Health in Scotland 2001

Working together for a healthy, caring Scotland
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LETTER TO THE FIRST MINISTER

Report of the Chief Medical Officer on the state of Scotland’s health for the year ended 31 December 2001.

To Jack McConnell MSP
First Minister

Dear Sir

The background theme to this annual report is “Working Together”. This key theme applies to multidisciplinary teams of health professionals and cross sectoral work across the health service, local authorities and the Executive.

As in past reports this review of health in Scotland during the year 2001 details the double burden of disease facing our country at the start of the 21st century. One element of this challenge is the growing burden of chronic disease. The other is that of new and re-emerging infectious diseases.

Cancer, coronary heart disease and stroke together account for around 60% of all deaths in Scotland every year. They, together with diabetes, are increasingly amenable to both prevention through healthier lifestyle and earlier diagnosis and more successful management by the healthcare system. Patients increasingly look to the services of complex multidisciplinary teams as much as to the skill and commitment of individual clinicians. This report surveys the way in which Scotland’s health professionals are working together through NHSScotland to provide the programmes and care packages to tackle these problems.

The real challenge however is to plan and provide for the future of Scotland’s health, to get upstream of these potential problems by a concerted effort to promote positive health. This demands that the health service works together with partners in local authorities and across the Executive to tackle the underlying causes of poor health. These are well known and include poverty and social exclusion, tobacco, drugs, excessive use of alcohol, poor diet, obesity and lack of exercise. The year 2001 saw a welcome commitment to make a step change in Scotland’s health status and this report sets out the background to this essential programme of investment in Scotland’s future health and wellbeing. We now need a period of sustained, focused action involving individual Scots, their communities and their voluntary and public services working together on health and its determinants.

This report has been produced by and reflects the work of many colleagues in the Scottish Executive Health Department, in the NHS, in the Scottish Medical Schools, the Health Education Board for Scotland, the Scottish Centre for Infection and Environmental Health, the Public Health Institute for Scotland and this year includes contributions from the Directors of Public Health for Highland, Forth Valley and Grampian. They all work together daily for Scotland’s health. My thanks are therefore due to all who have contributed to the preparation of this report and in particular to Dr Elizabeth Stewart and Miss Sandra Campbell, the co-editors and to Miss Sheena Cant, who so patiently and skilfully compiled the text and tables.

Yours faithfully

[Signature]

DR E M ARMSTRONG
Chief Medical Officer
Health Determinants
CHAPTER 1

HEALTH DETERMINANTS

INTRODUCTION: WORKING IN PARTNERSHIP TO IMPROVE THE HEALTH OF SCOTLAND

*Working Together for a Healthy, Caring Scotland* has been the theme of many of the documents published by the Health Department over the past year and is the key message of this Report. The ways in which we are working together in Scotland to deliver better health are woven throughout the Report, highlighted and emphasised in each chapter.

Scotland’s health is crucially important. However, it lags behind other Western European countries and many areas of the rest of the UK. Scotland has the potential to be a much healthier nation. It has been held back by deprivation and inequality on a substantial scale as was highlighted in last year’s report, *Health in Scotland 2000*. Improvements in health have been achieved but have yet to be shared equally by all members of society. Scotland is keeping track with health improvements in the rest of the UK and Western Europe, but to date remains persistently behind. Scotland has not yet achieved the additional health gains necessary to close the gap and catch up with comparable European countries. This requires widespread appreciation of the importance of health to Scotland’s social, cultural and economic well-being, and the expertise, capacity and determination across society to make a difference.

Why Scotland Needs a Step Change in Health

In the autumn of 2001, the Public Health Institute of Scotland (PHIS) produced a report entitled *Chasing the Scottish Effect – why Scotland needs a step change in health if it is to catch up with the rest of the UK and Europe*. The analysis shows that in Scotland life expectancy, although improving, lags behind comparable Nordic countries like Norway, Sweden and Denmark. Figures 1.1a–d males and 1.2a–d females show life expectancy for males and females by year between 1988 and 1998 for Scotland and selected EU countries. It can be seen that:

- Scotland’s life expectancy (with the exception of Portuguese males) is consistently lower than all the other listed EU countries.
- Each country’s life expectancy appears to be on a generally upward trend, with Scotland’s improving at neither the worst nor the best rate. This latter observation is confirmed in Figures 1.3a and b which show the percentage increase in predicted life expectancies for each country for males and females.

It is clear that if Scotland is to catch up with comparable countries in Europe, our life expectancy needs to improve at a faster rate.
Fig. 1.1a Males: Scotland, Belgium, Denmark, Germany, Greece, Spain

Fig. 1.1b Males: Scotland, France, Ireland, Italy, Luxembourg, Netherlands

Fig. 1.1c Males: Scotland, Austria, Portugal, Finland, Sweden
Fig. 1.1d Males: Scotland, Iceland, United Kingdom, Norway, Switzerland

Fig. 1.2a Females: Scotland, Belgium, Denmark, Germany, Greece, Spain

Fig. 1.2b Females: Scotland, France, Ireland, Italy, Luxembourg, Netherlands
Focusing on Priority Health Topics

Health in Scotland 2001

Fig. 1.2c Females: Scotland, Austria, Portugal, Finland, Sweden

Fig. 1.2d Females: Scotland, Iceland, United Kingdom, Norway, Switzerland

Fig. 1.3a Estimated trends in life expectancy: percentage increase between 1988 and 1998 in predicted life expectancy for selected countries (males)
In partnership with others, much of the Public Health Institute of Scotland’s (PHIS) work will concentrate on how this “step change” in health can be achieved. The “step change” concept was also central to the Healthy Scotland Convention in November 2001, where participants collectively identified the actions needed to bring Scotland’s health in line with comparable nations.

The Contribution of NHSScotland

NHSScotland is crucial to success in achieving the necessary step change in health, but cannot alone improve the health of the Scottish people. Healthcare services aim to improve the health of people who are ill and the NHS makes a major contribution to Scotland’s health. For example, there have been important improvements in 5 year survival for a range of cancers. As outlined in Health in Scotland 2000, important health targets for the year 2000 for coronary heart disease and cancer have been met and challenging new targets have been set in the NHS plans for the next few years. But to prevent ill health NHSScotland must embrace a wider role by leading strategic thinking and working in partnership with other agencies across the Executive to deliver services which people need, in accessible forms and which will deliver tangible health gains. That is the challenge.

The Wider Health Challenge: Social and Personal Well-being

The Executive’s role in improving health involves all aspects of its work in partnership with Scottish public and private life. It is bound up in the Executive’s social justice agenda and the ways in which resources are distributed.

Social and Personal Well-being

Health is important for Scotland’s future success. In addition to health care, good health is about social and personal well-being including:

- fulfilled potential in education
- good housing for those in the rented and public/social sectors
- social work services for those who are vulnerable
- the provision of wholesome food and the means to buy and prepare it
- supporting and encouraging individuals to play their part in adopting healthier lifestyles
- the resilience of individuals, groups and families in adversity.
This wider health challenge requires a shared vision, shared strategies and a sense of shared achievement at individual and community level and action to deliver the step change needed to bring Scotland’s health in line with comparable Western European nations.

**Cross Sectoral Working**

In this Report there are many examples of health problems and of the cross-sectoral work in progress to address them, which demonstrate imagination, commitment and partnership in action to deliver health gain. Local authorities, employers and their employees, communities and individuals are initiating sustained and co-ordinated action to improve health. This is as it should be. Enduring partnerships and commitment are needed to deliver long-term health gains in order to secure the step change in Scotland’s health which Scotland’s future deserves.

**Health Determinants - Maximising Scotland’s Health Potential**

Many factors determine health potential. Some of these are specific to individuals, such as genetic background, early life experiences and lifestyles. Some relate to socio-economic circumstances including income, occupation and housing quality and others relate to the general environment. However, the factors that determine health are not evenly distributed within Scottish society. Inequalities in the health of people in Scotland are evident and the poorest members of society are those who experience the worst health.

**Improving Health and Tackling Health Inequalities**

The Executive is committed to improving health and to tackling health inequalities. The Executive’s policy reflects the multiple influences on health and involves a threefold approach:

- influencing lifestyles to promote healthy behaviour and minimise lifestyles that cause ill health
- focusing on priority health topics – including action on coronary heart disease, cancer and mental health especially in the younger and older age groups
- improving life circumstances to influence the wider determinants of health.

The rest of this chapter focuses on Improving Lifestyles. Priority Health Topics are considered in Chapter 2 and Improving Life Circumstances is considered in Chapter 3.

**WORKING IN PARTNERSHIP TO IMPROVE LIFESTYLES**

*Our National Health – a plan for action, a plan for change* recognises that good health means more than the absence of disease. Work is underway to promote healthy lifestyles including action on:

- diet
- physical activity
- obesity
- smoking
- alcohol problems
- drugs.

There is a close relationship between people’s behaviour and their socio-economic circumstances. Many unhealthy lifestyles are commoner in those who are more economically deprived or socially excluded. While improving lifestyles is important to all Scots, particular effort must be made to encourage healthy lifestyles amongst poorer members of society. Diet and smoking are two important lifestyle factors where inequalities relating to deprivation are particularly evident.
Cause of Death
Deaths from cancer, coronary heart disease (CHD) and stroke (Scotland’s Big 3 killing diseases) account for around 60% of all deaths in Scotland every year. Smoking and poor diet are the most significant contributors to Scotland’s poor health.

DIET
The Size of the Problem
The Scottish diet is unhealthy, being high in fat, salt and sugar and low in fruit and vegetables. Diet is an important risk factor for cardiovascular disease, some cancers and diabetes.

Diet and Deprivation
The diet of Scots is poor but the diet of people in deprived communities is worst of all. An indication of the quality of the diet can be obtained from looking at consumption of fresh fruit and vegetables. Figure 1.4 shows the percentage of adults who eat fresh fruit once a day or more.

Fig. 1.4 Percentage of adults aged 16–64 years eating fresh fruit once a day or more by deprivation quintile

As deprivation increases, the percentage of adults regularly eating fresh fruit decreases. The figure also shows the changes between 1995 and 1998. Since 1995, the percentage of the population regularly eating fresh fruit has increased indicating that diet overall is improving. However, it has increased more in those from the least deprived areas than in those from the most deprived areas.

A significant gap continues to exist between the dietary status of those from low and high income communities. For these reasons, improving diet continues to be a high priority for the Scottish Executive, with a particular focus on deprived communities and children.

Strategic Direction
Health in Scotland 2001

Targets
The dietary targets for 2005, set in the Diet Action Plan, recommend:

- doubling the consumption of fruit and vegetables
- reducing the consumption of total fat and saturated fat by over 5%
- doubling the consumption of oily fish.

Progress is being made but further efforts are required in order to meet these targets.

Implementation
Many initiatives are underway at national and local level, including: the Scottish Community Diet Project, the Scottish Healthy Choices Award Scheme and a pilot Focus on Food project. These and others are described below.

Action on Deprivation: Working with low income communities to improve diet
The Scottish Community Diet Project specifically works with low income communities to improve diet. This Project was awarded the BBC Derek Cooper Award in 2000 for its contribution towards improving diet across Great Britain. Part of the Project’s work involves a small grant scheme, which supports the establishment and development of Community Food Initiatives. During 2001, funding for this grant scheme has been increased in line with the commitment given in “Our National Health” to increase support to the Project to allow it to help at least 50% more projects from 2001–2.

Healthier Food Choices
The Scottish Healthy Choices Award Scheme aims to change dietary habits in Scotland. Support for the scheme has been extended for the next 3 years, and increased to over £100,000 per annum. This will allow the Scheme to meet increasing demand and develop as a successful mechanism within the wider national efforts to change dietary habits in Scotland. The Health Education Board for Scotland (HEBS) continues to promote the Scottish Healthy Choices Award Scheme, which has been shown to have had a positive effect on the consumption of healthier food choices in a range of settings across Scotland.
Working in Partnership to Improve School Food

The Ministers for Health, Education and Social Justice have recently announced a joint initiative to improve food in schools. This involves the establishment of an Expert Panel to:

- devise national nutritional standards
- improve the appeal of school meals
- minimise social stigma associated with taking free school meals
- maximise the uptake of free school meals.

This announcement was made in conjunction with the publication of the Scottish Consumer Council Food in Schools Conference report. The Conference, which took place in May 2001, specifically aimed to identify barriers to providing healthy eating choices in schools and proposed practical action to overcome these. The Conference, which was organised by the Scottish Consumer Council, the Food Standards Agency (FSA), HEBS, and the Scottish Executive Health and Education Departments, took a whole school approach towards healthy eating in schools. The report outlined a range of practical actions that could be taken forward at all levels in order to improve healthy eating within schools.

Scottish Food and Health Co-ordinator

A welcome development in July 2001 was the appointment of the Scottish Food and Health Co-ordinator. The appointment gives further momentum to implementation of the Diet Action Plan and pulls together the various strands of dietary work being taken forward at national level. Work is focused on developing and co-ordinating the national contribution of:

- primary producers
- manufacturers
- caterers and
- major retailers.

Food and Health Vocational Training Course

Work is underway to develop and deliver a “Food and Health” vocational training course in partnership with the Royal Environmental Health Institute of Scotland (REHIS), the Health Education Board for Scotland (HEBS), the Food Standards Agency Scotland (FSAS), the Scottish Community Diet Project (SCDP) and Scottish Healthy Choices Award Scheme (SHCAS). Together they plan to develop and launch an Elementary level qualification in 2002, and then consider the need for Intermediate and Advanced level qualifications.

The aim of the “Food and Health” course is to provide basic food and health training to individuals working directly and indirectly with food in a range of settings, for example, local authority and commercial catering establishments, the voluntary sector, the tourist sector, universities and colleges delivering food-related courses and interested members of the public. On completion of the course participants will:

- have a greater understanding of health as a concept
- understand the concept of a balanced diet, including the “Eating for Health” plate model
- have a working knowledge of the nutrient content of a range of common foods
- have discussed the relationship between individual dietary components and overall diets and health, including basic information about food allergies and intolerances
have considered how to change foodstuff/diets/shopping habits/retail practices to make a positive impact on health

have discussed the barriers to healthy eating and how these might be overcome.

Encouraging breastfeeding
An important initiative is encouraging mothers to breastfeed. HEBS has continued its activities to encourage breastfeeding through the production of resources and initiatives to support parents and professionals and a new media campaign to promote a pro-breastfeeding culture in Scotland. In October 2001 HEBS issued a new Children in Action publication on nutrition and the under fives which revised guidance on effective interventions in the area.

Health Promoting Schools Unit
Health Promoting Schools and New Community Schools both play a role in improving diet. Health and Education Departments have been working throughout 2001, in liaison with HEBS, CoSLA and LTSScotland, to establish a Health Promoting Schools Unit to support schools implementing the health promoting schools concept. The Unit is to be established in early summer 2002.

Action on Deprivation: Breakfast Service Challenge Fund for vulnerable children
In November 2001, Ministers announced a joint Social Justice, Education and Health initiative to fund a £250,000 Breakfast Service Challenge Fund to expand services which support vulnerable children. This will build on current local activity to improve breakfast service provision in Scotland’s most disadvantaged areas. This initiative aims to reduce inequalities in children’s health and ensure vulnerable children get help to make the most of their school day.

Breakfast is particularly important for children as links have been demonstrated with increased concentration and learning at school and improved physical well-being. As part of a new strategic approach to give children a healthy start to the day, the new Challenge Fund will be based on the principles of provision of breakfast, play and oral hygiene. The first step will be to undertake a Breakfast Service Review to recommend a future framework for breakfast services and to assist the Scottish Executive in deciding how best to target the challenge fund. The review aims to complete mid 2002.

Nutrition and Older People
Surveys of older people at home and in long-term care have shown that many are under nourished. This impairs health and well-being and diminishes chances of recovery from supervening illness or injury. The new National Care Standards for Care Homes guarantee that older people will receive varied and nutritious meals, taking account of older people’s preferences and special dietary needs.

The nutrition of older people was one of the issues highlighted in the report of the Expert Group on the Healthcare of Older People (EGHOP), *Adding Life to Years*, chaired by the CMO, which met throughout 2001. The report endorsed the need for standards to be set and met for nutrition of older people in care settings and emphasised the importance of good nutrition in the physical, mental and oral health of older people.
INCREASING PHYSICAL ACTIVITY

The Size of the Problem

Research over the past 50 years has demonstrated that inactivity leads to increased risk of coronary heart disease, stroke and many other health problems. Lack of physical activity is an independent risk factor for the entire population and one that affects people of a normal weight. As is shown in the Scottish Health Survey 1998 (2000), six out of ten men and seven out of ten women in Scotland put their health at risk by being below the minimum recommended levels of physical activity. Among children, the scale of inactivity is of particular concern with three in ten boys and four in ten girls falling short of the amount of physical activity required for good health. Physical inactivity constitutes one of the most widespread health determinants in Scotland.

Strategic Direction

The Scottish Executive intends to introduce policies to tackle the causes of inactivity and to reverse the current trend of growing inactivity amongst the Scottish population. Following the commitment made in the Scottish Health Plan – “Our National Health” the Physical Activity Task Force was set up in June 2001. It is charged with developing a strategic action plan and programme for change to increase physical activity levels in Scots of all ages. It is due to report with recommendations mid 2002. This report will:

- give the issue of physical activity a much higher profile
- encourage new ideas
- set a base line target for increasing physical activity levels amongst our population.

HEBS, recognising that lack of physical activity is one of the most prevalent health risk factors in Scotland, has provided professional leadership to the Physical Activity Taskforce in 2001 reviewing evidence, current practice and helping with the development of a much needed new strategy for Scotland.

Targets

The targets are ambitious:

- to increase the number of Scottish children achieving the recommended level of physical activity to 80%
- to increase to 50% the number of Scottish adults reaching the recommended 30 minutes of physical activity on most days of the week.

To meet these targets action will aim to:

- direct policy within the SE to ensure that it is consistent with an active lifestyle
- strengthen and support local policies and structures for physical activity.

Implementation

A number of initiatives are already underway to increase physical activity:

Exercise and Children: Class Moves Initiative

The “Class Moves” initiative is run in collaboration between HEBS and SportScotland. It encourages daily physical activity and body awareness among primary school pupils. New materials and training for primary schools were produced during 2001 working in partnership with organisations in Wales and the Netherlands.
**On-line Training for Primary Care**
HEBS has developed an on-line training and information resource for primary care on the links between physical activity and obesity/weight management. The initiative also highlights the fact that the benefits of physical activity extend beyond the prevention and management of obesity. It is also beneficial to those of normal weight, or those slightly overweight.

**Exercise and Older People**
Muscle strength declines with age, but it can be maintained and even regained by regular physical activity. Exercise classes provide social and mental stimulation as well as physical improvement. As part of the HEBS “Health in Later Life Programme” the importance of work on strength and balance in the prevention of falls in older people has been highlighted. This has included designing awareness materials and training for acute primary, secondary care services and featured a healthy ageing supplement in collaboration with the Daily Record. HEBS has funded a pilot project in Dumfries and Galloway working with local partners to determine the physical activity priorities of local communities.

**Exercise and Mental Health**
In 2001, HEBS held a training seminar for health professionals to increase awareness of the growing body of evidence linking physical activity with the prevention and treatment of depression.

**OBESITY**

**Obesity in Adults**
Based on the Scottish Health Survey 1998 (2000) it is estimated that over 19% of Scottish men and over 22% of Scottish women (aged 16–74) are obese (derived as a Body Mass Index over 30). Other European surveys suggest that the rates of obesity in Scottish women are among the highest in comparable European countries (OECD Health Data 2001).

**Obesity in Children**
The increasing levels of obesity in Scottish children and the subsequent health implications for later life are of concern. Studies show that although children consume fewer calories than, for example, 40 years ago, levels of obesity continue to increase. Based on the Scottish Health Survey, nearly 8% of boys and 7% of girls are now classed as obese.
Child Health Surveillance System as a tool for obesity surveillance

“Assessment of the national Child Health Surveillance System as a tool for obesity surveillance at national and health board level” (December 2001) – report of mini project for Chief Scientist Office (CSO) (September 2000 – August 2001) by J Armstrong and J J Reilly in collaboration with the Child Health Information Team, Information and Statistics Division, Common Services Agency.

This study found that the prevalence of obesity (8.6%) in children aged 3–4 years in Scotland in 1998/99 was higher than the UK 1990 reference standard of 5%. This is consistent with previous reports that suggest an increase in the trend of childhood obesity. The study also explored the prevalence of obesity in school-aged children and found that, in three NHS board areas in Scotland (Lanarkshire, Borders and West Lothian), it increased from 9% in primary 1 children to 15.1% in secondary school children and was higher at each age than the UK 1990 reference standard of 5%. There was a marked increase between children in primary 3 and children in primary 7.

Obesity is a risk factor for

- heart disease
- high blood pressure
- arthritis
- diabetes.

In recent years there has been an increase in the number of younger people developing type 2 diabetes as a consequence of rising rates of obesity in young people which is discussed further in the section on diabetes.

Strategic Direction

It is well recognised that eating a healthy, balanced diet and keeping physically active help people maintain appropriate body weight. Together, physical activity and healthy eating can contribute towards reducing obesity, whilst contributing towards improved psychological well-being and self-esteem.

The Scottish Executive funded national and local initiatives to increase physical activity and improve diet such as those described in the sections above, will work together to combat obesity and towards improving the health of the Scottish population.

Implementation

On a local level, various initiatives are being taken forward to tackle obesity in response to local needs and priorities.

Pilot Study on Childhood Obesity

Yorkhill NHS Trust has been involved in a 6 month pilot research study on childhood obesity to identify whether a multi-disciplinary approach succeeds in managing obesity. If successful in helping children choose a healthier lifestyle and fitness level then it would become available as a first line of treatment for those obese children living in the Glasgow area.
Together, local and national action to improve diet and increase physical activity will contribute to ensuring that children and adults in Scotland maintain a healthy body weight, and reverse a worrying trend which impacts on both the length and quality of our lives.

**SMOKING**

**The Size of the Problem**
Smoking is a major contributor to ill health in Scotland especially in women, increasing the risk of many diseases. Thirty-four per cent of men and 32 per cent of women in Scotland are cigarette smokers. It is disappointing that smoking has not reduced to the same extent in women as in men. Smoking rates for women in Scotland are amongst the worst in Europe.

**Smoking and Deprivation**
There is a strong correlation with deprivation. Forty-nine per cent of men and 43 per cent of women from the most deprived areas of Scotland smoke. Between the 1995 and 1998 Scottish Health Surveys the smoking rates in the least deprived have changed very little. There has been a small increase in the percentage of men from the most deprived areas smoking, and a small decrease in women from the most deprived areas.

**Strategic Direction**
The White Paper ‘Smoking Kills’ was published in 1998 and set out three aims
- to reduce smoking in children and young people
- to help adults, particularly the disadvantaged, to give up smoking
- to help pregnant women give up smoking.

**Targets**
- to reduce smoking in Scots adults from an average of 35% to 33% by 2005. This has already been met, although it is too early to say whether it will be sustained. The target to further reduce adult smoking to 31% by 2010 remains
- to reduce the proportion of pregnant women smoking to 23% by 2005 and 20% by 2010
- to reduce the percentage of schoolchildren aged 12–15 who smoke to 11% by 2010.

**Implementation**
In 2001 continuing progress was made to implement the comprehensive and coherent package of action set out in the White Paper which included:
- increasing smoking cessation services for those who wish to quit
- the promotion of a Voluntary Charter on Smoking in Public Places.

**Smoking Cessation**
Two significant developments in 2001 are:
- the additional investment from the Health Improvement Fund enabled NHS Boards to step up their cessation activities in 2001
- Nicotine Replacement Therapy (NRT) was made available on prescription.
There are around 1.4 million smokers in Scotland and surveys suggest that up to 70% of them want to give up. However, unaided quit rates are only about 2% per year while those using NRT and cessation services can achieve a 10–20% quit rate. Smokers, whatever their age, who successfully quit will substantially reduce their risk of future smoking-related diseases.

**Smoking and Young People**

Important progress is shown in the fact that smoking rates have fallen from 11% to 8% among boys (aged 14–15). However, a disappointing trend is that the number of girls smoking remains unchanged at 13%. The Executive is working with HEBS to reverse this trend in girls through robust health education campaigns building on the successful STINX advertisement.

**Aspire to Stop Smoking - pack for use in Primary Care**

Aspire to Stop Smoking, a package of materials to help smokers stop and stay stopped, was launched by HEBS in December 2001. Principally for use in Primary Care the pack provides evidence-based advice for professionals and support materials for patients. The information pack has been complemented and supported by the creation of the Tobacco Unwrapped sub-site on the HEBS web (www.hebs.com).

**Smokeline**

Following a research review, a series of pilots have been commissioned to try different approaches to smoking cessation for young people. Work was started on extending Smokeline, developing more specific services for:

- young people
- pregnant women
- minority ethnic groups.

An audit of Local Authority Smoking Policies undertaken in partnership by HEBS, ASH Scotland and CoSLA was published at the end of 2001. Plans are underway for this to be followed up by the production in 2002 of good practice guidelines for councils and a repeat audit in 2003.

**Tackling Illegal Sales of Tobacco to Children and Young People**

The Executive is also keen to improve enforcement of the prevention of illegal sales of tobacco to children and young people and has been working closely with key interests including Scottish Chief Trading Standards Officers and CoSLA. An important development during 2001 was the Lord Advocate’s decision, following a review of prosecution policy, to allow a pilot scheme to assess whether test purchasing by children, of age restricted goods would work safely and effectively in Scotland. It is anticipated that these pilots will be established by autumn 2002.

Pilot youth card schemes, in which proof of age is an integral part, in Glasgow, Edinburgh, Argyll and Clyde and Angus, in conjunction with CoSLA and Young Scot also offer ways to cut down on sales to young people.
Forth Valley: Young People and Tobacco

Young people in Forth Valley have actually increased smoking in the past 4 years. Previously it was the middle-aged adult who smoked most. As Figure 1.5 shows, young men and women are now smoking more than any other age group.

**Fig. 1.5 Smoking prevalence (by age group and survey year)**

The major fall in smoking in Forth Valley has been largely due to fewer people starting to smoke rather than people giving up smoking (Table 1.1).

**Table 1.1 Smoking type by year**

<table>
<thead>
<tr>
<th>Smoker type</th>
<th>2000</th>
<th>1996</th>
<th>1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoker</td>
<td>29%</td>
<td>29%</td>
<td>42%</td>
</tr>
<tr>
<td>Never smoked</td>
<td>49%</td>
<td>47%</td>
<td>39%</td>
</tr>
<tr>
<td>Given up smoking</td>
<td>22%</td>
<td>24%</td>
<td>20%</td>
</tr>
</tbody>
</table>

The major challenge is supporting young people not to start and to support those who have established addictive habits.
To tackle this issue in secondary schools a successful pilot, “The Smoke-Free Class Competition”, has been trialled and is now being rolled out in other secondary schools in the area.

The competition has been run successfully in several European countries for over 10 years with the support of the Europe Against Cancer organisation. It has been shown to decrease smoking amongst the young people involved and to delay the onset of smoking in young people. In Forth Valley the first and only Scottish pilot took place involving all second year pupils at Lornshill Academy, Alloa (8 classes in total).

This initiative involved the Health Promotion Officer for Smoking and Young People delivering sessions within the Personal and Social Education class once a month. These sessions gave factual information about smoking as well as teaching young people the skills needed to remain a non-smoker.

Each month each pupil used a carbon monoxide monitor, the “Smokerlyzer”, which determines whether they have been smoking. This information is recorded as classes are only allowed to continue in the competition if they have less than 10% smokers.

The aims of the competition are:

- to encourage pupils to remain smoke-free by discouraging experimentation with tobacco
- to reduce the prevalence of cigarette smoking amongst the target group
- to clearly show that not smoking is acceptable
- to explore the benefits of remaining “smoke-free”.

The 6 month Lornshill pilot concluded in March 2001 and results showed that between 1 and 2 people per class actually stopping smoking. The success of the pilot has been attributed to using peer pressure in a positive way.

The Smoking Advice Service has been developed as part of Grampian's response to the white paper “Smoking Kills”. Although centrally co-ordinated the service is provided at a venue convenient to the client across Grampian. It has been able to reach those from disadvantaged areas with 14% of clients from deprivation category 7. Seventy per cent of clients are referred by their GP and client satisfaction with the service is high. The service represents cost effective use of NHS resources with an estimated cost per life year gained between £277 to £623.

Around a quarter of the 65–74-year-old age group smoke regularly. However, as stated in the Report of the Expert Group on the Healthcare of Older People *Adding Life to Years* recent evidence endorses the fact that it is never too late to give up. Stopping smoking leads to health gain at any age.
Health in Scotland 2001

ALCOHOL PROBLEMS

The Size of the Problem
As identified in last year’s report “Health in Scotland 2000” the Scottish Health Survey shows that:

- since 1995 there has been an increase in alcohol consumption among women aged 16–64; the proportion exceeding 14 units a week has increased from 13% to 15%
- among men aged 16-64 alcohol consumption showed little change over this period; the proportion of men exceeding 21 units a week was 33% in both 1995 and 1998.

Targets
- The year 2000 target was a 20% reduction in adults exceeding weekly limits. This was not met as excess drinking is on the increase especially in women.
- The current targets are:
  - to reduce the incidence of adults exceeding weekly limits from 33% to 31% for men between 1995 and 2005 and to 29% by 2010; and from 13% to 12% for women between 1995 and 2005 and to 11% by 2010
  - for young people, to reduce the frequency and level of drinking from 20% of 12–15-year-olds to 18% between 1995 and 2005 and to 16% by 2010.

Strategic Direction
Last year’s report referred to the Executive’s consultation on a Plan for Action on Alcohol Problems aimed at reducing alcohol-related harm in Scotland. Extensive consultations took place during the first half of 2001. Over 160 responses were received from a wide variety of sources including medical networks, the police, academics, drug and alcohol agencies, health education bodies, the drinks industry and licensed trade, children and young people’s and service user groups. In addition, several pieces of work were commissioned to add to the evidence base for the Plan. The Scottish Advisory Committee on Alcohol Misuse, which co-ordinates all key interests: health, local authority, the police, the drinks industry and the licensed trade provided valuable advice.
Plan for Action on Alcohol Problems

The Plan for Action on Alcohol Problems was published in January 2002 and sets out action for a range of bodies and individuals including the Executive, NHS Boards, local authorities, the police, the drinks industry and the licensed trade, businesses and the voluntary sector. The success of the Plan will depend upon partnership working. The aim of the Plan is to reduce alcohol-related harm in Scotland. Key priorities are:

- to reduce binge drinking because of the harmful social and individual consequences and
- to reduce harmful drinking by children and young people because of the particular health and social risks.

The wide range of action proposed under the Plan gives some indication of the complexity of the issues which need to be addressed in tackling alcohol problems. Action falls into four broad areas:

- changing culture surrounding drinking
- prevention and education
- treatment and support for people with alcohol problems
- the protection of individuals and the wider community.

Some of the action proposed under the plan includes:

- challenging attitudes to binge drinking through a new national campaign
- a framework for treatment and support services to assist those who plan and commission services to assess local needs and improve services
- new resources/ways to help parents talk to children about alcohol
- promotion of training and responsible practice for those serving and selling alcohol
- more support for local alcohol action teams
- improved training for staff in services addressing alcohol problems.

The Committee which was set up to review all aspects of liquor licensing met for the first time in August 2001 and is making good progress. The Committee is expected to report by the end of 2002.

HEBS Campaigns

HEBS advertising campaigns have thrown the spotlight on the risks of alcohol and drug misuse.

- The *Think About It* integrated campaign was aimed at teenagers and included a focus on the risks and consequences of alcohol and drugs.
- The *Drinkwise Campaign* was supported by HEBS, the Scottish Executive, and other national and local organisations.
- Other HEBS research included a study for the Scottish Executive on perception of factors that promote and protect against alcohol misuse. This was to assist in the development of the new alcohol misuse strategy and was published on the Scottish Executive website in August 2001.
HEBS also produced and published resources:
- Alcohol and Drugs Policies and Employment Pack
- Women and Alcohol, the report from an expert seminar.

### Grampian Youth Lifestyle Survey

The Grampian Youth Lifestyle Survey 1998 shows that amount and frequency of alcohol consumed has increased in the Grampian youth population. The ADAT (Alcohol and Drug Action Team) action plans include a range of activities to tackle this challenging area, including “Double Vision”, a hard-hitting play about family alcohol misuse and its effects. An alcohol advisor attends each performance and the outcomes of the work being done in schools and communities arising from this initiative are very encouraging. This has been a fruitful partnership across three local authorities and three Action Teams involving five Alcohol Drug and HIV Forums and delivering to approximately 2,400 people of all ages in a variety of venues.

### Alcohol and Older People

Many older people enjoy sensible social drinking, but excessive drinking increases the risk of:

- falls and injury
- confusional states
- gastrointestinal disease.

Older people are more likely to drink alcohol on a regular basis rather than to binge and are more likely to conceal their drinking. Around 6% of men and 1.5% of women in the 65–74 age group are estimated to be problem drinkers.

### DRUGS

#### The Size of the Problem

As identified in last year’s report “Health in Scotland 2000” injecting figures have risen, year on year, from 33% in 1995/96 to 39% in 1999/2000. Thirty-nine per cent of new problem drug misusers seen by services and notified to the Scottish Drug Misuse Database (SDMD) reported injecting “in the last month” (SDMD 1999/2000).

It is known that:

- 37% of new problem drug users in 2000/01 who had injected drugs “in the previous month” reported sharing needles and syringes “in the previous month” (Scottish Drug Misuse Database 2001).

- The proportion of injecting drug users who had a named HIV test who were positive for Hepatitis C antibody has fallen from 62% in 1997/98 to 48% in 1999/2000 based on tests from the four main testing centres in Glasgow, Tayside, Edinburgh and Grampian (SCIEH Survey 2000).
Drugs and Deprivation

A report by the *Social Inclusion Housing and Voluntary Sector Committee: Inquiry into Drug Misuse and Deprived Communities* (2000) concluded that problem drug use is strongly linked to social deprivation. The roll out of the new resources and much other action under the drug strategy are in line with the Committee’s main conclusions. In the broader field of Social Justice Strategy, we have now set targets that will impact on poverty, unemployment and disadvantage. They include milestones coinciding with national drugs targets aimed at reducing the incidence of drug misuse in general, and of injecting and sharing needles in particular. This approach will help to save lives and prevent the spread of blood-borne viruses such as Hepatitis C and HIV.

Strategic Direction and Implementation

Tackling drug misuse has been identified by the Executive as a priority crosscutting issue. *The Scottish Executive’s Annual Report on Drug Misuse*, published in November 2001, set out progress in implementing strategy (*Tackling Drugs in Scotland: Action in Partnership: March 1999*) and action plan (*Protecting our Future: May 2000*) and described future plans. This included information on what the additional resources of £100 million over the 3 years from 2001–2 for tackling drug misuse, would buy. In June 2001, the Executive announced further resources to tackle drug misuse over the same 3 year period, which brought the additional investment package to just under £130 million.

The new resources are funding activity on a range of fronts, in line with the four pillars of the drugs strategy:

- treatment
- communities
- young people
- availability.

Drug Action Teams

Drug action teams are the focal point for local action. They bring together:

- health
- local authority
- police
- voluntary sector representatives.

They are required to sign off jointly agreed plans to ensure that services on the ground are delivered in an integrated way and in line with national objectives and locally identified need.
Health in Scotland 2001

Targets
To measure progress, in 2001 the Executive published challenging national targets for tackling drug misuse across all four pillars. Examples are:

- all schools to provide drug education to every pupil and to have written procedures for managing incidents of drug misuse, in line with national advice, by 2002
- to reduce the proportion of young people under 25 who are offered illegal drugs significantly and heroin use by 25%, by 2005
- to reverse the upward trend in drug related deaths and reduce the total number by at least 25% by 2005
- to increase the number of drug misusers in contact with drug treatment and care services in the community by at least 10% every year until 2005
- to increase the number of drug seizures by 25% by 2004.

New expenditure included the provision of some £13 million over the 3 year period to help in achieving the target of increasing the number of people being seen by drug treatment services. In addition, NHS Boards have extra funding for their work on preventing the transmission of blood-borne viruses, including HIV and Hepatitis C. This includes work to reduce injecting and the sharing of needles by drug users.

Considerable work is now underway across the NHS and Scotland’s local authorities to improve drug treatment service provision utilising the additional resources. This covers a broad range of service provision including dual diagnosis clinics, services for young people, criminal justice treatment services, outreach and rehabilitation, including those incorporating training and employment opportunities.
## Focusing on Priority Health Topics
CHAPTER 2

FOCUSING ON PRIORITY HEALTH TOPICS

SCOTLAND’S MAJOR HEALTHCARE PROBLEMS: THE DOUBLE BURDEN OF DISEASE

Scotland faces a double burden of disease at the start of the 21st century. One element is the growing burden of chronic disease. The other is that of new and re-emerging infections diseases. The first part of this chapter focuses on the growing burden of disease from:

- Coronary Heart Disease/Stroke
- Cancer
- Mental Health
- Diabetes Mellitus
- Oral Health
- Chronic Fatigue Syndrome.

The second part of the chapter focuses on protection of health from:

- Communicable diseases
- Environmental hazards.

**Coronary Heart Disease, Stroke and Cancer**

Deaths from Coronary Heart Disease (CHD), Stroke and Cancer account for around 60% of all deaths in Scotland every year. Much of the work to improve lifestyles described in Chapter 1 is focussed on prevention of CHD, Stroke and Cancer with action targeted at:

- stopping smoking
- improving diet
- increasing physical activity
- reducing obesity
- encouraging sensible drinking.

This chapter reinforces aspects of prevention but focuses on health care for CHD, stroke, cancer and other priority health topics.
CORONARY HEART DISEASE/STROKE

The Size of the Problem

Coronary Heart Disease

In Scotland, an estimated half a million people have coronary heart disease (CHD), of whom 180,000 are symptomatic. Over the past 10–15 years the proportion of deaths in Scotland caused by CHD has fallen from 29% to 23%. Table 2.1 illustrates standardised CHD mortality by NHS Board of residence, from 1992–2000, and shows a steady decline year on year.

Table 2.1 CHD mortality - directly standardised rate(2) 1992–2000, by NHS Board of residence

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<td>223.9</td>
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<td>200.7</td>
<td>191</td>
<td>187.7</td>
<td>172.9</td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
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<td>273.1</td>
<td>233.8</td>
<td>227.5</td>
<td>230.7</td>
<td>226.5</td>
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<td>194.9</td>
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<tr>
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<td>270.3</td>
<td>240.3</td>
<td>236.6</td>
<td>222.6</td>
<td>220.2</td>
<td>194.2</td>
<td>204.8</td>
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</tr>
<tr>
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<td>177.3</td>
<td>181.8</td>
<td>150.8</td>
<td>174.2</td>
<td>137.9</td>
<td>148.7</td>
<td>143.6</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
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<td>243</td>
<td>221.6</td>
<td>192.1</td>
<td>201.6</td>
<td>177.1</td>
<td>181.9</td>
<td>177.1</td>
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<td>235.2</td>
<td>217.2</td>
<td>197</td>
<td>191.4</td>
<td>189.8</td>
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<td>158.1</td>
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<td>215</td>
<td>204.7</td>
<td>182.3</td>
<td>169.1</td>
<td>181.8</td>
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<td>204.5</td>
<td>200.6</td>
<td>184.3</td>
<td>169.4</td>
<td>172</td>
<td>167</td>
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<td>Greater Glasgow</td>
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<td>207.6</td>
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<td>177.7</td>
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<td>172.5</td>
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<tr>
<td>Lanarkshire</td>
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<td>296.1</td>
<td>275.5</td>
<td>264.2</td>
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<td>246.7</td>
<td>228</td>
<td>221.5</td>
<td>200.6</td>
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<tr>
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<td>Orkney</td>
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<td>234.3</td>
<td>227.7</td>
<td>217.9</td>
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<td>221</td>
<td>195.8</td>
<td>167.5</td>
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<td>279.4</td>
<td>210.3</td>
<td>192.1</td>
<td>189.5</td>
<td>212.3</td>
<td>194.1</td>
<td>175.7</td>
<td>128.6</td>
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<tr>
<td>Tayside</td>
<td>235.8</td>
<td>239.6</td>
<td>192.1</td>
<td>186.1</td>
<td>181.6</td>
<td>171.6</td>
<td>166.6</td>
<td>171.2</td>
<td>156.2</td>
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<tr>
<td>Western Isles</td>
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<td>237.9</td>
<td>200.5</td>
<td>274.4</td>
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<td>251.7</td>
<td>165.8</td>
<td>192.8</td>
<td>195.4</td>
</tr>
</tbody>
</table>

Notes
(1) From January 2000, deaths in Scotland have been coded using ICD10. Note that any apparent change in trend between 1999 and 2000 may be due to the move to ICD10 rather than a real change. The trend over this period should be treated with caution.
(2) Rates age standardised using the European standard population.

However, approximately 12,500 Scots continue to die each year from CHD, many prematurely. The burden of CHD falls most heavily on older people, with 81% of all CHD deaths occurring in people aged 65 and over. While mortality has fallen by around 50% in the under 65s, there has only been a 28% reduction in the over 75s. Table 2.2 clearly illustrates that the over 65 age group have the highest GP consultation rate for CHD per 1,000 practice population and these rates have remained fairly steady over the past several years.
Table 2.2 GP consultation rate for CHD per 1,000 practice population by age group 1996–2000

<table>
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<tr>
<td>25-44</td>
<td>4.4</td>
<td>4.9</td>
<td>5.8</td>
<td>4.6</td>
<td>5.4</td>
</tr>
<tr>
<td>45-64</td>
<td>93.0</td>
<td>88.8</td>
<td>94.9</td>
<td>82.7</td>
<td>77.7</td>
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<tr>
<td>65-74</td>
<td>185.9</td>
<td>198.7</td>
<td>207.6</td>
<td>197.5</td>
<td>192.1</td>
</tr>
<tr>
<td>75-84</td>
<td>165.7</td>
<td>181.6</td>
<td>187.1</td>
<td>185.5</td>
<td>176.1</td>
</tr>
<tr>
<td>85+</td>
<td>126.0</td>
<td>115.2</td>
<td>134.4</td>
<td>146.8</td>
<td>126.5</td>
</tr>
<tr>
<td>All Ages</td>
<td>47.5</td>
<td>48.6</td>
<td>52.4</td>
<td>49.2</td>
<td>47.3</td>
</tr>
</tbody>
</table>

Source: ISD Continuous Morbidity Recording (CMR)

Note:
(1) Includes small numbers of patients under 25.

Stroke
Similarly, stroke is an illness predominantly affecting older people. Annually around 1,500 Scots suffer their first stroke, of whom 75% are aged 65 or more. The annual incidence is estimated at approximately 3 per 1,000 population. Demographic trends in Scotland mean that the prevalence of both CHD and stroke will increase in subsequent decades as the proportion of the population aged 65 and over increases.

Targets
The year 2000 target for coronary heart disease, which has been met, was to reduce mortality among people under 65 by 40% between 1990 and 2000. The new target is to reduce rates by 50% in people under 75 between 1995 and 2010.

Coronary Heart Disease and Deprivation
There is a clear gradient of increasing incidence and mortality from coronary heart disease (CHD) with increasing deprivation. The correlation is most marked in those aged under 65. All groups of the population have enjoyed falling death rates from CHD over the 1990s (Figure 2.1). The absolute fall in numbers has been greatest in those from the most deprived areas. However, the percentage fall has been greater in those from the less deprived areas and the ratio of deaths between the most and least deprived has increased. This point is emphasised further in the section on the Coronary Heart Disease/Stroke Task Force.
September 2001 saw the publication of the final report of the Coronary Heart Disease/Stroke Task Force, chaired by Professor Ross Lorimer. The Task Force was established in response to a recommendation in the Report of the Acute Services Review (1998), with the primary aim of developing a clinical network of cardiac services throughout Scotland. The Task Force’s formal remit can be summarised as follows:

- to investigate and quantify the scope for increased intervention rates within the four current cardiac centres in Scotland, and to address known inequity of access. Waiting list issues will be addressed
- to build on existing work to develop a national database, in conjunction with ISD
- to provide advice on the strategic direction for organisation of adult cardiology services, with particular emphasis on coronary heart disease (CHD)
- to ensure implementation and audit of relevant SIGN guidelines
- to examine existing, new and developing cardiological procedures
- to advise on the future direction of stroke services in Scotland.

The report describes the current position in relation to mortality from CHD and stroke in Scotland. The Task Force report covers all aspects of coronary heart disease, from primary prevention through to cardiac rehabilitation and makes specific recommendations in each area. It draws attention to issues of equity of access and particularly the effect of deprivation on the incidence and outcome from CHD.

As already stated, socio-economic deprivation has a profound effect on the risk of having a first acute myocardial infarction (AMI) and the chances of surviving it. Figures 2.2a and b illustrate the much higher incidence in mortality from AMI in both men and women in socio-economically deprived groups (DEPCAT 5-7) than the more affluent groups (DEPCAT 1-2). The Task Force recommended that NHS Boards give particular attention to the needs of more deprived communities when planning services for CHD.
The report describes the concept of Managed Clinical Networks for cardiac services, the aim being to set up local networks linking primary and secondary care across Scotland which relate to each other. The local networks would in turn link to a high level intervention network undertaking coronary artery bypass grafting and angioplasty. The experience in Dumfries and Galloway of establishing a local network for cardiac services is described opposite.
Pilot Managed Clinical Network for Cardiac Services

July 2001 saw the official launch of the pilot Managed Clinical Network (MCN) for cardiac services in Dumfries and Galloway. Funded by the Scottish Executive Health Department it had three main objectives:

- to implement a local MCN for CHD in Dumfries and Galloway
- to address generic issues relevant to all MCNs, including clinical governance arrangements, finance and administrative support, public involvement and reporting arrangements
- to evaluate the impact of a local MCN on health outcomes.

The lead clinician for the Network, Dr Chris Baker, was also a member of the CHD/Stroke Task Force. The pilot MCN has already produced interim generic recommendations in the areas outlined above, and specific outputs relating to CHD patients including the development of:

- care pathways and protocols for patient management
- clinical governance protocols
- standard referral letters
- patient information leaflets
- patient held records.

The pilot MCN has agreed clinical standards with the Clinical Standards Board for Scotland (CSBS) and is providing locally based training for patients and the public involved in the MCN. It has been successful in securing NHS Board funding for previously neglected areas of CHD health care and has also secured charitable funding for specialist nurses and money from the publishing industry for “how to do it” manuals. The MCN is clearly acting as a lever for change locally and has demonstrated that strategic thinking and decision making about resource allocation can move from a closed process at NHS Board level to a more open process fully involving clinicians and patients. This has had an undoubted positive impact on morale locally and on how the future of cardiac services is viewed. The next step is to roll out the generic and specific lessons emerging from this pilot MCN across Scotland.

Coronary Heart Disease and Older People

As the Expert Group on Healthcare of Older People (EGHOP) identified, about 80% of all CHD deaths occur in people aged 65 and over. There is a concern that interventional treatments such as coronary artery bypass grafting or percutaneous transluminal coronary angioplasty are under used in older people. Heart failure is commonly caused by coronary heart disease, affects 20% of older people and is one of the commonest reasons for which they contact their GPs. Drug treatment is increasingly effective but there is again concern older patients with heart failure are less likely to be investigated and to fully receive some of the most effective treatment.

As outlined earlier and emphasised by EGHOP, mortality from acute myocardial infarction has been falling in Scotland over the past decade. There has been a reduction of about 50% in people under 65 but only of around 28% in the over 75s. Older people can gain benefit from multi-professional rehabilitation programmes after a heart attack. EGHOP recommended that older people with coronary heart disease should have full access to the developments that will follow from implementation of the CHD/Stroke Task Force Report. Some self help groups such as the Braveheart Project in Falkirk, provide mentoring service to their peers with coronary heart disease.
Stroke

The Coronary Heart Disease and Stroke Task Force report points to the significant amount of previous work undertaken in the area of stroke, including that of SIGN and CRAG. The Task Force recommends that, as for CHD, Managed Clinical Networks be established, proactively supported by NHS Boards. Such Managed Clinical Networks should include a dedicated stroke unit serving a specific geographical area and pay particular attention to the issue of integrated discharge planning and co-ordinated stroke rehabilitation. The report also recommends that NHS Boards review current provision of “one stop clinics” for assessment of transient ischaemic attacks (TIAs), but acknowledges that currently this will not be feasible in all parts of Scotland.

The Report of the Expert Group on Healthcare for Older People (EGHOP), *Adding Life to Years*, emphasised that good multi-disciplinary care improves the outcome in terms of survival and reducing disability. After discharge, patients and their carers should receive the professional support they need and should be put in contact with supportive organisations such as chest, heart and stroke clubs.

Looking to the Future: Coronary Heart Disease and Stroke Reference Group

The consultation period for the Task Force report ended on 31 December 2001, and the vast majority of the comments received have been supportive of its recommendations. The CHD/Stroke Reference Group has now been established under the chairmanship of Dr Nick Boon, Consultant Cardiologist, Edinburgh, and includes other cardiologists, stroke physicians, cardiac surgeons, general practitioners and representation from public health and professions allied to medicine. The Reference Group will produce a national strategy for CHD and stroke, based on the Task Force report and comments received on it. This work is expected to be completed by late summer 2002.
Have a Heart Paisley: A multi-agency partnership approach

The national demonstration project for prevention of coronary heart disease Have a Heart Paisley takes a multi-agency partnership approach to the prevention of coronary heart disease. During 2001 the project made good progress in its five main strands of work:

- call to action
- community capacity
- opportunities, environments and lifestyle
- developments in health care and health information
- learning and development.

The aim is to weave these strands together to create a new “Paisley Pattern” of better health. It is particularly appropriate that funding for this initiative of £6 million for a 3 year period starting in October 2000 was awarded to Paisley. Paisley has a significantly higher rate of CHD mortality than Scotland overall and has marked health inequalities within it. The overall CHD death rate in Paisley is 13% higher than it is in Scotland as a whole. Although the project is focused on this one area, which might be described as “Scotland in microcosm”, Have a Heart Paisley is acting as a test bed to help inform and stimulate effective action across Scotland as a whole in the field of CHD prevention.

Have a Heart Paisley builds on the experiences of other projects internationally and in particular the North Karelia Project in Finland. The project aims to change the lives and perspectives of every citizen of Paisley by impacting on life circumstances, lifestyles and specific cardiovascular issues. It also aims to prevent heart disease from developing and to delay the progression of existing heart disease, as well as ensuring access to appropriate care once the symptoms of heart disease are present. The objectives of the original project have been redefined in the past year to improve their focus as follows:

- to increase the number of people adopting healthy lifestyles
- to help community members and representatives, volunteers and professionals gain the motivation, self-confidence, knowledge and skills they need to play their parts in preventing CHD
- to influence policies and encourage environments that make healthy lifestyles easier to achieve, promote good health and protect against CHD
- to encourage and enable community involvement and participation
- to improve partnership working
- to strengthen primary and secondary prevention of CHD in healthcare settings
- to promote the recovery of people after an acute episode of CHD
- to establish a risk factor database and disease register for CHD
- to reduce inequalities in health, primarily relating to CHD.

The expectation is that, as in Finland in relation to the North Karelia Project, the lessons from Have A Heart Paisley will be rolled out across Scotland as and when they emerge, so that other areas can benefit and avoid duplication of effort in the battle to prevent CHD.
Focusing on Priority Health Topics

Health in Scotland 2001

**Forth Valley: “Braveheart” project: Supporting older people who have had heart attacks**

The Braveheart Project is an innovative Ageing Well Health Demonstration Project which has looked at the feasibility and effect of training non-medical senior members of the local community to run mentoring groups to educate, support and empower patients aged 60 years and over with ischaemic heart disease. Over 150 participants have now benefited from this service which has been managed by a project team representing the main partners including Age Concern Scotland, Health Education Board for Scotland, Forth Valley Acute Hospitals Trust, Forth Valley NHS Board and Merck, Sharp and Dohme Ltd. New developments this year have seen the project move from its acute base to the Forth Valley South LHCC with the support of the Scottish Executive and the original partners.

In its first 3 years the Project was run as a randomised controlled trial comparing the outcomes in the participants in the mentoring groups with a similar group of patients who received standard care only. Final results are awaiting publication.

There was a very high satisfaction rating from participants. The model of support appears inclusive of all socio-economic groups and encourages healthy alliances. Mentoring complemented existing secondary prevention and health promotion strategies. The intervention seems to be practical, relatively inexpensive, safe and promotes positive lifestyle changes in older people with coronary artery disease.

**CANCER**

**The Size of the Problem**

As highlighted in last year’s report *Health in Scotland 2000*, cancer has now overtaken coronary heart disease as the commonest cause of death in Scotland. In 1997 over 25,000 cases of cancer were diagnosed in Scotland and in 2000 almost 15,000 people died of the disease. Lung cancer is the commonest cause of cancer death in both sexes, followed by colorectal cancer in men and breast cancer in women.

**Cancer and Deprivation**

For many cancers, incidence and mortality are higher and survival is lower in people from more deprived areas. Looking at the incidence and mortality from all cancers combined gives an indication of the extent of the inequalities. Cancer incidence is 14% higher in those from the most deprived areas of Scotland and mortality from cancer 40% higher.

The year 2000 target for cancer was to reduce mortality from cancer in people under 65 by 15% between 1986 and 2000. This has been met. A new target to reduce mortality in people aged under 75 by 20% between 1995 and 2010 has now been set. There has, however, been little evidence of any impact on inequalities in mortality from cancer. Figure 2.3 shows the trends in death rates from cancer since 1991. People from all deprivation groups have seen a decline in rates, but the gap between those in the most deprived and least deprived areas remains. In fact, the ratio of death rates between the most and least deprived has increased slightly over the period.
Prevention of Cancer
The risk of developing cancer can be reduced through healthier lifestyles. Prevention is a priority and the key messages are:

- Do not smoke
- Eat more fruit and vegetables
- Take regular exercise
- Moderate alcohol consumption
- Avoid over-exposure to sunlight.

Strategic Direction
2001 saw the publication of two major reports that will drive the development of cancer services over the next several years.

- Cancer Scenarios: an aid to planning cancer services in Scotland in the next decade
- Cancer in Scotland: action for change.

Cancer Scenarios: an aid to planning cancer services in the next decade
*Cancer scenarios*, published in April 2001, analysed trends in incidence and likely impact of developments in treatment of the major cancer sites over the next 10 years. These projections will underpin planning processes and inform the investment decisions which must be taken.
Over the next 10 years, the “Cancer Scenarios” report predicts:

- An overall increase in the number of cases of cancer diagnosed from 25,800 per annum in 1995-97 to 33,000 per annum by 2010-14
- The number of deaths from cancer will increase from 14,900 to 16,300
- If only those under age 75 are considered, the number of cases will increase from around 17,200 to 19,500 but the number of deaths will fall slightly from 8,600 to 8,500.

The frequency of some cancers will change more than others, so that in men prostate cancer will overtake lung cancer. The incidence of lung cancer in men has been declining, but because smoking has not reduced to the same extent in women the incidence of lung cancer is predicted to have only levelled off by 2010-14. Lung cancer has already overtaken breast cancer as the leading cause of cancer death among women because of the increasingly favourable outcome of breast cancer due to earlier diagnosis and improvements in treatment outcomes. In 2010-14 the Scenarios prediction is 1,850 lung cancer deaths per annum in women compared with 1,188 breast cancer deaths.

Cancer in Scotland: action for change

In July 2001, the Executive published its cancer plan Cancer in Scotland: action for change, which considered the whole patient journey from prevention through to palliative care and made a series of detailed recommendations. The strategy proposed the reconfiguration of the Scottish Cancer Group and the establishment of three Regional Cancer Advisory Groups in the North, West and South-east. The major function of these groups is to bring together all those concerned with cancer care, working in Managed Clinical Networks in order to “draw up realistic and effective workforce, equipment and chemotherapy spending investment plans in agreement with NHS Boards”.

Implementation

Scottish Cancer Group

Following publication of Cancer in Scotland, the Scottish Cancer Group was restructured under the chairmanship of Dr Anna Gregor, newly appointed Lead Cancer Clinician for Scotland. The new group has a greatly strengthened representation from the voluntary sector and patients, as well as representation from the three Regional Advisory Groups, clinical disciplines and management. The remit of the Group includes advising on the implementation of Cancer in Scotland, bringing forward annual investment plans for cancer services and monitoring improvements in services, ensuring good practice and learning across Scotland. In the latter function, the Group works with the Clinical Standards Board for Scotland (CSBS) to advise on key aspects of services which should be monitored at national level. The Group will report annually to the Chief Medical Officer.

Capital Investment in Key Area of the Patient’s Journey

The first task of the restructured Group was to collate and co-ordinate the investment plans for the first of 3 years additional investment totalling £40 million. The emphasis in the first year was on capital investment to build capacity in key areas of the patient journey. The Minister for Health and Community Care announced in November 2001 investment totalling £10.75 million, of which £6.78 million was for capital equipment including a wide range of imaging and pharmacy equipment. In addition, new consultant posts in medical, clinical and paediatric oncology, radiology, pathology, surgery and palliative care were created and recruitment is underway. Other key posts were funded including pharmacists, radiographers (both therapeutic and diagnostic), clinical nurse specialists (including chemotherapy and palliative care), speech and language therapists and a bereavement counsellor. The second year’s plans are currently in preparation.
Full details of the allocations for the first year are available on www.scotland.gov.uk and www.show.scot.nhs.uk.

**Research to Strengthen Cancer Services**

The Scottish Cancer Group is committed to promoting a central role for research in the provision and development of cancer services in Scotland and specifically strengthen support for clinical trials. A joint consultation exercise/workshop on research infrastructure for clinical trials was held in early 2002. This will bring together clinicians working in research, research nurses, academic researchers and the voluntary sector research organisations to build on the foundations created by the Chief Scientist Office and CRAG over the past 10 years, through the contribution of the Scottish Cancer Therapy Network.

The Scottish Cancer Group will work through a number of task-specific subgroups. The Referral Guidelines subgroup, were charged with preparing guidelines for urgent referral from primary to secondary care in the spring of 2002. These guidelines were published in May this year and are available on the Cancer in Scotland website (www.show.scot.nhs.uk/sehd/cancerinscotland). Other subgroups will cover patient information, chemotherapy, quality improvement and information management and technology.

**Managed Clinical Networks**

Managed Clinical Networks bring together everyone involved in the care of a specific cancer to agree care protocols across the area covered by the Network and audit the outcomes of treatment. The Scottish Cancer Plan stipulates that Managed Clinical Networks for all cancers should be in place by 2002. They will provide the mechanism through which redesign of services (for example for lung cancer and colorectal cancer) will be pursued in order to ensure the speediest possible journey for patients and optimal use of resources. Networks will be brought together within their Regional Cancer Advisory Group and with other regional networks to ensure sharing of best practice and a consistency of approach to cancer services across Scotland.

A national networks workshop was held in August 2001 sponsored by the Scottish Cancer Group. This provided an opportunity for clinicians and other network members to consider the benefits for patients of successful networks as well as the challenges faced in network development. Although held soon after the publication of Cancer in Scotland, the momentum for change was clear, and SCG will continue to facilitate a series of National Network meetings to share innovations and best practice.

**Grampian Cancer Managed Clinical Network**

North East Scotland Cancer Co-ordination Advisory Group (NESCCAG,) the north-east component of the national cancer network, provides an overview of service planning across the range of health service partners. This well established partnership enables a highly consultative approach to be taken when planning investment of the cancer allocation.

State of the art imaging equipment, additional staff and development of audio-visual links across the region has been funded, promoting effectiveness as a Managed Clinical Network. These resources deliver advanced image processing, eliminating the need for invasive procedures, leading to earlier, more accurate diagnosis, a reduction in waiting times and a far higher quality of experience for many patients.
Cancer Open Forum
A Cancer Open Forum was organised by the Scottish Cancer Group to engage with all in Scotland who have an interest in the implementation of the cancer strategy. The Open Forum, held in October 2001, attracted 350 delegates from around Scotland including staff from NHSScotland from the primary, secondary and tertiary care settings, the voluntary sector and patient representatives and demonstrated areas of good practice and work ongoing across Scotland.

Clinical Standards Board for Scotland
Standards of care for the four most common cancers:
- breast
- lung
- colorectal
- gynaecological

were amongst the earliest priorities for CSBS. A series of standards were agreed through a rigorous process that included patients, professional and lay carers involved in the whole process of care. During the summer and autumn 2001, CSBS completed a round of visits to all Trusts to assess the extent of compliance with these agreed standards and their reports are expected to be published in the early spring 2002. These will provide an invaluable baseline against which to judge the improvements that are expected from overall implementation of Cancer in Scotland and the additional investments being made. Indeed many of the planned investments are focused on improvements in cancer services aimed at meeting CSBS standards. The process of standard setting and auditing, targeted investment and repeat audit will lead to identifiable improvements in cancer services and, importantly, in the experience of care by cancer patients.

Beatson Oncology Centre
During 2001, an action plan to address the longstanding difficulties facing the Beatson Oncology Centre (BOC) in Glasgow was announced by Greater Glasgow NHS Board. The Minister for Health and Community Care appointed a new clinical director (Dr Adam Bryson) to provide impetus and focus to the delivery of the Action Plan. An Expert Review Group (chaired by Professor Bernard Cummings from Toronto) spent 2 weeks in January 2002 meeting all parties, and reported to the NHS Board. Recruitment of a range of staff (including replacement and additional consultant oncologists) is under way, and the business case for moving the BOC from the Western Infirmary site to Gartnavel Hospital (with additional radiotherapy capacity and new in-patient facilities) is expected to be approved shortly.

Cancer and Older People
Cancer is commoner in later life with around one-third of all cancers diagnosed in people over 75 although they form only 7% of the population. EGHOP emphasised that older patients may not always receive cancer treatment that might benefit them. EGHOP recommended that older people with cancer should have access to the service developments that will follow from implementation of Cancer in Scotland: action for change.
MENTAL HEALTH

The Size of the Problem

Mental health problems are one of the commonest causes of ill health in Scotland. The lifetime risk of any mental disorder is 1:3. Depending on the criteria used, between 15%–20% of individuals will have had a mental health problem in the preceding 12 months. For women the rate is higher, for men lower. Many facets of social exclusion contribute to the prevalence of mental health problems - isolation, a history of abuse, homelessness, discrimination and communication problems. Continuing problems, such as being a long-term carer, marital conflict and a chronic physical illness also contribute. All these also increase the likelihood of substance misuse - drugs or alcohol - which in turn make mental health problems more likely.

Mental Health and Deprivation

Suicide is an important cause of premature death, especially among young men. Through the 1990s suicide rates in young men have steadily increased. There is a strong association between suicides and deprivation, with twice as many suicides occurring in those from the most deprived areas of Scotland. Over the 1990s the rates have increased by nearly 40% in young men from the most deprived areas of Scotland. While many factors are at work in causing this trend, it is important to take measures to improve prospects and promising futures for young, particularly unskilled men and support them at difficult times.

The steady rise in suicide rates in young men through the 1990s in Scotland, which contributes to a 250% rise over the last 2 decades, is sad evidence of social and environmental pressure - mental ill health contributes to a quarter of all suicides, with substance misuse adding at least that again. Any circumstance of social adversity doubles the rate of mental ill health among children and young people to 1:5. Mental health problems spill over into the older years.

Evidence comes from UK surveys, with the samples including people from Scotland, published during 2001 by the Office for National Statistics. Also the Confidential Enquiry into Suicide and Homicide by People with Mental Illness Report Safety First (2001) included a 3 year sample from Scotland for the first time.

Strategic Direction

The policy statement “Renewing Mental Health Law”, which was published in October 2001, set out the Executive’s response to the Millan Committee's comprehensive review of the Mental Health (Scotland) Act 1986, and provides the framework for new mental health legislation, which is to be introduced in the Scottish Parliament in 2002.

Policy and strategy development have followed the line set in the January 2000 Ministerial Summit, reflected in Our National Health (December 2000) emphasising the need for comprehensive mental health services. The 1997 Framework for Mental Health Services in Scotland again was confirmed as setting the philosophy and direction for service development. It was acknowledged that the management of anxiety and depression in the community, and support for positive mental health (as opposed to illness treatment) services should be emphasised.

Working in Partnership: Our Joint Future

Wider issues are important too. The Framework made it clear that the health service, whether in primary care or in specialist services, could not deliver services to the Scottish people on its own. It promoted local coalitions of NHS Boards, Trusts, Local Authority Social Work and Housing Departments and voluntary organisations, working to a much greater extent with service users and their carers. The Joint Futures Group Our Joint Future, with its proposals for ways to jointly resource and jointly manage all community services, will be the way to best meet the needs of people with mental health problems.
Focusing on Priority Health Topics

Health in Scotland 2001

It is quite clear what the social circumstances and skills are which an individual requires to maintain positive mental health.

- First, a person needs to be able to identify, describe and be willing to communicate inner feelings.
- Second, an individual needs to have some valued role in life, whether as an employee or as a member of a local community or social group.
- Third, comes a circle of supportive friends who can provide a sense of being valued.

The skills required include being able to solve problems, to be able to cope with feelings without seeking quick fixes such as alcohol or drug use and being able to empathise with how other people are feeling. This much is known; implementation is discussed below.

Implementation of Policy
Activity during 2001 falls under five headings:

- The Mental Health and Wellbeing Sub-group
- Quality Development
- Positive Mental Health
- Refreshing the Framework
- Shifting the Balance of Care to the Community.

The Mental Health and Wellbeing Sub-group
This Group was set up after the Ministerial Summit to “support, influence, and help advance the further strategic development of mental health services in Scotland”. It finished its first round of visits to NHS Board areas, and partner agencies, in spring 2001. The outcome of visits are published in full on its website (http://www.show.scot.nhs.uk/mhwbsg). While the Framework and other guidance material remains in force, for its second round the Group has given prominence to the issues flagged up in Our National Health. A written report after each visit goes to Ministers and to local partners and now a score sheet will be used to contribute to the new Performance Accountability Framework.

Quality Development
Three Scottish Needs Assessment Programme (SNAP) Working Groups have worked throughout 2001:

- on child and adolescent mental health
- liaison psychiatry and psychology (the psychological influences on physical health) and
- autistic spectrum disorder.

Reports from all three will become available during 2002. SIGN has guidelines on postnatal depression, alcohol problems in primary care and generalised anxiety disorders in preparation.

The Scottish Health Advisory Service is now using a standard template to structure its inspections. During 2001 the Clinical Standards Board Schizophrenia Standards were used by all Scottish Trusts to conduct an internal audit of compliance with five of the 13 standards. Visits for the purpose of external accreditation were made by groups of professionals and lay people (including users of services and carers). There are indications of good individual professional practice, within a very narrow scope. The wider dimensions, of patient information, of support
for carers, of psychological and occupational intervention and measures to reduce social isolation, are relatively neglected. There is little audit taking place to draw this to the attention of service providers and the components of local services often do not link well together. Clearly there is a considerable re-engineering and information management/sharing task ahead.

With support from the Clinical Effectiveness Programme for Scotland work on outcomes for people with schizophrenia, a young persons integrated care pathway for behavioural disorder and anxiety problems and an approach to medically unexplained symptoms has been carried forward.

### Working in Partnership for Positive Mental Health: Suicide Prevention

During 2001, a Framework for Suicide Prevention developed jointly by the Health Department and the Scottish Development Centre for Mental Health Services has been consulted on widely with a range of organisations and individuals inside and outside health, in the statutory and non-statutory sectors and among both user and carer groups. Progress has been made in developing a helpline for stressed young people, many of whom are wary of statutory services but who badly need information about local facilities which will help them with their difficulties. The Health Department is pleased at the progress made by a wide coalition of agencies in developing an approach to a formal positive mental health strategy for Scotland, using an allocation of £4 million from the Health Improvement Fund.

### The Framework

In the past year, a template for the provision of psychological interventions at all levels of care, from voluntary agencies to the most specialist of therapies, was prepared, widely consulted upon, and launched. This was complemented by a pilot project, in four Trusts, supported by the Mental Health and Wellbeing Development Fund, to examine best practice in the provision of efficient and effective psychological interventions. Absent from the original Framework document was a template for eating disorders and this deficiency has now been remedied.

### Changing the Balance

There is a tension between the needs of people with severe and enduring mental health problems, and the needs of those in the community with usually - but not always - less severe disorders, such as depression and anxiety. Dealing with the latter group falls to primary care services. People with depression and anxiety are generally extremely heavy consulters and there are great benefits for their peace of mind and well-being - mental health promotion - if they can be assessed and managed adequately. Many such people have wider difficulties in their lives and help means giving assistance to change circumstances and increasing a person's ability to cope. The increase in prescription of the newer oral anti-depressant drugs in the last decade, although alarming to some, is probably evidence that general practitioners recognise depressive disorder better and patients are willing to take the newer drugs with fewer side effects. However, coping abilities and changing circumstances are not enhanced by medication (although an individual's ability to start to deal with issues may be). For these reasons, psychological treatment has to become more available to people seen by their general practitioner. Such interventions need to be available locally, of good quality, provided by people with the necessary skills, working in the right practice framework.
Psychological Interventions
There is now a strong evidence base for a number of psychological interventions “talking treatments”. Such interventions can meet the needs of the majority of people with anxiety and depression found in the community, many of whom are reluctant to accept pharmacological intervention. Such interventions are also relevant to the management of alcohol problems and drug misuse, as well as many people found in general hospitals whose physical condition is complicated by mental health problems. A psychological intervention is the treatment of choice for women with postnatal depression. Many professionals can provide a psychological intervention, with the correct training, practice framework and continuing supervision. Workforce planning mechanisms are being used to ensure that a supply of people with the appropriate skills will become available to meet the growing need.

DIABETES MELLITUS
The Size of the Problem
Diabetes is one of the most significant health challenges facing modern society. Diabetes is the fourth-leading cause of death in the UK. It is a serious and progressive chronic disease with potentially devastating consequences for health. The complications of diabetes include a higher risk of:
- heart disease
- stroke
- kidney damage (diabetic nephropathy) that can lead to renal failure
- eye disease (diabetic retinopathy) that can lead to blindness
- peripheral vascular disease and foot ulceration that can lead to amputation.

It is estimated that around 3% of the Scottish population (about 150,000 people) have been diagnosed with diabetes, with many thousands more who are as yet undiagnosed or are at serious risk of developing diabetes in the future. Some commentators have suggested that the prevalence will double over the next 10–15 years.

Scottish Diabetes Survey
NHSScotland is making concerted efforts to improve the quality of diabetes data available both for patient care and for population-based planning and audit. This is being achieved by the development of regional clinical information systems and an annual national survey. The first Scottish Diabetes Survey was undertaken and reported in 2001. It is believed that Scotland is the only country in the world to achieve such a national picture.

The 2001 report included data from all 15 NHS boards. A total of 105,777 patients were reported, a prevalence of 2.07%. The difference between this and the estimated rate (of about 3%) is largely explained by the different stages of development of the regional registers. The Survey will be repeated in September 2002.

See Figure 2.4.
There are two main types of diabetes:

- type 1 (an autoimmune condition usually occurring in people under 30)
- type 2, which is strongly linked to obesity, poor diet and lack of physical exercise and which usually develops in people over 40.

About 85–90% of people with diabetes have type 2 diabetes. Diabetes is also more prevalent among ethnic minority groups – communities of Asian and African-Caribbean origin have a prevalence of diabetes between three and four times higher than those of European origin.

**Rising Incidence of Diabetes**

There is an increasing incidence of both type 1 and type 2 diabetes, but particularly type 2. The pronounced rise in type 2 diabetes is attributed to a combination of:

- better detection of the disease in its early stages
- changes to lifestyle, namely poor diet and lack of exercise leading to increasing levels of obesity.

**Diabetes and Deprivation**

Type 2 diabetes is associated with deprivation; those living in the most deprived areas of Scotland are more likely to develop diabetes.

**Diabetes and Children**

One of the most troubling trends in recent years has been the increasing number of younger people developing type 2 diabetes as a consequence of rising rates of obesity among the young. Type 2 diabetes is now being found in children as young as 13 and has been diagnosed in those from ethnic minority groups (who are known to be at greater risk of developing diabetes) and more recently in white children.
Focusing on Priority Health Topics

Health in Scotland 2001

Treatment of Diabetes

Treatment of diabetes has changed considerably over recent years with the traditional focus on control of blood sugar now matched by an equal emphasis on the management of risk factors, including hypertension, hyperlipidaemia and smoking. Central to diabetes management is the annual review which should include assessment of glycaemic control, surveillance for cardiovascular risk, surveillance for long-term complications (e.g. of the eyes and feet), surveillance for psychological complications and advice on lifestyle.

SIGN Guidelines: Management of Diabetes

There is now a substantial body of research indicating how diabetes can be prevented and how outcomes for people with diabetes can be improved. The Scottish Intercollegiate Guidelines Network (SIGN) has played a central role in collating the evidence base for clinical practice in diabetes. In November 2001 SIGN published a guideline on Management of Diabetes (SIGN 55). This revised and updated six earlier diabetes guidelines. The SIGN guideline provided the main source of evidence to support the development of the Scottish Diabetes Framework and the Clinical Standards for Diabetes published by the Clinical Standards Board for Scotland.

Scottish Diabetes Framework

Our National Health included a commitment to publish a Scottish Diabetes Framework to draw together existing guidance and best practice and to establish a national screening strategy for diabetic retinopathy. A multi-disciplinary working group was set up in April 2001 to produce the Framework. A consultation paper was widely circulated in July and the key milestones of the Framework were published on World Diabetes Day – 14 November 2001 – to coincide with the publication of the CSBS standards and the SIGN guideline. The full framework was published in 2002. The Health Technology Board for Scotland published an assessment of diabetic retinopathy screening in April 2002.

With an ageing population, the prevention and treatment of chronic disease will be one of the central concerns of NHSScotland in the 21st century. The current work being undertaken in diabetes will not only help towards tackling one of the most common and serious chronic diseases, but it can also provide a model for improving the management of other conditions.

Grampian: Diabetes Mellitus

The redesign of the management of patients with diabetes across primary and secondary care has been identified as a key local priority in Grampian. Although a significant number of patients continue to receive their care in the acute sector, positive steps are now being taken by LHCCs, in conjunction with secondary care clinicians to redress the balance. The new approach to caring for diabetic patients means encouraging them to play an active role in monitoring their own health. The aim is to move towards a model of shared care in Grampian with the majority of treatment being provided, more appropriately, in primary care. The benefits include patients being cared for closer to home and hospital consultants having more time to deal with complex cases. A Diabetes Integrated Care Project Team has been established to support this redesign process.
ORAL HEALTH

The Size of the Problem

Adults’ Oral Health

In the year ending March 2001, approximately 2 million adults and 750,000 children were registered with a general dental practitioner in Scotland, with many more patients accessing care through the community dental services and hospital dental services. Total tooth loss amongst Scotland’s adults has reduced dramatically in the last 30 years, with only 18% of adults suffering loss of all natural teeth in the most recent Office for National Statistics (ONS) Adult Dental Health Survey in 1998, compared with the 44% of Scottish adults suffering this fate as recently as 1972.

Children’s Oral Health

However, despite substantial improvements in adult oral health in Scotland since the 1970s, children’s oral health in Scotland remains poor, with only 45% of Scottish 5 year olds free from dental decay (in 2000), well short of the national target of 60% decay free by 2010.

Strategic Direction

The Action Plan for Dental Services in Scotland, published in August 2000, set out a range of strategic measures to improve oral health in Scotland, placing particular emphasis on improving oral health in children and in tackling the inequalities which impact significantly upon both dental health and access to oral health care. A raft of measures have now been put in place to tackle dental decay at key stages in life and to attempt to overcome the effects of deprivation:

- free distribution of toothbrushes and paste to all children aged 8 months, and targeted distribution to 2- and 3-year-old children in more deprived areas
- the Early Years Enhanced Capitation Scheme was introduced in 1998 to increase preventive activity for 0–5 year olds
- expansion of supervised nursery toothbrushing programmes in Scotland
- a Caries Prevention Scheme was introduced in November 2001 for children aged 6 and 7, to provide advice on preventing decay and to provide fissure sealing of newly erupted molar teeth
- significant projects on healthy eating in young children funded through the Health Improvement Fund Programme
- significant increased support through health promotion programmes from health visitors, pharmacists, nursery playgroup leaders and parents.

Children’s Oral Health and Deprivation

Tooth decay is the major dental disease of childhood. The causes of the disease are well understood and may be broadly attributed to consumption of dietary sugars. Reduction of dietary sugars and improved toothbrushing at least twice daily with a suitable fluoridated toothpaste will reduce levels of tooth decay and gum disease. However, it is known that children from less advantageous circumstances are less likely to have had their teeth brushed with a fluoride toothpaste or to have visited a dentist by their first birthday and hence changing the diet of Scotland’s young people is a priority.

Our greatest challenge is to reach those in the most disadvantaged circumstances. Consideration should be given to how we might most effectively achieve oral health improvement in this sector of the population. The role of water fluoridation in reducing dental decay in our most deprived communities should be considered as part of an overall strategy for oral health improvement. It is only by a multi-faceted approach that progress in improving the oral health of
all of our children can be achieved. NHS Boards, local authorities, the dental profession, medical professionals and health visitors, educational establishments together with playgroups, parents and carers are all crucial to achieving our aim of improving oral health. An example of work in Forth Valley is given below.

### Action on Deprivation - Dental Health in Forth Valley

Within NHS Forth Valley there are clear associations between deprivation and dental health. Twelve year old children from DEPCAT 5&6 areas, for example, have three times the number of missing and filled teeth than those children living in DEPCAT 1&2 areas.

In implementing our oral health strategy we have expanded daily pre-5 toothbrushing programmes to 107 establishments in DEPCAT 4-6 areas and a total of 6,133 infants are involved. A pilot project in the more socially deprived area of Camelon proved successful in strengthening links between community and general dental services and increasing referrals to local general dental practitioners as well as increasing the proportion of older children receiving preventive fissure sealants. This work is now being expanded to other deprived Social Inclusion Partnership (SIP) areas.

The appointment of a salaried general dental practitioner within Orchard House Health Centre, Raploch has significantly improved access to dental services for this SIP community. Around 1,700 adults and children have received dental care within the last 15 months.

A recent survey showed that respondents from more deprived areas were less likely to go to the dentist than respondents from the least deprived areas, for regular check-ups or at all. Contrary to expectation, in this survey, respondents from DEPCAT 6 appeared not to conform to this trend. It can be seen that the work carried out in deprived communities may be starting to have an impact.

### Fig. 2.5 Dental health and social deprivation

![Dental health and social deprivation chart](chart.png)
CHRONIC FATIGUE SYNDROME (CFS/ME)

CFS/ME is a relatively common clinical condition affecting approximately 20,000 people in Scotland per year. It can cause profound, often prolonged, illness and disability, with a substantial impact on both the individual and the family. All age groups are affected, including children. Hitherto patients and carers often encountered a lack of understanding from healthcare professionals. This seemed to stem from an inadequate awareness and little understanding of what the illness involved, often reflected in the general population. As a result the treatment and care has been patchy and inconsistent, compounding the difficulties individuals have experienced. There has been a paucity of good research evidence and research investment for a serious clinical problem. These were the findings of a working group set up in 1998 by the Chief Medical Officer (England) at which the Scottish Executive Health Department was represented.

It is clear that CFS/ME is not a purely physical disorder. It severely affects the morale and ability to cope of those who experience it. Neither is it a psychological condition alone, because of the many genuine and varied physical signs and symptoms associated with the disorder. So far there is an evidence base for psychological interventions based on cognitive behaviour therapy and graded task assignment, but little else. There is much left undiscovered so far with more research urgently needed into the optimum provision of care.

A short life action group has been established during 2002 in Scotland and started work to translate the CMO (England’s) report into a Scottish context. People with personal experience of CFS/ME, those who care for them, and representatives of voluntary organisations will be included as well as health and social care professionals.

PROTECTION OF HEALTH:
COMMUNICABLE DISEASES

Protecting Children from Vaccine Preventable Diseases - Childhood Immunisation

Vaccine Uptake Rates

Uptake rates for primary vaccination against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib) remain high, and the uptake of meningococcal serogroup C (MenC) vaccine at 24 months has been increasing since its introduction in 1999–2000.

Fig. 2.6 Vaccine uptake at age 24 months, Scotland by quarters, 1995-2001, Q3
Health in Scotland 2001

In contrast, the uptake of measles, mumps and rubella (MMR) vaccine has decreased markedly in 2001. This has also been the trend for England, Wales and Northern Ireland, although rates for Scotland continue to compare favourably.

The figure for MMR vaccine uptake in Scotland for all children reaching their second birthday in 2001 was 88.5%. Pre-school vaccination uptake rates for 2001 indicate that 92.7% of children received fourth doses of diphtheria and tetanus vaccines by their sixth birthday, 92.9% a fourth dose of polio vaccine and 88.3% a second dose of MMR.

Fig. 2.7 MMR vaccine uptake, age 24 months, Scotland, England, Wales and N. Ireland, 1995-2001

Disease Epidemiology

There were no reports of diphtheria, tetanus or poliomyelitis in Scotland in 2001, continuing to represent long-term successes in immunisation. The overall number of notifications and laboratory reports for pertussis remain relatively unchanged (Table 2.3). Analysis of hospital discharge data by ISD in 2001 showed that in recent years over 70% of patients hospitalised with pertussis infection were under the age of 6 months. There is evidence that these infants may be catching pertussis from older siblings, or possibly parents. An acellular pertussis booster for pre-school children was therefore planned in 2001, to be introduced into the routine childhood immunisation schedule from January 2002.

Table 2.3 Vaccine preventable diseases: notifications and laboratory reports, Scotland, 2000 and 2001

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<tr>
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<th>Notifications</th>
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<tr>
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<td>Tetanus</td>
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<td>Poliomyelitis</td>
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The number of notifications and laboratory reports received for measles, mumps and rubella continued to decrease in 2001 (Table 2.3), compared to previous years. Of particular note, for the first year on record, there were no laboratory reports received for measles. However, measles cases occurred in the early months of 2002, which emphasises that the continued control of measles, mumps and rubella can only be sustained by high levels of vaccine uptake in all communities throughout Scotland. MMR continues to be the safest way to protect children against these diseases. A discussion pack was published by the Health Education Board for Scotland, in collaboration with the Scottish Executive and SCIEH, in September 2001 to help parents and health professionals review the evidence about MMR and will help provide the basis for informed decision-making. The Scottish Executive also established an MMR Expert Group, in August 2001, to look at a range of issues flowing from the Health and Community Care Committee's report on MMR and examine evidence relating to the apparent rise in the incidence of autism among children.

Thirteen laboratory reports were received for invasive *Haemophilus influenzae* b (Hib) disease in 2001 (Table 2.3). Hib vaccine was introduced in 1992 and this is the highest annual number of laboratory reports since 1993. Reasons for the increase are still unclear, but the increase has been reflected throughout the UK and continue to be investigated, through collaboration in enhanced UK surveillance.

**Meningococcal Infection**

Following the dramatic decline of *Haemophilus influenzae* b (Hib) meningitis by a successful vaccination campaign in the early 1990s, *Neisseria meningitidis* or the “meningococcus” is now the leading cause of bacterial meningitis in the UK, with around 300-350 notified cases of invasive disease (principally meningitis and septicaemia) per year in Scotland. In spite of significant recent improvements in the early recognition and treatment of meningococcal disease, it continues to cause significant mortality (around 6% case fatality) and long-term morbidity. Over 90% of cases are caused by serogroups B and C, with very small numbers from rarer groups such as Y or W135.

The late 1990s saw a steep rise in notifications of meningococcal disease in Scotland after around 20 years of relative stability. The conjugate Group C meningococcal vaccine (MenC) was introduced in the winter of 1999 in a phased programme, at a point where Group C infections accounted for around 55% of typed cases. The evidence to date suggests a very successful impact on the burden of Group C disease. Surveillance data collated by SCIEH and the Scottish Meningococcal & Pneumococcal Reference Laboratory (SMPRL) show an absolute decline in numbers of cases (355 in 2000 to 271 in 2001, a decrease of almost one quarter) and a sharp reduction in cases of Group C infection in the vaccinated age groups following introduction of MenC vaccine (Figure 2.8). Only a single case of Group C infection has been reported to date in a fully vaccinated individual, emphasising the effectiveness of the vaccine. Although meningococcal disease remains predominantly a disease of very young children, a shift towards older age groups combined with the much higher mortality in adults remains a cause for concern. With seven out of the ten deaths in young adults in 2001 known to be a result of group C infection, the extension of the MenC vaccination campaign to those aged between 20 and 24 in January 2002 should help further reduce mortality, as well as overall incidence, in the under 25s.
Influenza

The flu season of winter 2000–2001 was exceptionally mild, in that the rate of consultations for flu-like illness barely exceeded the baseline activity threshold of 50 GP consultations per 100,000 population. This represents the lowest clinical reporting level since the GP-based “Flu-spotter” scheme began in 1971. Laboratory data did, however, indicate that there was a moderate amount of influenza B in circulation with reports characteristically being received well into the new year, long after influenza A had become sporadic.

Winter 2000–2001 was also the first year of the new enhanced surveillance scheme for influenza and other seasonal viral infections. The Scottish Enhanced Respiratory Viral Surveillance Scheme (SERVIS) is co-ordinated by SCIEH and collects weekly consultation data in real time on respiratory infections from over half of Scotland’s computerised Continuous Morbidity Recording (CMR) practices. Although the population sample covered by SERVIS is around 5% compared with the 10% for the traditional flu-spotter network, it is more representative geographically and for the first time provides age and sex information on those consulting for both influenza-like illness (ILI) and acute respiratory infection (ARI). This information is combined with a linked virological testing programme (a multiplex PCR technique, carried out by the Glasgow Regional Virus Laboratory), which, for the first time in 2000–2001, provided diagnostic data on other seasonal viruses which may also contribute to ILI and ARI consultations. Although based on a limited number of swab results, it was still possible to discern sequential peaks in the seasonal activity of picornavirus, RSV, influenza type A and influenza type B (Figure 2.9).
The SERVIS scheme is one of the most advanced and sophisticated routine influenza surveillance projects in Europe and together with flu spotter data, provided weekly information and advice for NHS Boards and Trusts throughout the winter. SCIEH also collated GP practice data on the take-up of flu vaccine in the last 3 months of 2001, in order to monitor progress towards the target of 65% uptake in people aged 65 and over.

**Tuberculosis**

The Enhanced Surveillance of Mycobacterial Infections (ESMI) scheme was implemented in January 2000, and is supplying continuous detailed information on tuberculosis in Scotland for the first time. The epidemiology of TB in Scotland is different from that elsewhere in the UK in several important respects, principally in that overall numbers are in slow decline, and that the majority of cases (around 85%) are indigenous rather than in persons born outside the UK. This contrasts with the situation in England and Wales, where numbers are increasing (particularly in London) and only around 40% of cases are UK-born. The detailed information held by ESMI will facilitate a number of approaches to tuberculosis control (and eventual elimination) through population or risk-group targeting and clinical audit. Risk factor analysis shows alcohol abuse to be the leading issue by a wide margin (50/85 with recorded risk factors), followed by healthcare workers (15/85), with smaller numbers of immunosuppressed people, homeless and hostel dwellers, and asylum seekers. There are already other areas indicated by ESMI which may repay further examination: for example, of the 360 Scottish cases reported to ESMI in 2001, 24 (8%) had been symptomatic for longer than 6 months at diagnosis. Overall, the data for 2001 (provisional) show little change from those collected for 2000. The value of the ESMI resource will increase as more data are collected in the forthcoming years.
Blood-borne Viruses and Sexually Transmitted Infections

HIV Infection

In 2001, 173 cases of HIV were reported to SCIEH; this was the highest annual total since 1997 and its excess of approximately 20 cases over the totals for each of the previous 2 years can be explained by the continuing increase in the numbers of diagnoses among heterosexuals who have acquired their HIV abroad, particularly in Africa (Figure 2.10). It is estimated that between one-third and one-fifth of such imported infections occur in Scottish travellers. The findings of a new surveillance initiative, established in 2001, to subtype the virus of each newly diagnosed individual, indicates some diffusion of African and Asian HIV strains among heterosexuals, indigenous to Scotland, who have declared no exposure abroad. While the transmission of HIV among injecting drug users (IDUs) remains rare and that among gay men is stable or in slight decline, the greatest HIV risk to the general population is posed by unprotected sexual intercourse among travellers who travel between Scotland and countries with a high prevalence of HIV. Accordingly, SCIEH and the Health Education Board for Scotland are increasing their efforts to improve public awareness of this danger.

Fig. 2.10 HIV reports, Scotland; by risk and year of report

In 2001, the Scottish Executive's Expert Group on the Treatment and Care of HIV and AIDS in Scotland (Chair: Dr Andrew Fraser, DCMO) published its findings. As at June 2001, 1,300 persons with HIV were in clinical care, of whom 75% were being administered Highly Active Antiretroviral Therapy (HAART). There was no evidence of any inequity in access to, or administration of, HAART, vis-à-vis area of residence or HIV risk status. It is predicted that the numbers of persons in Scotland receiving HAART will increase annually during 2001–2004 by about 60 (Table 2.4); the majority of new cases on treatment will reside in Lothian and Greater Glasgow NHS Boards. The increases reflect an increasing prevalence of known HIV infected persons in Scotland, mainly as a consequence of the anticipated large discrepancy between the annual numbers of persons diagnosed with HIV (150–180) and the annual numbers of deaths from HIV (30–70).
Table 2.4 Observed data for 2000 and predictions for 2001–2004: All Scotland

<table>
<thead>
<tr>
<th>Year</th>
<th>Under CD4 Monitoring at end of year</th>
<th>On HAART</th>
<th>Annual Increase</th>
<th>Not on HAART</th>
<th>Eligible for HAART</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 observed</td>
<td>1210</td>
<td>863</td>
<td></td>
<td>347</td>
<td>1004</td>
</tr>
<tr>
<td>2001 predicted</td>
<td>1308</td>
<td>922</td>
<td>+59</td>
<td>386</td>
<td>1073</td>
</tr>
<tr>
<td>2002 predicted</td>
<td>1403</td>
<td>983</td>
<td>+61</td>
<td>420</td>
<td>1144</td>
</tr>
<tr>
<td>2003 predicted</td>
<td>1489</td>
<td>1041</td>
<td>+58</td>
<td>448</td>
<td>1210</td>
</tr>
<tr>
<td>2004 predicted</td>
<td>1571</td>
<td>1099</td>
<td>+58</td>
<td>472</td>
<td>1276</td>
</tr>
</tbody>
</table>

Hepatitis C Virus (HCV) Infection

During January–June 2001, 890 persons in Scotland were diagnosed with HCV; this rate of diagnosis is consistent with that seen during the previous 3 years and brings the total number of known cases to 12,680. Preliminary estimates indicate that a further 20–30,000 infected persons in Scotland remain undiagnosed. The great majority of the 890 recent diagnoses are IDUs who are well represented in almost every Scottish NHS Board. A Scottish Executive sponsored study, undertaken by the Centre for Drug Use Research, University of Glasgow, and SCIEH in 2001, estimated high prevalences of HCV among IDUs in most health boards and that 10,000 of Scotland’s 22,800 current IDUs were infected (Table 2.5). There is evidence that harm-reduction measures – namely, needle and syringe exchange and methadone therapy – have led to a reduction in HCV transmission among IDUs but early findings from a CSO-funded study, conducted in 2001, of recent initiates to injecting in Glasgow, indicate that the incidence of HCV remains extremely high.

Table 2.5 Estimates of HCV infection among injecting drugs users by selected NHS Board area in Scotland

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>i) Anti-HCV prevalence from HIV testing</th>
<th>ii) Estimated number of current drug injectors</th>
<th>iii) Estimated number of HCV infected current injectors</th>
<th>iv) Estimated prevalence of HCV infected current injectors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0% 95% CI</td>
<td>N 95% CI</td>
<td>N 95% CI</td>
<td>% 95% CI</td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
<td>31 19-42</td>
<td>2138 1601-2990</td>
<td>663 368-1052</td>
<td>0.29 0.16-0.45</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>38 27-50</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>Borders</td>
<td>- -</td>
<td>348 128-1866</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>28 17-40</td>
<td>462 350-644</td>
<td>129 72-213</td>
<td>0.18 0.10-0.29</td>
</tr>
<tr>
<td>Fife</td>
<td>29 20-39</td>
<td>866 473-1913</td>
<td>251 105-584</td>
<td>0.13 0.06-0.30</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>23 10-35</td>
<td>838 635-1155</td>
<td>193 81-334</td>
<td>0.13 0.05-0.22</td>
</tr>
<tr>
<td>Grampian</td>
<td>38 33-42</td>
<td>4290 3033-7744</td>
<td>1630 881-2954</td>
<td>0.55 0.30-0.99</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>62 58-66</td>
<td>7187 6085-8615</td>
<td>4456 3676-5397</td>
<td>0.86 0.71-1.04</td>
</tr>
<tr>
<td>Highland</td>
<td>31 22-40</td>
<td>216 55-3385</td>
<td>67 4-1030</td>
<td>0.06 0.00-0.93</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>41 32-50</td>
<td>2369 1281-5289</td>
<td>971 414-2193</td>
<td>0.31 0.13-0.69</td>
</tr>
<tr>
<td>Lothian</td>
<td>36 31-41</td>
<td>3149 1730-6938</td>
<td>1134 510-5230</td>
<td>0.25 0.11-0.55</td>
</tr>
<tr>
<td>Tayside</td>
<td>53 45-60</td>
<td>942 464-2491</td>
<td>499 185-1306</td>
<td>0.24 0.09-0.64</td>
</tr>
<tr>
<td><strong>SCOTLAND</strong></td>
<td><strong>22800</strong></td>
<td><strong>19600-30600</strong></td>
<td><strong>10000</strong></td>
<td><strong>8500-12900</strong></td>
</tr>
</tbody>
</table>
Focusing on Priority Health Topics

Health in Scotland 2001

In early 2001, a Scottish Needs Assessment Programme workshop on “HCV in IDUs” identified the need to evaluate existing and implement new interventions, to prevent infection among this population; the complexity of the challenge is demonstrated by the observation, during the late 1990s, that the frequency of needle and syringe sharing increased in certain areas where there had been a concomitant increase in harm reduction service provision. The Scottish Executive’s Effective Intervention Unit has since released a “call for research” into interventions designed to reduce the incidence of HCV among IDUs.

Hepatitis B Virus (HBV) Infection

In 2001, SCIEH received 357 new reports of HBV; while this total was almost identical to that seen in 2000, there was a noticeable shift in the geographical distribution of infection. A marked decline in reports from Grampian – 54 in 2001 compared to 100 in 2000 and 114 in 1999 – was offset by small increases in Greater Glasgow and Lothian, and a dramatic increase in Lanarkshire (25 in 2000 to 43 in 2001). These observations reflect changing patterns in the spread of HBV among IDU populations. In the context of a resurgence of HBV among IDUs throughout Scotland in recent years, their immunisation against this infection, as recommended by the Health Departments, is strongly encouraged. Indeed, vaccination against both HBV and HAV (Hepatitis A virus) should be considered; in Grampian, during late 2000 and much of 2001, HAV was highly incident among IDUs. A case control study was conducted to ascertain if this virus had spread through the sharing of injecting equipment or through the traditional oro-faecal route; the results are awaited.

Example from Grampian: Blood-borne Pathogens

Preventing the spread of blood-borne pathogens, namely Hepatitis B, Hepatitis C and human immunodeficiency virus (HIV) is a local priority. There are currently outbreaks of Hepatitis A and B, primarily amongst drug injecting users in Aberdeen City. In Scotland, Grampian is second only to Glasgow for the rate at which people are diagnosed as Hepatitis C antibody positive.

The multi-agency Grampian blood-borne pathogen strategy aims to:

■ raise awareness of these infections
■ reduce the spread and
■ ensure effective investigation and management of patients affected.

Implementation of the strategy has included awareness campaigns targeting high risk groups, specialist blood-borne pathogen posts to provide timely advice and Hepatitis B immunisation and increased provision and access to needles and syringes.

Sexually Transmitted Infections, other than HIV

For sexually transmitted infections (other than HIV), the dominant observation in 2001 was the continuing rise in the numbers of Chlamydia diagnoses; 7,149 females and 2,772 males, representing 36% and 50% increases on the previous year's figures, were recorded by Chlamydia testing laboratories. The upward trend in diagnosis has been evident throughout the country since 1997. The increases are considered to reflect increased high risk sexual behaviour among general populations of young male and female heterosexuals, improvements in the sensitivity of the diagnostic test and major increases in screening activity, particularly among females. The large discrepancy between the numbers of male and female diagnoses is explained by the paucity of screening activity among asymptomatic males outside the Genitourinary Medicine Clinic setting. Large variations in the incidence of Chlamydia detection among NHS boards in 2001 suggest that screening practice varies considerably at a geographical as well as a gender level.
The finding that the incidence of Chlamydia diagnosis among both males and females in Highland exceeds rates in most other health boards, supports the view that this infection knows no boundaries.

In 2001, the incidence of gonorrhoea, which had been increasing since 1997, plateaued; the majority of the 817 cases diagnosed in 2001 were male and residents of Lothian and Greater Glasgow, observations which, in part, reflect the higher proportion of gay male cases in these areas. In contrast to Chlamydia, gonorrhoea is generally confined to relatively small sexual networks comprising either gay men or heterosexual men and women in areas of deprivation; however, there are signs to indicate that gonorrhoea is beginning to spread into the wider heterosexual population.

Work is proceeding on a second health strategy for Scotland. Its research stage has now been completed. This includes a review of current sexual health services in Scotland and an analysis of the Scottish sample in the recent National Survey of Sexual Attitudes and Lifestyles. That work will inform the further development of the strategy which will address (among other matters) recent increases in the incidence of Sexually Transmitted Infections and the still high rate of unintended teenage pregnancies in Scotland.

**Healthcare Associated Infection**

It is estimated that any one time 9% of hospital in-patients has a healthcare associated infection (HAI). HAI may include surgical site infections, urinary tract infections, respiratory tract infection, infections due to specified micro-organisms such as methicillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile*. The Report of the National Audit Office in England *The Management and Control of Hospital Acquired Infection (2000)* estimated that 15% of HAI can be prevented with appropriate infection control resources. An estimate of the cost of HAI to the health service in Scotland prepared in 1999 has been updated (A Walker 2001) in the light of newly available data and puts the costs as at least £101 million.

Effective control of HAI requires robust surveillance of HAI, infection control and risk management processes embedded within trusts’ organisational structures. During 2001, the Scottish Executive Health Department has agreed the measures that are to be put in place by trusts in order that HAI can be effectively contained, the operation of these processes monitored by the SEHD and information about the way the NHS deals with HAI made available to professionals and the public.
National and Local Surveillance of Healthcare Associated Infection

Few robust data on the incidence of healthcare associated infection (HAI) are available and much of the existing data do not permit comparisons to be made of the incidence of these infections in different hospitals partly because of differences in definitions and in methods of measuring infection and partly because of differences in the risk to patients of HAI as a result of their own vulnerability or in the hospital environments.

The urgent need to obtain robust data on HAI incidence has been addressed by the Advisory Group on Infection's Subgroup on Surveillance of HAI and Antimicrobial Resistance. The recommendations of the subgroup on HAI surveillance were adopted by the Scottish Executive Health Department and these were conveyed to trusts in Health Department Letter (2001) 57. This HDL requires trusts to use national standardised methodologies to undertake local surveillance:

- trusts are required to implement surveillance of surgical site infection (SSI) following two surgical procedures selected from a short list and provide data for national reporting by April 2003
- trusts undertaking neurosurgery are required to implement surveillance of SSI after neurosurgical procedures
- national reporting of MRSA bacteraemias is to be in place by April 2002.

SCIEH has been funded to collaborate with Trusts in the implementation of HAI surveillance by developing standardised national methodologies, facilitating and assisting with local implementation and collating the national datasets. Early in 2002 a national protocol for surgical site infection was circulated to trusts and development of MRSA bacteraemia reporting was well underway in preparation for the publication in April 2002.

A National HAI Surveillance Steering Group has been set up with the brief to oversee and advise the SEHD on the implementation of the national programme of surveillance of HAI in Scotland, to monitor this and to report on progress. One area of surveillance requiring particular attention is the surveillance of surgical site infections in the period after the patient has been discharged from hospital. Patients are no longer under direct medical supervision and accurate ascertainment of wound infection according to a standard definition is not straightforward. There is no international consensus about the best way to obtain robust data on the incidence of post discharge surgical site infections. A number of pilot projects to examine and evaluate different methods are being implemented.

Managing the Risk of Healthcare Associated Infection

Health Department Letter (2001) 53 "Managing the Risk of Healthcare Associated Infection in NHSScotland", also published in June and based on the recommendations of a report of a joint SEHD and NHSScotland Working Group, requires trusts to address the risks of healthcare associated infection. Responsibility for healthcare associated infection is placed with the Trusts’ Infection Control Committees. Trusts are required to develop training and development programmes for staff, to ensure that the infections control teams are sufficient in personnel and resources to take on the workload associated with risk management including the production of annual infection control programmes and to undertake self-assessment of their performance in risk management of healthcare associated infection. Their annual reports and the results of self-assessment against the Infection Control and other relevant standards will be subject to appraisal by the Clinical Standards Board for Scotland (CSBS) against the CSBS’s Standards for Infection Control published in December 2001.
Antimicrobial Resistance

Currently surveillance of antibiotic resistance in medical practice includes reporting of methicillin-resistant *Staphylococcus aureus* (MRSA), voluntary reporting to SCIEH by 15 laboratories of qualitative data on resistance based on 15 “alert organism/antibiotic combinations” and qualitative data on resistance in Enterobacteriacea. Data on MRSA in Scotland have been collated by SCIEH from the routine reporting to SCIEH by laboratories which has been in place since 1971. Figure 2.12 shows the marked increase since 1998 in MRSA bacteraemias reported to SCIEH. There has not been much change in the same period in reports of methicillin-sensitive *Staphylococcus aureus* (MSSA). Nationally routine quarterly reporting of data on MRSA is to be introduced from April 2002.

Recommendations for national surveillance of antimicrobial resistance are being prepared by the Advisory Group on Infections’ Subgroup on Surveillance of Healthcare Associated Infection and Antimicrobial Resistance which has been meeting during 2001. The subgroup has been considering surveillance in medical, dental and veterinary practice. Their report, which will be available in the first half of 2002, will address the issue of national reporting of routinely generated data, the lack of standardisation of laboratory protocols for testing and reporting (including quantitative reporting of resistance), resistance data from reference laboratories, further development of MRSA surveillance and development of surveillance of antibiotic resistance and prescribing in intensive care units. Proposals for surveillance in dental practice and the issue of surveillance of antibiotic resistance in veterinary practice will also be considered.

**Fig. 2.12 Trends in MSSA and MRSA bacteraemia in Scotland, 1992 to 2001**
Deliberate Release of Biological, Chemical or Radiological Materials

The events of 11 September 2001 and the deliberate release of anthrax in the USA have focused attention on the necessity for preparedness by health services, in collaboration with other agencies, for events caused by deliberate release of biological, chemical or radiological materials. While the overall control of responses to such an incident are at UK level, there is a necessity for NHSScotland to ensure the establishment of local and national expertise, resources and training to secure safe management of response to an incident, particularly at the early stages. To this end, the Scottish Executive Health Department issued guidance *Deliberate Release of Biological and Chemical Agents in Scotland* as the core Scottish document for public health action.

One of the effects of the acute global interest in bioterrorism has been the development of documentation (e.g. scientific and technical information, national and local policies and strategies, interagency guidance). SCIEH has undertaken to provide access to the latest versions of key documentation for public health action and has also been very much involved in surveillance activities. The issue of bioterrorism is one that is unavoidably high on the agenda for the foreseeable future and that will require a continuing strategic programme of awareness and preparation.

The events of 11 September also highlighted the importance of ensuring that the health service in particular but the emergency services in general, were able to cope with the potential deliberate release of hazardous chemical agents. Immediate efforts were directed at identifying the existing capabilities, training needs and resources within Scotland. This resulted in significant additional resources being allocated for specialist equipment, to enhance the ability of Ambulance and A&E services if called upon to handle contaminated casualties or to decontaminate people exposed to chemical agents. In addition research was undertaken by SCIEH to determine the availability of equipment capable of detecting the presence of chemical agents and also the capability of the health service to screen patients for hazardous chemical exposure. This provided useful baseline information for planning future needs and capability levels.

Training

A series of training events were held aimed primarily at NHS staff to raise awareness of issues associated with deliberate release scenarios. Multi-agency events were also held in order to stress the importance of co-operation and joint working between the NHS and the Emergency Services.

An explicit aim of the training was to enable NHS Boards to identify local issues relating to planning, capability and readiness which required enhancement to meet the challenges posed by a deliberate biological, chemical or radioactive agent release within their locality.
ENVIRONMENTAL HEALTH
Public perception of risk was a major factor in determining the environmental health topics which generated attention in 2001.

Foot and Mouth Disease
Concerns regarding potential environmental health threats focused heavily on foot and mouth disease in 2001. The outbreak created a significant environmental burden, mainly in Dumfries and Galloway, in terms of ensuring the safe disposal of the animal remains. The subject also generated public anxiety. These concerns focused on the potential health impact of exposure to the smoke plumes from pyres and to the possible long-term contamination of soil and water sources from the burial of remains and pyre ash. Considerable efforts were made by a wide variety of UK government and local agencies, including Dumfries and Galloway Council and NHS Board, DEFRA, SEPA, SEERAD, SEHD and SCIEH, to undertake environmental risk assessment and monitoring. The reassuring conclusion of studies carried out in Dumfries and Galloway on the risk associated with pyre smoke, was that there was no significant threat to the health of the local population from production of dioxins or other hazardous substances. Monitoring of groundwater and public supplies will continue for some time but evidence to date has not confirmed any significant problems in drinking water. On behalf of SEHD, SCIEH developed a website to provide a single access route to the environmental monitoring data for Scotland (www.fmd-enviroimpact.scieh.scot.nhs.uk). This continues to provide information on the work done by the relevant agencies and access to all existing monitoring data for Scotland.

Exposure to Environmental Agents
Concern about potential adverse health effects associated with exposure to an environmental agent included:

- open cast coal mining in Lanarkshire
- sewage treatment plants and disposal of treated sewage to land
- composting
- chemical accidents and spillages including chlorine at a leisure centre
- depleted uranium used in munitions testing near the Solway Firth
- mobile phone masts and “electrosensitive” people.

Two issues in particular were the subject of planning enquiries, the outcomes of which both underlined the growing recognition of the relevance of environmental health issues in determining the planning decisions.

New Sewage Treatment Plant
Concerns about odours and possible risks to public health were raised by local residents, objecting to the siting of a new sewage treatment plant next to a water reservoir on the Island of Bute. The resulting planning enquiry decision found in favour of the local community objections and required the then West of Scotland Water to include covers in the plans for the sewage treatment tanks at the new plant, to minimise odours and to reduce the possibility of airborne release of pathogenic organisms to the surrounding population.
New Open-cast Coal Mine

In Lanarkshire, a proposal for a major new open-cast coal mining project was rejected by a planning enquiry and this was upheld subsequently following an appeal. In this case the local health concerns related to the potential for generating excessive amounts of fine particulate matter (PM 10) from the excavation of soil and materials and production of diesel emission particles by the heavy machinery and transport equipment, which in turn might pose a health threat to the local population.

The “Precautionary Approach”

The Precautionary Approach (or Principle) is the term used to define situations where it is accepted that even in the absence of definitive evidence, the potential for adverse health effects alone can justify a course of action or a refusal to allow a new development.

In both situations the planning system adopted a “precautionary approach” to potential environmental health threats. This marked a significant shift in the weight attributed to potential, as opposed to definitely proven, health threats. These represent landmark decisions in that they establish precedents for the use of the precautionary principle in assessing the potential health impact of new developments that have environmental impacts.

2001 also saw the introduction of new legislation in Scotland, concerning how proposals for new industrial developments gain approval by SEPA, known by the acronym PPC, standing for Pollution Prevention and Control. NHS Boards became statutory consultees and now have the right to comment and contribute to the assessment of possible health impacts of new developments, which might emit potentially harmful substances to the local environment. This has provided the opportunity to request modifications to proposals to further minimise health risks. SCIEH hosted a training seminar on PPC and developed a guide together with a proforma to assist NHS Board consultees in analysing and commenting on local developments.

As with other environmental health issues, the public perception of the hazards posed by local industries may differ from the views of public health professionals, who base their responses on interpreting available scientific knowledge. Professionals commonly approach issues using the traditional concepts of risk assessment and the “source-pathway-receptor” model, as means of determining the plausibility of any association between an environmental agent and an alleged health effect. The response of the public is frequently based on heartfelt but often poorly specified concerns regarding the possibility of adverse effects associated with often highly visible or controversial developments, such as the introduction of genetically modified crops. The challenge to professionals for the future lies in helping the public to understand better the rationale for the scientific approach to evaluating hazards and in explaining risk assessment in terms that can be understood and accepted but which also address genuine public concerns.
Working in Partnership to Improve Life Circumstances
The key theme of this Report is working together in partnership to improve health in Scotland. This chapter focuses on some specific cross sectoral issues and gives further examples from NHS Boards of partnership working to tackle inequalities and improve life circumstances.

Improvements in Scotland’s health in recent times have not been shared equally by all Scots. Improving Scotland’s health therefore means improving the health of the poorest members of society and closing the gap in health between the most and the least deprived sectors of society. The Government’s social justice agenda includes work in partnership with all parts of Scottish public and private life to improve Scotland’s health. In addition to promoting healthier lifestyles this includes wider issues which impact on health such as:

- realising potential in education
- addressing housing needs
- providing social work services for vulnerable people and groups
- the provision of wholesome food and the means to buy and prepare it
- supporting individuals in adversity.

**WORKING TOGETHER TO TACKLE DEPRIVATION AND SOCIAL EXCLUSION**

The Executive is committed to tackling inequalities in health and improving life circumstances including the socio-economic environment, income, occupation and housing quality. Policy reflects the multiple influences on health and involves a threefold approach:

- influencing key lifestyle factors which affect health. Action on smoking, diet, obesity, physical activity, alcohol and drug misuse, have been covered in Chapter 1 with special emphasis on tackling the influence of deprivation
- focusing on priority health topics – including coronary heart disease, cancer and mental health and protection of health, discussed in Chapter 2
- improving life circumstances to influence the wider determinants of health which are discussed in this chapter.

**Improving Life Circumstances**

Tackling adverse life circumstances is a vital part of tackling health inequalities. Attempts to address life circumstances are primarily by cross sectoral action on poverty and promoting social inclusion. A wide range of actions is being undertaken.
### Progress

Some progress is already apparent:

- the proportion of children in relative low-income households has fallen by 5% between 1996/97 and 1999/2000
- overall unemployment in Scotland is at its lowest level in nearly two decades
- the percentage of unemployed working age people has fallen from 8.5% in 1997 to 5.8% in 2001.

However, 29% of children still live in low-income households. The proportion of working age people living in relatively low-income households has changed little since the mid-1990s. Although unemployment has fallen in the most disadvantaged parts of Scotland, the ratio between the worst areas and the Scottish average has only decreased slightly.

**Fig. 3.1 Unemployment rates in the worst areas and the Scottish average**

![Unemployment rates graph]

Source: Claimant Count: Office for National Statistics General Register Officer for Scotland

### Action to Improve Education

Cross sectoral Scottish Executive policies are in place to address life circumstances. Action is being taken to improve the skills of our young people

- through improving school attainment,
- reducing school exclusion, and
- ensuring 16-19 year olds are engaged in education, training or work.

Schooling time lost through exclusions has gone down slightly between 1998/99 and 1999/2000. While performance in Standard Grade achievement has improved across the board in Scotland, the gap between the poorest performing 20% of pupils and the rest has remained. In addition, 14% of 16-19 year olds are currently not in education, training or employment and this has seen little change over the last few years.

### Better Housing in Disadvantaged Areas

Improving the quality of housing in our most disadvantaged areas has also been important for the Executive. The 1996 Scottish Housing Condition Survey estimated that 8% of all dwellings in Scotland suffered from dampness and 21% suffered from problems of condensation. The 2002 Survey will allow us to assess what progress has been made.
Are We Making Enough Progress?

Routine statistics suggest that although health is generally improving in Scotland, little progress is being made in tackling inequalities. For most of the major causes of mortality, the gap between the least deprived and the most deprived has remained the same or widened over the 1990s.

We cannot expect recent initiatives to show immediate impacts on deaths from diseases like coronary heart disease and cancer. However, lifestyles may be influenced in the short term and will influence future health. There have been some small but encouraging reductions in smoking prevalence in women from the most deprived areas of Scotland in the late 1990s. The next Scottish Health Survey, which is due to be undertaken later this year, will show whether these improvements have been sustained. However, other lifestyle statistics are less promising. In particular, differences in diet appear to be increasing.

The commitment to tackling life circumstances is a key aspect of tackling health inequalities. There have been some encouraging changes, in particular the reduction of children living in poverty and this is likely to show long-term benefits. However, more progress is essential. External factors, such as the economic cycle, will inevitably influence future progress.

Improvements in health and reductions in inequalities are likely to be a long-term process. In all these areas continued cross sectoral, multi-disciplinary action is essential if these efforts are to succeed.

Further Action in Collaboration with the Health Department

A wide range of actions is being undertaken. These include:

- Four national health demonstration projects which include tackling health inequalities within their aims
- Healthy Living Centres
- Social Inclusion Partnerships
- Action across a range of Executive departments and beyond.

Health Demonstration Projects

There are four health demonstration projects, in the priority areas of:

- child health
- sexual health of young people
- coronary heart disease
- cancer.

These were set up to run for 3 years and act as testing grounds for action and a learning resource for the rest of Scotland. Starting Well, Healthy Respect and Have a Heart Paisley were all launched in Autumn 2000 and Cancer Challenge was launched in May 2000 as part of a UK-wide pilot of screening for colorectal cancer.

Each project has specific aims and objectives, appropriate to its own topic, but all share certain key principles including the important principle of “an emphasis on reducing inequalities in health and tackling adverse life circumstances”. Lessons learned from the projects will help to inform policy and practice nationally. Key elements of the Demonstration Projects are now in place. The projects are starting to consider what lessons can be learnt for policy and practice generally, including how to access, involve and meet the needs of priority groups and decrease health inequalities. Scotland-wide Learning Networks will be set up in the coming year.
Healthy Living Centres

Healthy Living Centres are intended to provide a focus for communities to develop better health at the local level and concentrate, in particular, on areas of socio-economic deprivation. The centres vary according to local need. Examples of projects include:

- the Inverkeithing Area Project led by West Fife Local Health Services which has a community flat providing a base for services and advice to young people and families with young children
- the Stirling Health Hub led by Stirling Health and Wellbeing Alliance, which provides a base for staff to provide outreach services and well-being activities to six regeneration areas
- the Health Hit Squad led by East Ayrshire Council which uses a staffed mobile resource unit to raise awareness of health issues and promote healthy lifestyle in 17 regeneration areas.

Social Inclusion Partnerships

There are 48 Social Inclusion Partnerships (SIPs) in Scotland. Their aim is to regenerate communities most in need by bringing together key public agencies, the private sector, voluntary sector and representatives of the community, whether in a geographical area (e.g. Greater Govan in Glasgow) or for a specific group of vulnerable people (e.g. ethnic minorities in Fife).

The SIPs funded a range of projects to tackle health inequalities during 2001. These include:

- a Recreation Partnership Project in East Ayrshire SIP to promote positive social interaction and improved health for children aged 5-12. This funded nine Kids Clubs in the SIP coalfield communities, providing free and reduced rate access to leisure and recreation facilities as well as promoting healthy eating and general well-being
- a project in Glasgow to provide alternatives to women who are involved in prostitution and to help prevent vulnerable young women from moving into prostitution. An Intervention Team was set up to offer counselling, advocacy, advice on housing as well as helping women to access mainstream services
- funding of a Health Development Worker in Moray, involved in exploring ways to engage young people from improving their dental health to thinking about alternatives to alcohol on a Friday night.
Action Across Executive Departments

Important action across the Executive and wider UK government action in 2001 included:

Expansion of the New Community School Pilot
These schools are intended to create a community resource for social inclusion of children and adults. They provide a range of services including:
- education
- health promotion
- family support services.

In 2001 the trial phase of the New Community Schools Pilot began. There are now 62 projects involving over 400 schools.

Launch of the UK Fuel Poverty Strategy
In 2001 the UK Fuel Poverty Strategy was launched, which is a central heating initiative for pensioners and social tenants. Its main target is “to end the blight of fuel poverty for vulnerable households by 2010”. The Scottish Executive has set a target:
- to “ensure that all pensioner households and tenants in the social rented sector will live in a centrally heated and well insulated home by 2006”.

Funding was announced in 2000 to install central heating in such households.

Increase in Changes to Working Family Tax Credit
The Working Family Tax Credit (WFTC) was introduced in 1999 to encourage parents without jobs to move into employment and to provide additional help to those with low paid jobs. In Scotland 124,000 families are receiving WFTC and it is estimated that the benefits and tax changes since 1997 have resulted in families with children being, on average, £1,000 better off per annum. From 2003 an integrated system of income-related support for families and children is being introduced with a new Child Tax Credit and Working Tax Credit. This is intended to streamline the system and increase take-up levels.

Action by the Health Education Board for Scotland
Tackling deprivation and social exclusion is crucial to success in health promotion. Factors such as these present the greatest challenges to the health improvement effort as they act directly on people’s health and on their life circumstances in a way that can present major barriers to people’s capacity to change. The activities of the Health Education Board for Scotland (HEBS) are geared towards helping communities, organisations and individuals to increase their involvement in health improvement activities. Key to this is HEBS support to a wide range of workers from statutory and voluntary sectors in developing their health promoter roles. Some of HEBS initiatives on topic based priorities have been given earlier in Chapters 1 and 2. Other activities by HEBS include the following:

- HEBS continued the funding of the Community Health Exchange (CHEX), which provides networking support and training for community health workers developing good practice guides and contributing to policy development. In partnership with Glasgow Healthy Cities Project, work was undertaken on a guide on community development and health and this incorporates the popular Understanding the Policy Maze and a Directory of Community Health Projects in Scotland.
In partnership with Edinburgh University and CHEX, HEBS extended the network of trained tutors who can deliver the Health Issues in the Community course in communities across Scotland.

Open Doors, a youth work project at Polmont Young Offenders Institution, was managed in 2001 by a partnership involving HEBS, Community Learning Scotland, the voluntary sector and a range of statutory organisations including employment and housing. A very positive evaluation of this multi-agency project has revealed the potential for addressing health promotion needs of this particularly vulnerable group of young people with a generic youth work approach.

The Health Promoting Health Service Framework was launched in June 2001 and provided a flexible tool to assist health service staff in their health promotion roles. HEBS is encouraging wide uptake of the Framework and it is being tracked for impact at nine specific sites ranging from a community pharmacy to a whole Trust.

Funding support was maintained for Voluntary Health Scotland, thus providing opportunities for networking and co-ordinated input into health promotion policy.

HEBS started work on establishing three new programmes, with support from the Health Improvement Fund, for

- Children and Families
- Young People, with a special emphasis on tobacco
- Health in Later Life.

HEBS has been an active partner in the CoSLA-led initiative to pilot public health training for senior local government officers and elected members. Workshops were delivered initially in three council areas on, for example, inequalities in health and the importance of a shared understanding between local authorities and NHS Boards in improving health through the community planning process. By the end of the year, plans were being made to roll the programme out to other areas.

HEBS mass media campaigns continued to focus for adults on the Big 3, covering the prevention of coronary heart disease, cancer and stroke. Advertising and PR highlighted the preventability of Scotland’s main killers whilst encouraging the public to make small but manageable changes to their behaviour in terms of tobacco, eating and physical activity.

The Think About It teenage health initiative continued its track record of using new and sometimes unusual approaches in challenging teenagers to think about their health, behaviour and relationships. The Think About It campaign includes materials on tobacco, alcohol, drugs and sexual relationships.
Action by the Public Health Institute of Scotland

The Public Health Institute of Scotland (PHIS) was established in January 2001, following the recommendations of the Review of the Public Health Function. The main role of PHIS is to help increase the effect of the combined efforts of the many national, regional and local organisations and groups that work to improve health in Scotland. PHIS is committed to working with existing public health networks and creating new ones from across Scotland to develop and strengthen practice. It also plays a key role in improving communications about public health in Scotland, contributing to national policy developments and serving as a reliable and respected source of advice on public health.

The PHIS work plan reflects discussions with the many constituencies in Scotland, both within and outwith the NHS, with an interest in health improvement. The work plan is organised under three main themes:

- Public health information
- Evidence
- Skills.

The Areas Highlighted in the Ottawa Charter for Health Promotion are

- Healthy public policy
- Healthy environments
- Healthy communities
- Healthy individuals
- Reorientating services

These are used to organise the public health evidence section of the work programme.

During 2001 significant milestones were achieved.

- The launch of the constituency profiles in March was the first expression of one of the major pieces of work in the PHIS programme, the Public Health Information project.

- Since then a Public Health Information Network for Scotland has been established with over 100 members. Network seminars were held in April and November to share information about a variety of relevant projects including pilots aimed at developing holistic or integrated datasets in local areas in Scotland. In addition three working groups of the network were established to test the use of such “holistic” data.

- PHIS has supported the development of the new LHCC Public Health Practitioner (PHP) posts, in conjunction with the Scottish Executive. Almost all PHPs were in post by the end of 2001 and PHIS has contributed to:
  - the production of an agreed competency framework for the posts
  - the creation of a national network
  - the development of a national training programme
  - the commissioning of a national evaluation process.
The Public Health Workforce
Throughout 2001 PHIS was involved in debates about the definition and development needs of the public health workforce. Agreement was reached with the Public Health Function Implementation Group that work should focus initially on multi-disciplinary public health professionals with a full time public health role and on the wider group of professionals who contribute to the improvement of health but are not full time public health professionals. PHIS will produce in 2002 a framework for taking forward the development of a postgraduate level qualification for the first group and training opportunities for the wider group.

Induction Programmes for NHS Boards
PHIS also had significant input into the induction programmes for the unified NHS Boards and led a consultation exercise on maximising the contribution of health promotion to health improvement. In other areas of work, good progress was made on the establishment of a wide range of working groups and networks, looking at issues such as healthy public policy, public health pharmacy, the healthy environment and health impact assessment.

Better Communications
PHIS has actively sought to develop its links with organisations outside Scotland, particularly with the Health Development Agency and the King's Fund, who share many of the same interests as PHIS. Several meetings have also been held with the Public Health Observatories in England, leading to discussion in Scotland on the formation of a Scottish Public Health Observatory comprising ISD, SCIEH, HEBS and PHIS. PHIS will take the lead on this and link in with the developing network in England.

PHIS is committed to maintaining two-way communication with its constituencies and has produced a leaflet “What is PHIS?” outlining its objectives and ways of working. This leaflet has been distributed widely to the health service, local government, the academic sector, the voluntary sector, community groups and many others. “What is PHIS?” emphasises that PHIS is a resource for all of Scotland and includes a feedback slip so that people can register their interest in being involved in PHIS working groups and networks and comment on the work and approach being taken.

2001 was a “start-up” year for PHIS, during which a great deal was achieved establishing the organisation, clarifying its work programme and developing extensive networks involving all parts of Scotland and a great many organisations and groups. PHIS has already made its mark in influencing and defining the health improvement agenda for Scotland and as it enters its second year of life the work of its many networks should make a significant contribution to moving that agenda on.

ACTION BY NHS BOARDS
Examples of work from the NHS Boards, Forth Valley, Grampian and Highland have already been given earlier in Chapters 1 and 2 and further examples follow in this section.
WORKING TOGETHER TO IMPROVE HEALTH IN FORTH VALLEY

**Forth Valley ‘Food Links’**

This new three year partnership programme is funded by NHS Forth Valley, Falkirk, Clackmannanshire and Stirling Councils and a Scottish Executive Sustainable Action Grant. It has developed from “Food Futures”, an eighteen month pilot programme that ended in March; one of only twelve UK and three Scottish pilots. From the pilot a strategy for the ongoing development of a sustainable local food sector was developed, local food initiatives were supported and a local partnership forum formed.

Action groups established include:

- community cafes
- vegetable growing schemes
- farmers’ markets
- cooking skills groups.

Forth Valley Food Links will encourage the development of a sustainable local food sector. In particular it will seek to:

- improve access to fresh local produce
- promote environmentally sustainable production methods
- reduce economic leakage in Forth Valley.

The underlying principles of working in partnership, inclusivity and sustainability are needed to tackle the hard issues of what people eat, what choices are available, what people can afford to eat and how they can change.

**Making Communities Safer in Forth Valley**

An integral part of health is about both being and feeling safe and secure. A survey of young people carried out by Falkirk Council in 1998 highlighted reasons for young people feeling safe and unsafe.

<table>
<thead>
<tr>
<th>Reasons for feeling unsafe</th>
<th>Reasons for feeling safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being alone at night</td>
<td>Being with friends</td>
</tr>
<tr>
<td>Fear of being attacked</td>
<td>Being in a crowd</td>
</tr>
<tr>
<td>Being in a strange area</td>
<td>Daylight</td>
</tr>
<tr>
<td>Drunks and drug users</td>
<td>Being in their own house</td>
</tr>
<tr>
<td>Public transport</td>
<td>Knowing the area</td>
</tr>
<tr>
<td>People from other areas</td>
<td>Well lit place</td>
</tr>
<tr>
<td>Gangs/fights</td>
<td>CCTV</td>
</tr>
<tr>
<td>No decent street lights</td>
<td>Being with the family</td>
</tr>
<tr>
<td>Bullies</td>
<td>Living in a good neighbourhood</td>
</tr>
</tbody>
</table>

Source: Falkirk Council: Young People’s Strategy Survey 1998

Many factors impact on this and they all require an approach by all agencies working in partnership. Central Scotland Police and NHS Forth Valley 2 years ago developed a post unique in Scotland: that of an NHS police liaison officer working in and as a full member of the Directorate of Public Health.
This has been a most fruitful partnership and a large number of issues and problems have been addressed and resolved or improved through this post. Examples of the type of areas of work have included:

**Improving the Safety and Security of NHS Staff, Patients and Visitors**
The safety and security of persons using NHS property is paramount. A survey in August 2000 of NHS staff at both Falkirk and Stirling Royal Infirmaries showed that 21% have been the victim of crime in the workplace (the greatest proportion relating to assault). In order to reduce these risks training courses on management of violence and aggression have now been set for all staff working in Forth Valley Acute and Primary Care Hospitals. Similar training is also provided for GPs and staff. Security and safety surveys have also been carried out at Acute Trust and PCT property with relevant advice provided in order to improve personal safety and security at those premises.

**Domestic Violence**
It is considered that one in five of all women and children experience domestic violence. The problem is however often not even broached by NHS staff for fear of being unable to respond or because they feel it is not any of their business. Police, social services, primary health care, hospital staff and others can tackle this much more effectively together. Forth Valley was one of the first areas in Scotland to take a partnership approach to this. A domestic violence training worker for both NHS and Council staff now works in Forth Valley to raise awareness and help to ensure women experiencing domestic violence are supported and directed to help and not ignored or turned away. Only by working in partnership can we achieve the change in culture and attitudes that means that it is unacceptable in all sectors of the community for a man to be violent to his wife or partner.

**JOINT WORKING IN GRAMPIAN**
Grampian has made a substantial investment in joint working for health, particularly in the last four years and welcomed the Scottish Executive’s initiative to build public health capacity with a health improvement post in each local authority in Scotland. The additional funding supports each local authority as it develops its public health role, to tackle health inequalities and to promote the health of communities. The challenges in producing and implementing joint local health improvement plans within the framework of the community planning process will be assisted by working towards a shared understanding of the respective roles in improving the health of our communities.

**Health Imperatives**
In order to meet the health, social, educational and economic needs of the people of Grampian, a wide range of public organisations are working together sharing their skills, knowledge and resources. The development of data sharing agreements with the community planning partners will improve our data and planning to address life circumstance. As a priority, two networks are being developed. A Child Health Network will be established by March 2003 to develop a coordinated strategy for child health services.

Priority action includes targeting children, young people and their families in low-income households in disadvantaged communities. The two social inclusion partnerships tackle determinants of ill health in four communities of Aberdeen City and with young people in Moray.
Health in Scotland 2001

The Great Northern Social Inclusion Partnership

The Great Northern Social Inclusion Partnership, established in 1997, is implementing its health plan. Initiatives include a credit union, Food Co-ops, community well-being project and support for lifestyle changes such as giving up smoking, being more active and tackling drug and alcohol issues.

The Health Improvement Fund supports increased nutrition and dietetic input into disadvantaged areas including provision of weaning boxes to support health visitors facilitate weaning sessions with parents, provision of training for staff in family centres and nutritional assessment of snacks served and a utensil loan scheme. The fund has also been used to support the healthy eating policy work with local authorities providing financial support to pilot schemes aimed at increasing fruit consumption.

The Moray Youthstart Social Inclusion Partnership

The Moray Youthstart Social Inclusion Partnership, the Moray Council, Princes Trust and NHS Grampian support the Mobile Information Bus (MIB) which aims to identify and address the health needs of young people (12–18 years) in rural areas. Designed with input from young people, the MIB has comfortable seating, private areas and computers/video/music to create the right atmosphere. Staffed by local community workers and health promotion assistants young people are supported to identify and address their needs with the help of local agencies. The 6 week programmes of activities have resulted in transport schemes into the nearest city, shelters to provide meeting places, sessions on health topics and advice from Grampian Careers and the CAB.

Child Health in Grampian

Improving child and family health is both a national and Grampian priority. The importance accorded to this group is evidenced in the multi-agency attendance and input to the locally convened Child Health Improvement Programme Child Health Seminar held at the end of 2000. The outcome of this event and more recently, the application of the Health Improvement Fund resources was an acknowledgement of the need to improve the co-ordination of the planning and delivery of children's health services in Grampian. In response to this a review of current issues and working arrangements was commissioned with the ultimate objective of making recommendations to NHS Grampian on a way forward to developing a strategic framework for children's health services. The recommendations are for the appointment of a strategic co-ordinator and a clinical lead who will work together in partnership to develop the strategic framework. Central to this will be the development of a Grampian-wide NHS-based network which, ultimately, will expand to include local authorities, the voluntary sector and other agencies involved in the provision of services to children and their families.

Scotland’s Health at Work in Grampian

Scotland’s Health at Work is the national award scheme established in 1996 to reward employers who demonstrate commitment to improving health and well-being in their workforce. This unique partnership between private and public sector partners (CBI, STUC, Enterprise companies, CoSLA, Federation of Small Businesses, NHSScotland) now reaches almost 21% of the Scottish workforce with 661 organisations involved in the scheme. SHAW’s energies in 2002–03 will be focused on working with small and medium sized enterprises plus supporting our public sector partners.
NHS HIGHLAND

Joint Working to Improve the Health of Young People

NHS Highland has identified the health and well-being of children, young people and families as a priority. The core aims include:

- developing health and well-being through public health and health promotion activities
- developing a combined child health service within the NHS in Highland
- developing integrated child health services in partnership with the Highland Council and key agencies
- reducing health inequalities and promoting social inclusion amongst children, families and young people.

NHS Highland has worked closely with the Highland Council and its other partners to address these aims. Indeed, structures for integrated children’s services delivery are well advanced in Highland.

The Joint Committee on Children & Young People presides over a structure that co-ordinates policy, service development and delivery across the responsibilities of Health, Education and Social Work. At the level of eight distinct areas in Highland\(^1\), services come together in Area Children’s Services Forums. These Forums bring together Area Managers from Education and Social Work and Locality Services Managers from the Local Health Care Co-operatives.

New Community Schools in Highland

One of the principal vehicles for effective joint working has been the piloting of New Community Schools. The New Community School (NCS) concept is essentially about optimising educational opportunities and life prospects for children, by ensuring that they and their families are offered integrated education, social work, family support and health and health promotion services. The initiative is highlighted as a cornerstone of improving life circumstances in the 1999 White Paper Towards a Healthier Scotland.

The Current Situation in Highland

Two school clusters in Highland successfully applied to become New Community Schools – the associated school groups of Inverness High School and Alness Academy. Both are now into the final year of their 3 year programmes.

These pilots have been co-ordinated locally by the Area Children’s Services Forum. Integrated multi-agency teams (typically comprising health, social work and community education) are co-located within the school base and are led by an Integration Manager. Multi-agency local management groups provide leadership and support locally and there is a central strategy group.

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\(^1\) Inverness, Nairn, Badenoch & Strathspey, Lochaber, Caithness, Sutherland, East, Mid & West Ross, and Skye & Lochalsh
NHS Highland Input

This occurs at three levels:

- Membership of the NCS Strategy Group by NHS Board (Director of Public Health & Health Policy and Health Promotion Manager) and primary care managers including the Children’s Services Manager. The strategy group overviews both NCS projects, as well as ensuring strategic alignment across health, child and family and education policy areas. It is also responsible for the strategic overview of evaluation and future New Community school roll-out. The Director of Education chairs the group.

- NHS membership of NCS local management groups is at LHCC level, though there is also input on an advisory level from Health Promotion and Public Health Specialists (such as in relation to sexual health). Local management groups are responsible, in conjunction with the Integration Manager, for operational planning and management.

- Operational input to NCS, through school nursing and other health professionals.

In addition, a whole time post has been funded from the Health Improvement Fund to support the development of health promoting schools across Highland. The post, which is jointly managed through Education and the Health Promotion Department, is initially focusing on the two New Community Schools. Priorities for the post include nutrition (largely through School Nutrition Action Groups), mental health and accidents.

The Pilots in Highland

The pilot projects’ focus has been on the individual child, his or her family and the community. The aim has been to meet each child’s needs in the round. The key has been the integrated provision of services – teachers, health professionals, social workers, community education workers, and others working together as a team. Additionally, many other personnel have become formally and informally aligned or associated with these core teams. This has allowed health professionals to work alongside other professionals on common objectives and as part of shared programmes of work.

Each project has fully recognised the extended role of the family and the community. As well as involving the wider community in specific planning events, the NCS pilots have welcomed and deployed volunteers from the community within strands of activity.

Many initiatives have taken a whole school approach, including out-of-school-hour activities, breakfast clubs and health promoting school developments. As well as targeting improved health for children, at both an individual and group level, each pilot has begun to take a real whole school approach by also addressing the health needs of school staff. Services and resources have been targeted at children, families and communities in greatest need. These services have been sustained at times when schools have traditionally been closed to local communities, including in the evenings and school holidays. The schools have also reached out into the local communities, with activities such as breakfast clubs and out-of-school care taking place in local halls.
Tri-partite quality assurance processes, involving health workers alongside other professionals, have confirmed the success of this approach, in engaging both children and families and in making significant inroads to promote social inclusion:

- enhanced support to families
- improved school attendance
- evidence of sustained achievement
- heightened awareness of healthier lifestyles
- improved nutrition.

**Evaluation**

Evaluation of New Community Schools is being undertaken on a national and local basis. The Scottish Executive is managing the national evaluation. Locally, both quantitative and qualitative measures are being used, including those considering social inclusion, educational and health outcomes. Lifestyle surveys have been conducted in each school cluster, and both NCS have been subject to quality assurance (QA) visits undertaken by a multi-agency team comprising health, education and social work.

**The Future**

It is the intention of the Scottish Executive to roll out NCS across all schools in Scotland. Additional resources have been earmarked, which in Highland will amount to over £1 million per annum, with both existing and other new resources being added to order to enable roll out. The roll out of the New Community School approach across all schools in Highland is now being planned. This will focus around a number of key targets, including outcomes for improved health:

- percentage increase in number of 5–15 year olds free of dental caries
- percentage decrease in number of young people aged 12–15 engaging in drug, alcohol and substance misuse
- percentage reduction in pregnancy rates for 13–15 year olds
- percentage increase of schools with Health Promoting School status
- percentage of children looked after for more than 6 months with health needs – including mental health – assessed at least annually.
Health in Scotland 2001

STRENGTHENING THE WORKFORCE
Nursing and Midwifery

2001 saw the publication of two landmark documents, *Caring for Scotland – the Strategy for Nursing and Midwifery in Scotland* and *Nursing for Health – A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public’s Health*. Together these strategic reports set out the future direction for nursing and midwifery in Scotland. A direction based upon:

- Promoting health as well as health care
- Community and user participation in service development and delivery
- Social justice
- Effective partnership working between different professions, sectors and agencies
- Integrating clinical governance and effectiveness into service delivery
- Gaining maximum benefit from information technology.

*Caring for Scotland*

*Caring for Scotland* recognised that advances in knowledge and technology combined with public demands for greater involvement in deciding where, when and how care is delivered, require increasing flexibility and accountability from healthcare staff. The determination underwriting *Caring for Scotland* is that whatever the future shape of health care, Nurses and Midwives will be prepared to respond. They will be at the forefront in providing the best possible standards of care built on principles of partnership, accountability and professional excellence.

Some specific highlights of development over the year are summarised below:

**National Review of the Contribution of Nurses to the Care and Support of People with Learning Disabilities**

Health is important to all in Scotland and no more so for people with learning disabilities, many of whom have considerable health needs. As part of the evolving agenda set by *The Same as You? A review of service for people with learning disabilities*, it is important to identify the contributions made by health professionals, including nurses, where the emphasis is on promoting independence and social inclusion for all people with learning disabilities. A National Review of the contribution of nurses to the care and support of people with learning disabilities commenced in June 2001. Work involving users, carers, nurses and many others took place across Scotland to identify the range of contributions made by nurses and midwives now and the developments required in the future.

**Clinical Leadership**

*Caring for Scotland* and *Nursing for Health* recognised the importance of clinical leadership as a driver for improving the quality of care. Clinical leaders in nursing and midwifery need to have the ability to lead in their local teams and organisations, across professional and agency boundaries and in national forums. Sisters/charge nurses in hospitals and community settings are already acknowledged leaders who make crucial contributions to ensuring high standards of clinical care. Significant investment in developing the leadership skills of this group was made during 2001 as a vital component of leadership development in NHS Scotland.
Professional Regulation
Legislation to introduce a new regulatory body for nursing was introduced to the Westminster Parliament in November 2001. On 1 April 2002, the Nursing and Midwifery Council (NMC) took over from the UK Central Council for Nursing, Midwifery & Health Visiting (UKCC) which has governed nurses for the past 22 years. The new streamlined organisation will be more flexible, more responsive and will allow development of professional standards to reflect the changing workforce needed by the modern NHS. As part of the establishment of the NMC, the role of the National Board for Nursing, Midwifery & Health Visiting for Scotland also ended on 31 March. Caring for Scotland proposed the establishment of a Scottish Nursing & Midwifery Education Council with a remit to support post-registration education. Development work during 2001 ultimately led to a more creative solution, bringing together responsibility for the education of all NHS staff into a new Special Health Board, NHS Education for Scotland. It will take a strategic approach to the development of multi-disciplinary skills, helping to underpin new models of working crucial to the modernisation of NHSScotland.

Nursing for Health
Nursing for Health recognised that nurses, midwives and particularly health visitors are all key members of the public health workforce. In doing so, it has created new opportunities and contributed to a new climate for health improvement work in NHSScotland. In particular, the creation of Public Health Practitioner roles in each LHCC has enhanced the value of public health work within LHCCs and created a vital bridge between public health practice and leadership. The new practitioners, coming from a variety of clinical backgrounds, will be catalysts for change, forming new partnerships and helping co-ordinate local activity to more effectively meet the health needs of communities.

The development of the public health nurse role, bringing together health visiting and school nursing into a single discipline, better equipped to meet the health needs of local communities, is already starting to have an impact on the effectiveness of practice. Further work during 2002 will focus on developing and applying the skills of the public health nursing community.

Facing the Future
On 19 November, the then Minister for Health, Susan Deacon, welcomed key players from the nursing and midwifery professions, the NHS, education and the private sector to a major recruitment and retention convention in Edinburgh. The purpose of the convention was to begin to address the long-term workforce needs of the NHS. Following the convention the Minister for Health and Community Care announced a £5 million investment in new initiatives to launch the national year of recruitment and retention in 2002. The initiative includes:

- Return to Practice programme
- Guaranteed minimum of 1 year's employment in NHS for 1,500 newly qualified nurses graduating by October 2002
- Creation of 1,000 clinical leaders by December 2002
- Nurse cadet schemes.

Taken together these developments reflect the vibrant nature of nursing and midwifery in Scotland. 2001 saw significant development building upon existing strengths to create an exciting vision of future practice.
Examples

Glasgow Primary Care Liaison Team
As part of the national review of the contribution of nurses to the care and support of people with learning disabilities, new and innovative nursing practice has been identified. The Glasgow Primary Care Liaison Team is one such example. Initially funded for 2 years by Greater Glasgow NHS Board, the Team, comprises specialist Community Learning Disability Nurses, a Health Promotion Officer, Speech and Language Therapist, Administrator, Research Assistant and sessional General Practitioners. The team all work collaboratively with Primary Care Teams, Glasgow University, Glasgow Healthy City Partnership, service users and carers to assess health need individually and across Glasgow. The Primary Care Liaison Team aims to improve access to and support Primary Care services by developing and promoting best practice. The work of the Team is being evaluated as part of on-going research and offers a potential model that could be developed across Scotland in the future.

NURSE/MIDWIFE CONSULTANTS
The advent of the Nurse/Midwife Consultant is recognised as a real opportunity for nurses and midwives to strengthen clinical leadership within the profession. Establishing nurse/midwife consultant posts will contribute to better outcomes for patients, clients or communities’ multi-disciplinary teams, by improving services and quality of care. These posts more often involve cross-boundary, interagency and interdisciplinary collaboration and will reflect the local health planning and national policies and strategies. For example:

Nurse Consultant in Cancer Care
As part of their Trust Cancer Strategy North Glasgow University Hospitals NHS Trust developed a new clinical leadership post responsible for leading and developing cancer nursing practice in the Beatson Oncology Unit. The post holder has a key role influencing the development of cancer services in Scotland predominately through the Scottish Cancer Group, West of Scotland Regional Cancer Advisory Group and the Lead Cancer Nurses Forum (Scotland).

Consultant Public Health Nurse
Tayside NHS Board have developed the post of Consultant Public Health Nurse. The post holder takes a lead in identifying and addressing the health needs of homeless people as well as playing a key role in the Board’s public health and primary care network and leading the development of public health nursing both locally and nationally.
# Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADAT</td>
<td>Alcohol and Drug Action Team</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMI</td>
<td>Acute Myocardial Infarction</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<tr>
<td>ASH</td>
<td>Action for Smoking and Health</td>
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<tr>
<td>BOC</td>
<td>Beatson Oncology Centre</td>
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<tr>
<td>CAB</td>
<td>Citizens’ Advice Bureau</td>
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<tr>
<td>CBI</td>
<td>Confederation of British Industries</td>
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<tr>
<td>CCTV</td>
<td>Closed Circuit Television</td>
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<tr>
<td>CFS/ME</td>
<td>Chronic Fatigue Syndrome/Myalgic Encephalitis</td>
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<td>CHD</td>
<td>Coronary Heart Disease</td>
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<td>CHEX</td>
<td>Community Health Exchange</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CMR</td>
<td>Continuous Morbidity Recording</td>
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<tr>
<td>CoSLA</td>
<td>Convention of Scottish Local Authorities</td>
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<tr>
<td>CRAG</td>
<td>Clinical Resource and Audit Group</td>
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<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
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<tr>
<td>CSO</td>
<td>Chief Scientist Office</td>
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<tr>
<td>DEFRA</td>
<td>Department of Environment, Food and Rural Affairs</td>
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<tr>
<td>DEPCAT</td>
<td>Deprivation Category</td>
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<tr>
<td>EGHOP</td>
<td>Expert Group on Healthcare of Older People</td>
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<tr>
<td>ESMI</td>
<td>Enhanced Surveillance of Mycobacterial Infections</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
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<tr>
<td>HAI</td>
<td>Healthcare Associated Infection</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<tr>
<td>HDL</td>
<td>Health Department Letter</td>
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<td>HEBS</td>
<td>Health Education Board for Scotland</td>
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<tr>
<td>Hib</td>
<td><em>Haemophilus Influenzae</em> Type b</td>
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<tr>
<td>HIV</td>
<td>Human Immuno Virus</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
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<tr>
<td>ILI</td>
<td>Influenza-like Illness</td>
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<tr>
<td>ISD</td>
<td>Information and Statistics Division</td>
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<tr>
<td>LHCC</td>
<td>Local Health Care Co-operative</td>
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<td>MCN</td>
<td>Managed Clinical Network</td>
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<td>MenC</td>
<td>Meningococcal Sero Group C</td>
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<td>MIB</td>
<td>Mobile Information Bus</td>
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<tr>
<td>MMR</td>
<td>Measles, Mumps and Rubella</td>
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<td>MRSA</td>
<td>Methicillin-resistant <em>Staphylococcus Aureus</em></td>
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<tr>
<td>MSSA</td>
<td>Methicillin-sensitive <em>Staphylococcus Aureus</em></td>
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<tr>
<td>NCS</td>
<td>New Community School</td>
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<td>NESCCAG</td>
<td>North East Scotland Cancer Co-ordination Advisory Group</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
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<td>PHIS</td>
<td>Public Health Institute of Scotland</td>
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<td>PHP</td>
<td>Public Health Practitioner</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>RSV</td>
<td>Respiratory Syncytial Virus</td>
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<tr>
<td>SCG</td>
<td>Scottish Cancer Group</td>
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<td>SCIEH</td>
<td>Scottish Centre for Infection and Environmental Health</td>
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<tr>
<td>Acronym</td>
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<td>SDMD</td>
<td>Scottish Drug Misuse Database</td>
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<td>SEERAD</td>
<td>Scottish Executive Environment and Rural Affairs Department</td>
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<tr>
<td>SEHD</td>
<td>Scottish Executive Health Department</td>
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<tr>
<td>SEPA</td>
<td>Scottish Environment Protection Agency</td>
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<tr>
<td>SERVIS</td>
<td>Scottish Enhanced Respiratory Viral Surveillance Scheme</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<tr>
<td>SIP</td>
<td>Social Inclusion Partnership</td>
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<tr>
<td>SMPRL</td>
<td>Scottish Meningococcal and Pneumococcal Reference Laboratory</td>
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<tr>
<td>SNAP</td>
<td>Scottish Needs Assessment Programme</td>
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<td>STUC</td>
<td>Scottish Trades Union Congress</td>
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<tr>
<td>TIA</td>
<td>Transient Ischaemic Attack</td>
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