simpson mentioned, provide an important way of supporting children through such transitions.

I therefore think that we need to do far more than we ever did. I accept that, in the old days, because lots of people saw a situation, it was possible to synthesise ways of dealing with it. However, we need to get even smarter in that regard, because the problems in some areas are severe.

Nanette Milne: To follow on from Gil Paterson's point about access to primary care, I recently had an interesting meeting with somebody from Optometry Scotland who has a practice in a deprived area. He feels that his practice is a good point of entry to the system because people are happy to go and get their eyes tested, which allows the practice to signpost them to wider health services. I presume that the same would apply to community pharmacies. I can see the possibility for quite a lot of collaboration at local level in that regard, which would be beneficial.

Derek Feeley: That is absolutely right. Dental practices are another example of how people can be signposted on to other services. We are working hard to ensure that, whether or not we are talking about independent contractors, the contractual arrangements in deprived areas reflect and incentivise such signposting so that any engagement with primary care becomes one that is not just about treatment, but about information, guidance and signposting to other services.

Nanette Milne: That can be done for all ages.

Derek Feeley: Absolutely.

Aileen McLeod (South Scotland) (SNP): Sir Harry, you said that health inequality is an issue for the whole of society and not just for the health service, and that we are dealing with an intergenerational failure. In your annual report, you talked about the implications of people's genetic make-up and how that can be affected by their socioeconomic environment and then passed from one generation to the next. It then becomes embedded to the point where it becomes the norm and is part and parcel of people's culture. Obviously, as you said, that perpetuates the cycle and so, as well as the inequalities in income, welfare and power, a variety of health inequalities accumulate. How do we deal with that challenge of genetic make-up?

11:30

Sir Harry Burns: I mentioned epigenetics because it is emerging as a real issue in some studies. We do not yet have a specific epigenetic study. We have identified and measured, in

affluent and deprived Glaswegians, chemical changes to DNA that are often associated with epigenetic change. However, I mention that just to underline how complicated the problem is. Whenever you think that you have reached a reasonable approximation of the answer, some new aspect of science comes along and you think, "Wow, how does this affect what we are doing?"

In the course of the next year or two, we plan to conduct studies in Scotland to see to what extent epigenetics might be contributing to the problem. That particular issue arose from a study that was carried out in Sweden. Using data on nutrition and health going back to 1900, over several generations of people, in a fairly isolated part of Sweden, the study found that the risk that was accrued to young men and women in the early 1900s was expressed in at least two subsequent generations, irrespective of the experience of the people in those generations. The geneticists say that there is now good evidence that you can modify the activity of your genes in ways that can be passed on to subsequent generations.

It is leading-edge research, but we know too that some epigenetic changes can be reversed easily. That is work in progress, but it underlines the fact that there is no magic bullet; there is a complex biological consequence of adversity that gets handed on in a cycle from one generation to the next. However, the jury is still out on that as far as Scotland is concerned.

Bob Doris: As I have heard more information about the early years collaborative, I have been thinking that, going beyond that, the issue is a societal one that is about people investing in and being in control of their futures. Using wider role funding, a local housing association, the North Glasgow Housing Association, has appointed a full-time sports and activities co-ordinator who is starting to make a significant local impact. The association sees itself as a core investor in its community. Will such organisations be part of the early years collaborative approach? I am keen to get a sense of whether the usual suspects will be involved or whether the approach will be widened out to every stakeholder in communities.

Sir Harry Burns: You are absolutely right. I have seen Glasgow Housing Association and other local housing associations in Glasgow beginning to get significantly involved in the agenda. The critical thing is that it is not about a top-down approach; it is about working with people to develop new sets of opportunities or insights and to give them some control over their environments. We very much want housing associations and anyone else who feels that they have a role to play to be involved in the agenda, and we would actively encourage it.

Bob Doris: Are such organisations being actively encouraged as part of the early years collaborative? How is that work being taken forward?

Derek Feeley: One way in which the collaborative works is that it gives control over the changes to the people in the localities. We do not tell them what to do; we give them a range of options that they can follow, and that menu certainly has options around physical activity.

The other bit of comfort that I can give you—Harry Burns alluded to this—is that we are considering how best to bring some of that approach to physical activity. A bit of that work will be explicitly connected to the early years collaborative. Another bit, we will probably want to do separately, because everybody benefits from physical activity, not just children. However, we would want to do that work in a connected way, so even if organisations are not formally part of the early years collaborative, there is no reason why they should not be part of a broader physical activity collaborative in due course.

The Convener: On behalf of the committee, I thank both our witnesses for their evidence. We look forward to examining it and to working with you again in future.

11:35

Meeting suspended.

11:41

On resuming—

Teenage Pregnancy Inquiry

The Convener: Agenda item 2 is our first evidence-taking session in our inquiry into teenage pregnancy. It might be useful if we begin by introducing ourselves.

I am the MSP for Greenock and Inverclyde, and the convener of the Health and Sport Committee.

Nicky Coia (NHS Greater Glasgow and Clyde): I am the principal health improvement officer for sexual health with NHS Greater Glasgow and Clyde.

Bob Doris: I am an MSP for Glasgow, and the deputy convener of the committee.

Ann Eriksen (NHS Tayside): I am the executive lead for sexual health and blood-borne virus with NHS Tayside.

Gil Paterson: I am the MSP for Clydebank and Milngavie.

Gareth Brown (Scottish Government): I lead the blood, organ donation and sexual health team in the Scottish Government.

Dr Simpson: I am an MSP for Mid Scotland and Fife.

Felicity Sung (Scottish Government): I am the sexual health and HIV national co-ordinator at the Scottish Government.

Drew Smith: I am an MSP for Glasgow.

Mark McDonald: I am an MSP for North East Scotland.

Dr Maggie Watts (NHS Ayrshire and Arran): I am a consultant in public health medicine with NHS Ayrshire and Arran, for which I am the sexual health lead.

Aileen McLeod: I am an MSP for South Scotland.

Dr Lorna Watson (NHS Fife): I am a consultant in public health medicine with NHS Fife, and I lead on sexual health strategy.

Nanette Milne: I am an MSP for North East Scotland.

David Torrance (Kirkcaldy) (SNP): I am the MSP for the Kirkcaldy constituency.

The Convener: Before we move to our first question, I note that I will give priority to our guests when it comes to speaking today. I think that the MSPs understand that; we are trying to encourage witnesses to engage in a discussion. If someone says something that you feel that you need to add to or with which you disagree, you may say so. If you do not say so, we will assume that you agree with the comments.

David Torrance will ask the first question.

David Torrance: I represent Kirkcaldy constituency, which has the highest teenage pregnancy rate in Europe, even though we have education in schools, partnership working between Fife Council and NHS Fife, drop-in centres, community pharmacies, an active third sector—with organisations such as Kirkcaldy teens, the YWCA and the YMCA—and community halls.

What evidence is there of planned teenage pregnancy, and what factors play a part?

11:45

Dr Watson: I cover the Fife area, so I will start. We are particularly concerned that the recent statistics for Scotland show that the rates in Fife are higher than those in other health board areas.

Teenage pregnancy covers a spectrum of circumstances. We are aware that some young people decide that they want a pregnancy at a young age. Some of the issues behind that are to do with self-esteem and the degree of respect that is afforded in their relationships and community. It might reflect a lack of aspiration or of job opportunities.

That illustrates that teenage pregnancy is a complex issue to unpick. Many young people did not think that it would happen to them and the pregnancy is in no way intended or planned, but we certainly come across young people who say that it is what they want. When we are aware of that, we work with the young people and with the local services on the ground to consider their needs and to understand their situation. We perhaps try to explain to young people that there are a lot of wider factors to consider before planning a pregnancy, such as the circumstances into which the child will be born, whether their relationship is stable, whether they can build a stable home for a family and whether they are mature enough to cope.

That answer brings out a number of the complexities. I am sure that my colleagues will be able to expand on it.

Ann Eriksen: I agree with the point about the complexity of the issues. NHS Tayside covers Dundee, which has historically had some of the highest rates of teenage pregnancy. That prompted us to carry out local research to get a better understanding of young women's circumstances and to find out whether pregnancies are planned or unplanned, the extent to which they are unplanned and how ambivalent young women are about being pregnant.

The research—which was carried out fairly recently, in 2011—showed that, for the young women who said that they wanted to be pregnant and wanted a baby, it was very much about looking for love and affection and looking for someone whom they could love unconditionally and who would love them in return. Another reason was to do with gaining recognition and status in their family and the community. Some young women might not see educational attainment or employment as providing that status, so it almost seems that having a baby means being recognised as moving into adulthood.

Another factor that came up in our research, and which comes through in the wider evidence as one of the strongest predictors of whether someone will be a young mum, is whether their mum had them when she was young. There are issues to do with the patterns in communities and families.

A final theme that emerged was that some young women hope that they will be able to get their own accommodation and so be able to move out of the family home. That was interesting, because the point had been raised for a number of years but the professionals had not felt that it was a factor. However, the young women raised the issue and clearly had that perception.

Nicky Coia: Mr Torrance's question was about the extent to which teenage pregnancies are unplanned. The core issues in planned teenage pregnancies have been well articulated, but our sense from the research evidence base, and particularly from the abortion rate in teenagers, is that most teenage pregnancies are unplanned. We have heard about the issues and caveats to do with planned pregnancies, but our sense is that most teenage pregnancies in Scotland are unplanned.

Ann Eriksen: I very much echo what Nicky Coia says. That the vast majority of teenage pregnancies are unplanned was certainly borne out in the local research in Dundee. However, the factors that influenced decision making were quite different in the group of young women who expressed a desire to have a baby.

Felicity Sung: That is sometimes why we use terminology such as "unintended". The word "unplanned" indicates a real sense of what a person wants to do and the reasons why. A baby or a pregnancy may not be intended, but it might not be unintended. That links to some of the complexities around fatalism and to issues around aspiration, education and giving young people, including young women, a reason to delay parenthood. It is sometimes helpful to think about the word "unintended" rather than the words "planned" or "unplanned".

The Convener: I do not get a sense that that research told you much that you did not already know, perhaps other than about the driver of setting up accommodation. When the strategy was outlined and targets were set, there would have been a similar understanding. What has happened or not happened in the time since then that has resulted in the targets not being met and the lack of progress on the matter? That is what has brought about the committee's attention to it and the inquiry.

Gareth Brown: From the Government's perspective, it is true that we did not meet the target that we set, but we missed it by 0.3 per cent, I think. The area is still challenging, but it is important to recognise that there have been signs of progress. The official ISD Scotland statistics that are produced annually show that teenage pregnancy rates in under-18s and under-20s have gone down consistently over the past four or five years; indeed, I think that they are now at their lowest levels since 1994. That is not a reason for complacency—we still need to do work—but there are signs of progress.

I think that that situation reflects the fact that we launched the first Scottish full strategy on sexual health and teenage pregnancy back in 2005 and we have kept up the momentum. We have maintained funding and messages to our local partners about the importance of education in schools and access to sexual health clinics. There has been consistent investment in resources and activity, and we are starting to see a downward trend. That is not to say that we have solved the problem, but I would hate to leave people with the impression that there has been no progress, because there has certainly been some progress.

Ann Eriksen: We commissioned the local research essentially because, at that stage, the data from ISD Scotland suggested that teenage pregnancy rates in Dundee were double the national rate. It was important for us to understand whether the factors that we know about from the international and national evidence were at play in Dundee or whether there was something more significant than that. The local research confirmed that Dundee was not particularly different, although there are probably stronger factors relating to social and community norms around early parenthood.

A significant amount of work has been carried out locally on the basis of the national strategy, and I can certainly say from local data in Tayside, and Dundee in particular, that there was a 50 per cent reduction in all teenage conceptions in Dundee in the past five years to the end of 2012. It is absolutely right to say that we should not be complacent, but it would be wrong to arrive at the conclusion that no progress has been made. The

same may well be the case in other parts of Scotland where there are more up-to-date data.

The Convener: It may have been how I asked it, but I do not think that there was any implication in my question that no progress has been made. I think that the committee understands that progress has been made in the under-18 and under-20 age groups, but we would like to have a practical understanding of how that has been delivered on the ground.

We also want to know why, according to the figures that we have, there has been little or no progress in the younger age group. I am sure that when we get further into the discussion we will talk about the variation across Scotland and how we can tackle it. Do we need to shift our priorities?

Gareth Brown: I will make a couple of observations in response to your question about the under-16s; other witnesses are more knowledgeable than I am and might say more.

The pregnancy rate in under-16s has been consistent and has been fluctuating around the same figure. In a Scottish context, we are talking about a very small number—we might be talking about 600 cases a year—and, given that cases are widely dispersed around the country, there are very small numbers in local areas. That is not to say that we cannot do anything about the issue. People who conceive at such a young age will have particular needs and be in particular circumstances.

I am not aware that anyone internationally has cracked the issue of pregnancy in the very young. The issue is difficult to get into. In some ways it relates to what you heard in the previous evidence session about intergenerational issues, deprivation and complex needs. You are right to say that the rate has not significantly improved, but we must bear in mind the context of the numbers being very small and the complexity of tackling the issue.

The Convener: The figure equates to about 3,000 babies over a parliamentary session. Harry Burns talked about the challenge that is presented by very young mothers.

Gareth Brown: Something that is often missed is that the ISD figures on teenage pregnancy include conceptions that result in termination, so they do not necessarily reflect the number of births.

Dr Watson: On the challenge of making progress, we know that the areas in which the rate is particularly high are often the ones with the socioeconomic inequalities that the committee has been discussing.

There are also cultural factors. We find that in some areas it is quite the accepted norm that someone will have a baby when they are young. The perception in the environment is, “Well, I did it, so it’s okay.” We need to realise that, if that is the attitude, things will not change. Therefore, we have to challenge some of the cultural norms and acceptance around the issue. It is very much about working with parents and carers to support them to have the right kind of conversations with young people, when they are at the right age. Not everybody feels competent to do that.

It is important to support people in the environment—parents, carers, school staff and youth workers—so that young people can engage in positive activities, have positive aspirations and feel empowered to make choices in their lives, rather than feel that having a baby is the norm and the accepted way to behave in their community. There are issues to do with activities and perceived boundaries in the areas where young people are growing up. It is about more than sex and sexual health services. What do we do before the young people get to that stage?

We need to look at the context of the relationships that young people make. Are they respectful relationships? We hear worrying stories about a lack of respect between girls and boys in some communities. We also hear about access to pornography and about a worrying use of social media and electronic devices. People might think that some boundaries are old-fashioned, but there is an issue to do with the values that we are transmitting to young people. We might be talking about a small minority of young people, but we need to think carefully about how we got into this situation and how we can tackle cultural issues.

12:00

Felicity Sung: I agree with Lorna Watson. There is really good evidence on the importance of talking, not just about sex and sexual relationships but generally, as part of the relationship between a parent or carer and a child from a very young age. Evidence from the healthy respect demonstration project shows that, if there is such connectedness between a parent or carer and a young person, those conversations help to set up the boundaries that were mentioned. That can help to support the young person to delay forming a sexual relationship, to be strong and to have relationships that are based on mutual respect and so on. It can really help them in terms of delaying parenthood.

Nicky Coia: On the attitudes that we heard about in some communities where there is a more positive or more enabling attitude towards childbirth in the teenage years, there is a job to do to skill up a range of workers, including youth workers and other practitioners on the ground, to be able to frame a different set of options for young people in a way that does not come across as judgmental. Sometimes, the risk that they will

come across as judgmental is a barrier for staff. Communication should be framed in the context of wanting better for the young person, with people saying "I want more for you, and I want you to want more for yourself." That ties into the point about aspirations.

The Convener: The respect issue was understood when we developed the strategy but, a number of years on, the outcome for the group that we are discussing has not been successful. The committee is looking for some ideas and for your experiences, which might influence our recommendations. What have you learned?

I am going to bring in Mark McDonald, but others will get an opportunity to respond.

Mark McDonald: There is a double-edged sword. Obviously, we want to reduce instances of underage pregnancy. There are instances in which people are over the age of sexual consent—they may be in a stable relationship—and a pregnancy occurs, and there are instances in that age group in which unplanned pregnancies occur.

My focus is more on those who are under 16, who are at much more risk due to social issues as a result of a pregnancy, be it planned or unplanned. The difficulty is that, if there is a stigma around that, such individuals will be more likely to disengage from services or from social groups. If we accept that, no matter how much success we have with the message, there will still be people out there having sex, how do we ensure that that does not translate into unplanned teenage pregnancies?

When a teenage pregnancy occurs, whether it is planned or unplanned, how do we ensure that the appropriate support is in place for the individual? I was 28 when we had our first child and it was a terrifying experience. I cannot begin to imagine what it would have been like if we had been half that age. How do we ensure that people get appropriate access to antenatal support, for example? They might find themselves alone in a room with couples in their 30s who are having children.

How do we ensure that the stigma that is attached to teenage pregnancy does not lead to people disengaging while, at the same time, doing all that we can to prevent teenage pregnancy from occurring? That is a difficult balancing act, but I would be interested to hear the witnesses' views on it.

Gareth Brown: I will respond to a couple of your points. There are a few things that we have promoted and pushed since "Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health" was produced. If young people are having sex, how do we ensure that that does not turn into a pregnancy? We ensure that good-quality sexual health services are available to all young people at or near schools. We provide good access to condoms and contraceptives, which means that people in that situation can use contraception if they need to.

You are absolutely right to say that it is important that people get support when they end up pregnant, particularly if they are younger. A relatively recent development that might bring a lot to that is the family nurse partnership, which works with particularly vulnerable young people. There is evidence that the partnership might be able to increase the time between pregnancies, which can allow those who are working with young people to have an impact on their lives. Others might know more about that than I do, but it is clear that it gives tailored and intensive support to the young people who need it most.

Felicity Sung: As Gareth Brown has said, we have done good work through high-quality services and the provision of longer-acting, reversible contraception, which, for young women in particular, can mean implants. That kind of contraception lasts for about three years and, although it does not protect young women against sexually transmitted infections, it protects them against unintended pregnancy. That is something else that we have been working on to help young people prevent such things from happening.

Ann Eriksen: On the question of gaining a practical understanding of what we need to deliver and how we deliver it on the ground, we began by explaining some of the complex factors that influence teenage pregnancy. We must acknowledge that there is no one thing that we should be doing and that we need a range of interventions of the scale that is required to influence change.

I absolutely support people's comments about the importance of young people making informed decisions, of consistent and high-quality sex and relationships education that builds young people's skills, communication and confidence and of young people being able to access sexual health services, particularly contraception. Undoubtedly, more effective contraception has had an impact on reducing teenage pregnancy, but we need to couple such things with interventions in the earliest years of childhood, such as the early years collaborative, which Harry Burns mentioned in the previous evidence session, and the really important intensive support that is provided through programmes such as the family nurse partnership, which right from the beginning builds young people's resilience and aspirations.

I should also highlight our work with adolescent and preadolescent young people on building their aspirations, expectations for themselves and self-efficacy. The encouraging evidence in that respect

concerns the experiences that young people are having—instead of being told things, they are getting opportunities to volunteer, to buddy, to be peer educators and to get involved in their own communities. That offers some protection not just against teenage pregnancy but with regard to many of the outcomes that we are trying to improve for children and young people.

All that needs to be coupled with the competent workforce that Nicky Coia mentioned of youth workers and teachers who are really confident in delivering meaningful and relevant education in our schoolrooms and way beyond that in the school context. There also needs to be a strong partnership with local authorities, the health service and the third sector and a commitment to working together to tackle the issues with evidence-based approaches.

The most important issue is how we work with communities. Instead of doing things to people, we should take the kind of asset-based approaches that Harry Burns talked about and work alongside communities and particularly young people to identify approaches, share the evidence that we have as professionals, help communities share their experiences and then look to develop shared solutions that are more meaningful to people's lives and communities. We have done that for the past two or three years in communities in Tayside with the highest teenage pregnancy rates, and the tremendously innovative response that we have had from young people and the community in general has been very heartening and certainly much better than we could have expected.

That is resulting in changes in how we deliver sex and relationships education in the classroom. We have peer educators who want to go out and work in communities. The issue is how we work with communities. The focus is very much on improving outcomes for children and young people.

Before the meeting, we were discussing things in the coffee room—as you do—and most of us felt that it was important to get it across that, although the focus has very much been on sex and sexual health services, the focus and responsibility for teenage pregnancy should be much broader. That is about the leverage to change young people's life circumstances. That is why we welcome the shift in the framework to give leadership on teenage pregnancy to local authorities, because they have more influence.

Nicky Coia: I will pick up on the different contributions to addressing teenage pregnancy that various partners can make. Ann Eriksen talked about sexual health. I guess that Scotland has been on a journey in the past 10 years. We have had the respect and responsibility strategy, which focused on ensuring that we had good-quality sexual health and relationships education in schools throughout Scotland, which we hope was reinforced by parents and sexual health services. Scotland needed to address that because we were not in that position 10 years ago. The strategy very much enabled that work to happen.

It is interesting that, simultaneously, an additional financial allocation was given to local authorities through Learning and Teaching Scotland to enable teacher training. A range of things happened in 2005 and 2006, after which the downward trend in teenage pregnancy rates in Scotland started to kick in. I do not think that that was an accident.

As for where we are now, we need to keep the solid foundation that we have built in sexual health, as Ann Eriksen said. We cannot let that go. However, we now need to do wider work. At the risk of repeating what everybody else has said, I refer to the early years work and the work on teenage transitions. That relates to what shows up in research evidence as youth development approaches and is very much about taking young people's talents and natural interests and getting them to apply those in a voluntary capacity and so on.

The next challenge for us is the issue of smaller neighbourhoods. We have looked at things on an NHS board basis and a local authority basis. We now need to get underneath the figures and look at smaller neighbourhoods where the rates are particularly high. We need to do some very focused work. I guarantee that there are workers in every area who, if they were told, "These are the indicators that tell you which young people are at risk of teenage pregnancy," could tell us who those young people were. We need to skill those workers up to put in place the right interventions.

Dr Watson: I will go back to what Mark McDonald said about stigma and the concern that young people might be put off accessing services such as antenatal services. We are quite aware of that. When young people give birth and become parents, that should be seen as a positive event and they should be supported to parent their child and have that child grow up with a positive future. We are very aware of the need to support young people who come through in that situation.

With respect to antenatal services, as we have heard, the family nurse partnership has been introduced for teenage parents. That is great but, before that, vulnerable young people in the under-16 group are identified by midwifery staff and generally have some form of enhanced antenatal care in which there is more one-to-one support that looks more broadly at the aspects of vulnerability in the young people's lives.

If young people are offered antenatal classes, they might be with other young people who are in similar circumstances. As Mark McDonald said, it may well not work for them to be in with a bunch of people in their 30s. There must also be a targeted approach through antenatal services and the antenatal inequalities framework.

12:15

We are very conscious that people who are pregnant have different needs, and the under-16s are definitely part of that. Some of the coexistent issues may be domestic abuse, substance or alcohol misuse, learning disability or borderline learning disability. The issue is not always age alone; we have to consider the circumstances of young people—or, indeed, people of any age—who require maternity care.

We need to consider carefully the level of support. That ties into inquiries such as the confidential inquiry into maternal deaths. We know that vulnerable young people or those who are in complex social circumstances are more likely to experience adverse outcomes.

Our antenatal services and the antenatal and postnatal support services will be very much enhanced by the family nurse partnership. However, enhanced support for vulnerable people in such circumstances predates that.

I will make one point on prevention. Accessible drop-in services for young people are important. They are not usually just about sexual health. Young people can go to such services for advice on smoking, mental health issues or other concerns. In most cases, the advice that a drop-in service or a school nurse offers is not solely about sexual health.

Great efforts are made so that such services are accessible and confidential and so that, as far as possible, young people can go to them without feeling that a stigma is attached. Young people must be engaged in those services to ensure that they meet their needs and perceptions.

Dr Watts: I will pick up on what Lorna Watson said about the next steps beyond pregnancy. We have a difficulty with what to do with a young person under 16 who has a baby. The child's parents do not quite know what to do or how to normalise the situation. The school certainly does not know what to do, how to normalise it or how to get such children back into education. We know that their outcomes will be much better if they can return to education and consider a more positive prospect.

Sexual health must be viewed not in isolation but alongside other risk-taking behaviours, such as using alcohol, experimenting with drugs and pushing the boundaries. We know that one important element in that is how parents respond to such behaviour, how they manage their children and how the rest of society manages those children.

We need to ensure that the links are made with other agencies that address alcohol and drugs issues, for example. In our area, we have a strong link between sexual health services and the alcohol and drug partnerships to try to move things forward.

I am conscious that, in Ayrshire and Arran, we have quite high levels of under-16 pregnancy. We have a strong deprivation gradient, which is another element that we are trying hard to consider. Our concern is that socioeconomic circumstances are such that the situation may get worse before it gets better.

Teenage pregnancy is not an issue for sexual health services or the health service alone. There is a strong need to try to engage and work with partners who, for a variety of reasons, do not want to be engaged. In Ayrshire, we certainly still have issues to overcome in that.

Bob Doris: I point out to Dr Watts that I did not set her up for my next question, which links in well to what she said. That was unintended.

Ann Eriksen mentioned the link between teenage pregnancy and whether the girl's mother had a child at a young age. I imagine that the support that the witnesses give very young mums who are having their first child will determine how their children will be 13 or 14 years down the line, so we must always look at the medium to long term.

Yesterday, the committee visited Smithycroft secondary school in Glasgow, where young mums from across the city, who can choose to be supported in their own secondary schools, have the option of continuing their education with much wider societal support that is linked with a variety of age groups. Having spoken to individuals involved in the project, I understand that the initial evidence suggests that the likelihood of multiple pregnancies among those young mothers—of them going on to have a second or third child—is reduced, which should be a positive outcome for them.

The hope is that, within a few years, those young mothers will have formed a positive relationship with their children. When we met them yesterday, they were fantastic. They are obviously forming wonderful relationships with their children, so the likelihood that their children will flourish and that the young mothers will not have further unplanned teenage pregnancies should be higher.

I see from the nodding heads that the witnesses are likely to say that that is the kind of project that we need. Rather than just have an affirmation that such support is a good thing, it would be more useful to the committee to know about the prevalence of such quality support across the country. How do we ensure that we reach all parts of the country where that is clearly needed?

Dr Watts: Such support is not that common, although city areas find it easier to provide than rural areas do. We need to ensure that the support is not simply a project but that it is sustained. Whatever we do has to be something that can continue and is not just a one-off. We cannot just say, "We will try this; it might work and, if it does, we will think about whether we should put money into that or into something else."

We need a service that we can continue to provide. I imagine that people are trying to build that kind of sustainable service into education. We would encourage that, so that we have control through secondary preventions to ensure that there is good family spacing and sufficient support—with sufficient support from the community as well—for each individual child.

Dr Watson: In Fife, we have a young mothers initiative with a specific worker who supports those who are still in education so that they can remain in education and stay engaged. That brings in quite a wide range of supportive elements.

There might be more concern when people have left school or are disengaged from school, because it is then a little bit harder to provide the setting in which all the supports can be put in place. If the conception happens just before the young person turns 16, quite often she will leave school and the school may not be aware that the pregnancy has occurred. When the people in the school see the statistics, they may come back to us to say that they were aware of only one or two pregnancies, whereas in fact the numbers were greater. When people are still in education, the support can be easier to co-ordinate.

Gareth Brown: From the Government's perspective, we are always interested in the evidence and in anything that works, so the sort of project that Bob Doris mentioned sounds really good.

Under "The Sexual Health and Blood Borne Virus Framework 2011-15", which we published in 2011, we are trying to move away from telling local authorities and NHS boards exactly what to do and, instead, to guide them on what we want to achieve. Rather than say that something will necessarily work all the time, we should try to avoid taking something that works in one area and just plugging it into another area. As has been mentioned, local authorities, NHS boards and communities need to decide what works locally and investigate that.

We have tried very much to make the funding that supports the sexual health and BBV framework flexible and to make its outcomes high level so that people locally can innovate—it is almost a case of liberate to innovate—and so that they are given the opportunity to find out what works. If projects that work are now percolating through, we want to learn from them and see whether they can work elsewhere. It is not automatic that, for example, something that works in an urban area will work in a rural area, but I am sure that we can always learn things from such projects.

Nicky Coia: I would like to say something about the funding of a resource such as that in Glasgow, which was a very hard-won service to deliver. It is not funded directly through sexual health moneys. It is quite difficult politically to achieve funding for such a service because teenage pregnancy is seen, particularly at a local authority level, as sexual health business. Trying to contextualise such a service beyond sexual health to attract funding can be really challenging.

That illustrates my belief that local authorities have a central role in addressing teenage pregnancy. Going forward, it would be useful to have much clearer guidance and direction for local authorities about what that means for them in their community planning structures and children's services structures, with regard to the stuff that is not necessarily about sexual health but about wider sets of issues. Although it is clear in the framework that local authorities are the lead for the issue of teenage pregnancy, my experience of working with colleagues in local authorities is that, when faced with such a requirement, their next question is, "Okay, what next?"

The committee has heard what a complex issue teenage pregnancy is, so making sense of it and turning that into practical, tangible action is challenging. I therefore think that there is a place for clearer guidance for local authorities and particularly for community planning partnerships on their respective contributions to the agenda.

The Convener: It is interesting following the earlier evidence session with this one, in which we are hearing about things being the council's job.

The interaction of services is a point that we have picked up in the past couple of days, having had the benefit of visiting Smithycroft secondary school as well as hearing the evidence in the earlier session. It would be interesting to develop that point with regard to shared information—you mentioned earlier that not all services will be aware of teenage pregnancies. We picked up the

point about midwifery services and how they connect, as well as, obviously, education services.

It was suggested earlier that we need a strong and wide range of quality interventions. However, there is the question of access. I suggest that that is perhaps a job for the Scottish Government and that perhaps it should at least identify where best practice is. Local autonomy in this area is a virtue, given what we have heard. Is there evidence in the witnesses' networks that there is good access right across the board to, for example, the people involved in midwifery services, education and the health service? Are they working together effectively to create the interventions that we want? What are the barriers to your doing a better job and delivering in this area? We have Scottish Government officials present, so let them take some messages back.

Dr Watts: It depends on whether we start out at the level of primary prevention or the level of identifying a young person who has fallen pregnant. We can split it into those levels. If it is about the primary prevention work, then it is quite difficult to demonstrate that we have an issue that needs to be addressed collaboratively. That is because of the small numbers and high variability involved in the case of under-16s who become pregnant.

The actions that we have taken around, for example, family nurse partnerships and moving into some of the asset-based approaches are starting to develop a momentum and to build success. However, we are also aware that young people, particularly the under-16s, are much more likely to conceal a pregnancy and present late. They might not even realise that they are pregnant until they go into labour.

We would love to encourage early access and early antenatal care, but that is not practicable for a number of these children, who do not identify that they have an issue that they need to deal with or who have other issues in terms of family disruption, their relationship with their boyfriend or the lack of one, or substances that they use. Those elements also come into play.

The Convener: It is really complex.

Dr Watts: If it were simple, we would have solved it.

The Convener: Yes. We are getting the message today that all these problems are really difficult. I think that that is why we are having an inquiry.

12:30

Ann Eriksen: Although we welcome the local authorities' transition and leadership role, it is extremely important that this has always been a partnership. It is a partnership of local authorities, health, the voluntary sector and the communities, and that will always remain the case. Health has a fundamental role in not just delivering services, but ensuring that we share the evidence on what works and the epidemiological data that we hold.

In Tayside we have worked very hard. I believe that the committee is coming to Dundee next week to gather evidence. We have good, strong partnerships with community planning in all three council areas and that is no different for sexual health and teenage pregnancy. We invested quite a lot of time in setting out why teenage pregnancy matters and is relevant. In doing that, it was quite important not just to concentrate on under-16s. As a number of people have said, the number of under-16s who get pregnant is quite small and it can seem quite a marginal issue to council colleagues who deal with issues that affect much larger populations. We invested a lot of time in setting out why the issue matters, why it is relevant and what we can all do together to make a difference. Embedding that in the work around getting it right for every child and the early years framework has been very important.

Getting the buy-in and strategic leadership at the right level is pretty crucial. Having the ear of the chief executive, the director of education and the director of social work is vital, because they are the people who can make some of this happen locally.

Gareth Brown: You asked about the extent to which those sorts of partnerships are working across the country. We go out under the sexual health and BBV framework and visit each NHS board at least once a year—we finished a series of those visits at the tail end of last year. We invite local authorities and other parties along, as well, so it is not just an NHS board visit. We use those visits to probe just these sorts of issues across the framework and find out how well things are working. It is true that things are working in some areas better than they are in others.

We have to bring back what we find out and facilitate learning between different parts of the country. For example, if the relationship between the health board and the local authority in Tayside is working very well, we can try to export that to other parts of the country. We have very good networks with all the executive leads, who meet regularly and who can share that sort of experience.

However, it is a challenge, because local authorities think that teenage pregnancy is a health issue. From my perspective, a lot of things that could contribute to a reduction in teenage pregnancy are things that local authorities do or should be doing anyway, but if you put a teenage pregnancy badge on it, local authorities get a bit

nervous. The issue is about deprivation and aspiration—all the things that local authorities do, and do well. We just need to have that sort of conversation with them at the right level, which can be difficult.

The Convener: It would seem that the variance might come down to some of the political skills. You have described the process that you have to go through to get buy-in from a local authority: you have to have a good relationship with the chief executive and win the argument with them. That process is hardly free flowing and it is down to the skills of individuals.

Dr Simpson: Partnership is obviously very important. The multi-agency resource service and the child protection network have merged into WithScotland, which is an academic unit that draws together research and best practice on child protection, and helps to channel that back out. If you like, it is an organised, centralised unit that supports progress in that field. Do we have the same thing in the sexual health field? Sexual health is not dissimilar to child protection, except that, as you said, sexual health is seen as more of a health issue than a social work issue whereas MARS and child protection were very much a social work thing. There was quite a lot of work involved in getting health engaged with child protection.

Do we have good analysis and promotion of research evidence? Do we do toolkits in the same way as WithScotland does? How do we reward success? If a project works in an area and achieves despite funding difficulties and all the rest of it, as Nicky Coia said, how do we reward that? Is that a central function or do we leave it to local authorities to continue to battle away? Do we say, "That's great—we'll now put 20 or 30 per cent of the funding into that, because it's working," and send a signal to everybody else that they need to follow that project?

Gareth Brown: There was a lot in what you said. I am not aware that we have a formal hub, such as the one that you described, but good research activity is going on in Scotland and across the UK. We have good links with good, respected academics who we can draw from and share. We have regular meetings with people in networks across Scotland and we can share information well.

There are toolkits, such as the reducing teenage pregnancy toolkit, but I sense that you are asking whether there is a concentrated hub where all the activity can take place and be considered and where what has worked in areas can be considered. Perhaps we need to formalise that a bit more; we have relied on networks and having conversations.

We are still developing the sexual health and BBV framework, which was launched in 2011. We have only just finished the first series of visits, and perhaps we need to learn how we take the evidence more formally into a mechanism that will evangelise about what works. If the Parliament recommends that, we will be happy to look at that.

The Convener: No one else wants to respond to Richard Simpson—we were satisfied by the response—and no other committee members want to ask a question.

We had a pre-meeting and the witnesses had a coffee meeting. The subject is important and we appreciate you coming along. You might have wanted to put on the record issues that have not been covered; if so, I give you the opportunity to do that now. We are also happy to have further representations through emails or letters. We encourage you to follow our inquiry and, given your specialist interest, we would appreciate your observations on other evidence that is given.

I give you the opportunity to put on the record any issues that you feel that we have not covered.

Nicky Coia: The committee has covered pretty much everything that I wanted to say. In summary, teenage pregnancy is not just a sexual health issue; it is about deprivation. There is no magic bullet and to deal with the issue we need complex, multifaceted interventions, which must happen in partnership. If the inquiry's outcome was clear guidance on that to sets of stakeholders in various sectors, I would welcome that.

Ann Eriksen: I very much support what Nicky Coia said. I will return to the issue that we just left. It would help to think about research in the Scottish context on what works and not just about capturing what appears to be working locally and disseminating that better than before—lead executives have recently looked at that in relation to the framework more broadly. Understanding our population's needs is crucial. That concerns research and supporting nationally the quality evaluation that would be needed for that.

The Convener: The witnesses should not feel pressure to speak if they do not have issues to raise.

Dr Watson: I do not think that we have mentioned looked-after children, who are one of the groups that are at risk. We have been keen to engage with social work colleagues and carers in relation to them. There are barriers. For example, we set up a training session for foster carers at a time and in a place that they said would suit them, but I think that one person turned up, and they were already quite clued into the subject. The level of engagement is an issue, as is understanding which groups are at risk and who the key people

to give consistent messages are in relation to the young people.

Another aspect is involvement in training social workers, who are in contact with a lot of the vulnerable young people who might be at higher risk. We have managed to train social workers, but we might go back another year and find that they are too short staffed or that there are too many pressures for them to take that work on. Those are the kind of issues that we come across.

A few years ago, I remember discussing with a headteacher the delivery of education and the importance of work to prevent teenage pregnancy. It was an extremely interesting discussion. The headteacher explained that the young people in the area had no job prospects in the community and that there was a lack of good male role models and a lack of positive alternatives. From his point of view, there were other issues to deal with. He did not think as strongly as we did that good-quality sex and relationships education had a place in that area precisely because of those circumstances and because there were vulnerable young people there.

Dr Watts: I might challenge that, to some extent. If we consider teenage pregnancy as a symptom and not as a condition, that enables us to put it in the wider socioeconomic context and to consider it alongside the behaviours of young people in relation to alcohol and drugs. Is the fact that they behave as they do an intergenerational thing? Is there an epigenetic element, which Harry Burns talked about?

I will put on a different hat and mention foetal alcohol harm. We know that children who are exposed to alcohol in pregnancy are more likely to consume alcohol and to be at greater risk when it comes to teenage pregnancy. That is a different strand. For me, the symptomatology is important.

Gareth Brown: I want to make one final comment that I am sure everyone in the room understands and agrees with, but which it is nonetheless useful to make. Despite all that we have said about teenage pregnancy, a teenage parent is not necessarily a bad parent. We always do what we can not to stigmatise teenage parents in general in such conversations, and I am sure that everyone in the room understands that. Our efforts to reduce teenage pregnancy are not about stigmatising those who find themselves in that situation.

The Convener: I thank you all for your attendance and your help. I encourage you to observe our inquiry and to continue to participate in it, when you feel it necessary to do so.

Witness Expenses

12:44

The Convener: We move on to agenda item 3, which is to ask the committee to delegate authority to me, as convener, to arrange for the Scottish Parliamentary Corporate Body, under rule 12.4.3 of standing orders, to pay any expenses of witnesses in the health inequalities inquiry. Does the committee agree to do that?

Members *indicated agreement.*

The Convener: Item 4 is to ask the committee to delegate authority to me, as convener, to arrange for the SPCB to pay, under rule 12.4.3, any expenses of witnesses in the teenage pregnancy inquiry. Does the committee agree to that?

Members *indicated agreement.*

Petition

Smoking Ban (Review) (PE1451)

12:45

The Convener: Item 5, which is our final item, is to consider the committee's approach to PE1451, by Belinda Cunnison. Members will have read the paper prepared by the clerks. I invite comments from members.

Aileen McLeod: As committee members will be aware, we have received an extra paper in support of PE1451, in the form of a letter from Mr Bill Gibson, who is a constituent of mine. Mr Gibson has asked that I present his evidence to the committee.

By way of background, Mr Gibson is a founding member of Freedom to Choose Scotland and chairman of the International Coalition Against Prohibition. He visited me at my regional office in Dumfries on Friday, when he presented eight years of research on two DVDs, which contained audio and video evidence to support the claims, and substantial written evidence on the health effects of second-hand smoke, which I have also brought to the committee.

The written evidence sets out a lot of comprehensive scientific evidence that Mr Gibson has put together. Freedom to Choose Scotland believes that the evidence shows that ventilation is improving. It contends that advances in ventilation and air cleaning technology and the existence of the European indoor air quality standard EN 13779 relating to ventilation for non-residential buildings justify a review of the smoking prohibition and control provisions of the Smoking, Health and Social Care (Scotland) Act 2005.

Gil Paterson: I have a couple of points to make. I have some experience of ventilation in the automotive industry. I engage daily with hundreds of companies that are involved in protecting their workforce from pollution and breathing in particulates that would damage their health. In my view, there is no ventilation that would—in any shape or form—protect someone in a workplace from smoke.

In the example from the workplace that I am talking about, the person is inside a sealed container. The pieces of apparatus to extract the air cost enormous amounts of money not only to buy in the first place, but to operate efficiently. The only way that an individual can be protected is by providing them with a full mask, but that is not enough, because air must be brought in to pass over the face so that nothing comes in that can be breathed. In the automotive industry they do not spend money for nothing, I assure you.

There is no question but that ventilation systems are improving—I am sure that they improve every day—but, if someone was smoking in a pub or a public place, or a room such as the one that we are in, the smoke must pass you by before it gets out.

That takes us to the other element: passive smoking. We are quite clear that the ban is having a great effect on the public's health and, with regard to passive smoking, people are getting the message that the problem is not only what you do to yourself, but what you do to others. The idea that we would interrupt a good programme at this stage is not a good one. I do not think that this programme should ever be interrupted, at any stage. I do not think that there will come a time when we should lift the smoking ban. I do not think that technology will get to the stage at which people will be able to smoke in a room and, at the same time, people who work in that room will be protected. In a pub situation, employers have a duty of care in relation to their staff. The idea that we would listen to this petition and relax the law at this time is entirely wrong. We would be putting people at work at risk.

Freedom is freedom to do things concerning yourself, not freedom to do things to other people. I would not support the continuation of this petition in any shape or form.

Dr Simpson: I have to leave, convener, but I absolutely support Gil Paterson. I agree that the proposal would be a retrograde step. The ventilation debate was held in 2001. It stopped the legislation coming in earlier, when Kenneth Gibson and I first proposed a ban in 1999. Although ventilation has improved, there is no way that, without a full mask, the suggestion will work. Passive smoking will be dangerous in any case. Proof of that is what led to the act. I do not see that changing. I think that the petition should be closed.

The Convener: One of the strongest points that Gil Paterson made was that, although we might argue about the overall impact on smokers and non-smokers, there has been a hugely positive impact with regard to the exposure to second-hand smoke of bar workers and workers in the hospitality industry. The first principles of health and safety suggest that you would not introduce ventilation but eliminate the hazard. I think that the legislation has eliminated the hazard to those workers, but that is my own opinion.

Does anyone believe that it is necessary to take further action on the petition?

As no one has indicated that they take that view, do we agree to close the petition?

Members *indicated agreement.*

The Convener: That concludes our meeting. Thank you all for your participation and patience.

Meeting closed at 12:53.

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