Healthier Scotland

The Journal

April 2013

Socialist Health Association Scotland

SHA Scotland is a campaigning organisation which promotes health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We believe that these objectives can best be achieved through collective rather than individual action. We campaign for an integrated healthcare system which reduces inequalities in health and is accountable to the communities it serves.

SHA Scotland members meet three times a year at Glasgow City Council Chambers. The next meeting is on 16 May starting at 7pm. Membership of the Socialist Health Association costs £25 p.a. and details of how to join are on our website www.shascotland.org

Forthcoming events:

SHA Scotland & UNISON Scotland fringe meeting at Scottish Labour conference

Tackling health inequality

Friday 19 April 2013, Palace Hotel, Inverness at 5:30pm

Chair: **Gordon McKay** – Chair UNISON Labour Link Scotland
Jackie Baillie MSP – Shadow Cabinet Secretary for Health
Dr David Conway – Chair SHA Scotland

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Healthier Scotland – The Journal

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Welcome

to the April 2013 edition of ***Healthier Scotland – The Journal.***

The Socialist Health Association was founded in 1930 to campaign for a National Health Service. While we will take pride in celebrating the 65th anniversary of the NHS later this year, our main focus is looking forward. We campaign for improvements not only in health services but in health – and particularly in tackling inequalities in health service access and in health outcomes.

Healthier Scotland: the Journal is part of our attempt to take the health debate in Scotland forward. We welcome the level of political consensus in Scotland around health that means we avoid the ideological dogma that is undermining the NHS in England. However, we have huge health challenges to address and that requires new thinking on how to address them.

In this edition we start with Iain Gray's challenge to the health consensus. He argues the status quo is no longer an option for NHS Scotland. Dr Margaret McCartney author of 'The Patient Paradox' argues for a different type of reform by concentrating resources on those who are ill. Dave Watson then provides an overview of health inequality in Scotland and asks if structural change can be part of the solution.

Shelia Duffy outlines the role tobacco use plays in health inequality and Richard Simpson follows that up with his proposed private members bill on measures to address alcohol misuse.

The debate over homeopathy in the NHS has resurfaced with the NHS Lothian consultation and a vigorous internal debate within the SHA. So we invited a doctor and a scientist to give us their contrasting views on the subject.

Gordon McKay rails against the media portrayal of mental health and Matt Mclaughlin highlights the role of nurses in NHS Scotland as their numbers fall yet again.

We hope you find this edition of *Healthier Scotland* interesting and we are grateful to the contributors for their time and effort. To keep the discussion going we would welcome feedback and views. Please go to our website or blog.

Dr David Conway – Chair

Dave Watson – Secretary & Editor

Time for Change?

Iain Gray MSP argues that steady as she goes is no longer an option for NHS Scotland.

Someone said that there are two kinds of politicians; those who fail, and those who get out in time. Many are now asking if Nicola Sturgeon is one who got out of the Health portfolio in the nick of time?

When I was a junior health minister, Sam Galbraith, MSP and surgeon told me, "there is a health crisis in the newspapers every day – don't worry about it". That was not true for much of Nicola Sturgeon's tenure in Health. It is now though, and NHS crises abound.

An A&E in Fife repeatedly closed due to staff shortages. Hundreds of A&E patients across Scotland waiting more than 12 hours to be seen. Doctors claiming the children's heart unit at Yorkhill is "unsafe". Four patients every week "starving to death" in our hospitals, according to one front page. The Health Inspectorate found dirty wards in Inverness, a lack of training in the ambulance service and "neglect" of the elderly in Edinburgh's Royal Infirmary. Their damning report on Ninewells was "not published". A Royal College is warning that a Mid Staffs type scandal could happen here.

So, has Alex Neil been left to clean up Nicola Sturgeon's mess? Two reports from Audit Scotland provide some clues. The first was a summary of the NHS's financial position. On the face of it all NHS Boards met their financial targets. But the auditor general pointed out that this had been achieved in ways which are unsustainable. Many boards had made savings which were non-recurring. Others "borrowed" money from the Scottish government to balance the books. Together they had simply shelved £1 billion of maintenance, some of that critical to patient care. Overall the Auditor general pointed out that NHS budgets had declined in real terms, and will decline further in years to come. NHS staffing is at its lowest since 2006, nurse and midwife numbers at their lowest levels since 2005. A total of 5,000 posts have gone in the past three years. Capacity has plummeted too, with 1,000 fewer beds since Sturgeon became health secretary, with the Royal College of Physicians saying patients' lives are at risk. The picture painted was of a service only just holding the lid on. The Auditor General called her report an "amber warning".

Then came Audit Scotland's waiting times report. They could not prove waiting lists had been systematically falsified except in Lothian, but neither could they explain why numbers of "socially unavailable" patients had soared until the moment Lothian was rumbled, at which point other boards suddenly found they had far fewer unavailable patients after all. Whatever else was going on, Audit Scotland concluded that targets had been prioritised over patient care. In Lothian at least that meant staff being bullied and intimidated into doing what counted rather than what mattered.

Sturgeon was well regarded in the NHS. She took care to communicate with, and acknowledge staff. She was a conservative Minister, avoiding reform and the challenge to staff interests this often involves. Yet she also set ever shorter waiting time targets for purely political purposes without consideration of how they could be achieved, and at the same time cut the staff who had to deliver them. Her no compulsory redundancy policy was laudable, but without reform it created random shortages and left staff being asked to do more of the same with fewer colleagues.

Fifteen years ago patients were waiting two years for treatment, and cutting waiting times was the right priority. In 2013 it cannot be the sole measure of success in our NHS. Labour Health Ministers made mistakes sometimes, but they were willing to reform to improve outcomes. We must start thinking about the NHS we want again, and start reforming again. Care of the elderly should be comprehensively integrated in a National Care Service, neither NHS nor local authority. Most non-territorial health boards should go, releasing funds to the front line. Highly technical surgery has to be centralised in centres of excellence to maintain skills and the best possible outcomes. Conversely, routine procedures, rehabilitation and palliative care should be delivered in smaller local hospitals. GPs should take core responsibility for these units – even if their contract has to be changed to allow it. We should increase the power of Boards to distribute GPs so that there are more where we need them most – in areas of deprivation where patients have multiple health problems.

That is no more than base camp for addressing health inequalities; supposedly Nicola Sturgeon's overriding priority in health. In fact a third Audit Scotland report says that these inequalities got worse under her stewardship, as they have for decades. We need to change the NHS, and not just the cabinet secretary or the IT system. Steady as she goes is no longer an option for staff or patients.

Iain Gray is the MSP for East Lothian and is Convenor of the Scottish Parliament Public Audit Committee

Back to Basics

Dr Margaret McCartney in her book ' The Patient Paradox' argues we should concentrate resources on people who are ill.

Over a decade ago, I read an article in the Independent which claimed that regular CT body scans were the way to stay well. At first glance, it sounded perfect - why wouldn't you want to have preventative healthcare, spotting problems before you even knew about them? How clever, to want to pick up health problems at such an early stage - how could I object?

At that time, I had been reading up on the science of mammography screening. It was apparent that the messages women were getting from the health service - basically that turning up could save your life - wasn't the whole truth. 'Problems' would get picked up when it was impossible to know whether the changes identified on the xray would lead to a harmful cancer. Because no one could be sure which were the problematic changes and which weren't, all women were treated as though this could be harmful.

This creates over treatment - radiotherapy, chemotherapy and surgery being used when the woman could never benefit from it - because she was never going to die from breast cancer. But women weren't getting told that this problem existed on such a wide scale. It's estimated that for every 11 women picked up as having breast cancer at screening, only 1 actually benefits from treatment.

Similarly, cholesterol and blood pressure measurements in people who are well leads to treatment for people who won't benefit from it- as does cervical, bowel and aortic aneurysm screening. The balance of risk versus harm is usually delicate. Yet people are advertised to as though there was no down side to consider. We are not often treated as individuals who have our own views on where the balance of risks lie. Yet for all the investment into screening as a public health tool, other effective forms of public health - like laws for a minimum price for alcohol in England, or plain tobacco packaging, or fair welfare benefit medical assessments - have been subject to political whim rather than a response to the evidence on them.

The 'patient paradox' I keep finding, as a GP, is that when people don't need to be patients they are offered screenings which they are likely not to benefit from, and are turned into patients where they get side effects and risk overtreatment. Yet when we do actually need prompt attention, the wait for evidence based cognitive therapy for depression, for example, can be three or four months.

We need to get back to basics - prompt treatment for suffering, and fair information for screening. We should leave the well alone, protect them with evidence based public health law - and concentrate resources on people who are ill. Simple, but sadly, radical.

Dr Margaret McCartney is a Glasgow GP. The Patient Paradox - why sexed up medicine is bad for your health, is published by Pinter and Martin http://www.pinterandmartin.com/the-patient-paradox

Tackling Health Inequality

Dave Watson asks can structural change help tackle health inequality?

If there is one constant and seemingly intractable health challenge in Scotland it is health inequality. The Joseph Rowntree Foundation's, '*Monitoring poverty and social exclusion in Scotland 2013*', is the latest of a number of reports that draw attention to this issue. The health section highlights three main points:

- Health inequalities in Scotland are not only stark but growing. A boy born in the poorest tenth of areas can expect to live 14 years less than one born in the least deprived tenth. For girls, the difference is eight years.
- Rates of mortality for heart disease (100 per 100,000 people aged under 75) are twice as high in deprived areas as the Scottish average.
- Cancer mortality rates in the poorest areas (200 per 100,000) are 50% higher than average, and have not fallen in the last decade, while the average has fallen by one-sixth.

The latest '*Long-term Monitoring of Health Inequalities: Headline Indicators*' report also shows that healthy life expectancy among men in the poorest areas of the country is just 47. The Glasgow Centre for Population and Health provides a summary of Scotland's mortality position relative to other mainly Western European countries. Sadly, it would appear that Scotland is "Still the sick man of Europe" - but women are getting sicker too. Finally, Sir Harry Burns explained to the Holyrood Public Audit Committee that health inequality is biggest issue facing the country.

The Scottish Government has established a Ministerial Taskforce on Health Inequalities to examine all available evidence and to suggest new or improved ways to reduce the difference in life expectancy and health among the whole population. Audit Scotland has suggested that resources to be shifted from more affluent areas to poorer ones to tackle persistent health inequalities. Scottish Labour Leader, Johann Lamont MSP has also opened a debate about spending on some universal services.

I spent some six months last year as an expert advisor to the Christie Commission and tackling inequality is a theme that runs throughout that report. While reducing inequality is a much bigger issue than reorganising public services, the Commission highlighted preventative spending and breaking down service silos as approaches that could make a difference. In a less publicised section, the report points to plans in the islands to create all purpose authorities by merging health boards and councils.

There is an element of this approach in the Scottish Government's health and care integration plans. Although instead of merging services, the favoured model is a sort of local quango made up largely of health board and council representatives. They have recently published the consultation response and there is significant criticism of this approach, not least on grounds of democratic accountability. This is an issue taken up at the recent CoSLA conference, reflecting concerns over growing centralisation of public services. The Christie Commission in their tests for structural reform also cautioned against centralisation.

The role of local government in tackling health inequalities has perhaps been forgotten in recent years. The new guide for councillors published by CoSLA and NHS Scotland is therefore a welcome initiative. The guide's key suggestions for action to address health inequalities include providing services universally, but with scale and intensity that are proportionate to the level of disadvantage. While offering intensive support, it cautions against targeting geographical areas defined as deprived because this means missing the vulnerable who live elsewhere. Particularly rural areas that have people experiencing inequalities that may be harder to identify. The guide also reinforces the Christie recommendation that local agencies work together with common aims and measures to reduce health inequalities.

However, barriers remain to better joint working. I highlighted a number of these in evidence to the Holyrood Local Government Committee recently. The top down service design model is still prevalent, instead of engaging with staff and service users as Christie recommended. There is too much emphasis on contractual procurement that has resulted in a race to the bottom in care service quality. And there is a need for a broad staffing framework to enable flexible working between staff from different agencies.

Another approach is to return to the Christie nod in the direction of all purpose authorities. Merging councils and health boards would structurally join up services and ensure they were democratically accountable and a bulwark against centralisation. As Christie again recognised, our councils are the largest in Europe and no one on the continent would regard our councils as 'local'. The Liberal Democrat's constitutional change proposals recommend the creation of Burgh councils to run truly local services. However, no one is seriously suggesting that even most of our current councils are large enough to run acute services. So we are really talking about merging community health with other council services, including social care.

One country that already does this is Norway. They have small local councils based on natural communities that provide most local services, including community health and care provision. They also have regional councils for strategic functions. I was discussing this with a trade union delegation from Norway only a few weeks ago and they agreed that this does provide joined up and democratically accountable services. However, they also pointed out that integration between primary and acute health services did not operate well under this model. This could be a problem in Scotland as one of the biggest challenges is shifting resources from acute to community, by reducing unplanned admissions to hospitals.

In essence it appears that wherever you draw the organisational line integration is challenged. This is particularly the case when staff operate in a silo mentality and services are fragmented through marketisation. The Welsh Government is developing a 'One Wales' approach that seeks to break down these barriers, but this is more difficult in a country the size of Scotland. We could however develop a one public service approach, as Christie suggested, that creates common statutory duties, staff training, total place budgeting and reduces other barriers to joint working. It may well be that this approach delivers better long term results than structural change.

Dave Watson is the Secretary of Socialist Health Association Scotland

Tobacco and Health Inequality

Shelia Duffy argues that tobacco use is a key driver of health inequalities

The current economic climate is creating a range of challenges for families and communities up and down the UK, felt most acutely in the most deprived areas. With new concerns dominating the agenda it can be difficult to find time to talk about the impact of smoking on Scotland's poorer communities – even without the lingering myth that tobacco is a prop which people fall back on in difficult times, and 'one of the only pleasures left' for people on lower incomes (as ex Cabinet Minister John Reid put it).

Yet with rates of smoking four to fives times higher in the poorest areas than in the richest, tobacco use is a key driver of health inequalities, which are higher in the UK than in the rest of Central and Western Europe. And for the nearly 70% of smokers who say they want to quit, this is no prop but an unwilling addiction.

Tobacco continues to impact on people's health and well-being in such a familiar way that it risks going un-noticed. Meanwhile a quarter of all adult deaths in Scotland are attributable to smoking – with tobacco killing half of its long term users. Crisps and sugary drinks just do not do this. 32% of these deaths were in Scotland's most deprived areas – twice that of the most affluent groups. In these communities people smoke more heavily and are less likely to succeed in quitting. This killer destroys families, impacts on health and the day-to-day quality of life, while generating enormous profits for the tobacco companies. The cost of keeping up a tobacco addiction means that families have less to spend on food and housing.

It is time that we, as a society, did more to protect our more vulnerable citizens. Where is the sense of anger against an industry which long ago gave up any interest in the health of its customers, with a long track record of lies and deception and which every day put its own profits before the well-being of people? While so much is said about the ethical performance of the banks, very few smokers can even name the tobacco companies behind the all-too-familiar brands.

Yet the behaviour of the tobacco companies has been so bad that an international treaty, signed by our Government and nearly 170 others, sets out "an irreconcilable conflict between the tobacco industry's interests and public health policy interests." What other industry can claim such an accolade? And now, as if worried that others might take over the villain spot, we hear that British American Tobacco, with brands such as Lucky Strike and Rothmans and profits of nearly £6billion, doesn't pay a single penny in UK corporation tax.

The Scottish Government is about to launch a new 5-year strategy on tobacco and health, with tackling inequality as a core theme running through the document. It is in the heart of our poorest communities where the battle will be most keenly fought. By working with communities to understand the role of tobacco in their lives, by supporting young people to make healthy choices on tobacco and by providing flexible stop-smoking support that can be tailored to the needs of all users we can aspire to the next generation growing up free from the harm and inequality caused by tobacco.

Shelia Duffy is the Chief Executive of ASH Scotland

The Case for Homeopathy

Dr Susan McAllion makes the case for homeopathy in the NHS

Scotland has a long and happy association with homeopathy. In 1880 a dispensary was opened which gave free treatment to the poor. The first homeopathic hospital in Glasgow opened in 1914 and after several moves it is now located on the Gartnavel site.

There are also homeopathic hospitals in London and Bristol and all three hospitals have been part of the NHS since it began in 1948.The hospitals and NHS clinics (of which there are several in Scotland) treat tens of thousands of patients per year who are referred by GPs, PCTs and NHS specialists.

Four of five major comprehensive reviews of RCTs in homeopathy have reached broadly positive conclusions.[1-4] Based on a smaller selection of trials, a fifth review came to a negative conclusion about homeopathy.[5] In 2005, the Bristol Homeopathic Hospital carried out the largest service evaluation of homeopathic treatment so far, which reported that 70% of 6,500 follow-up patients experienced improvement in their health. Many had tried conventional treatment first without success.

The most recent hospitals outcome study confirms the positive findings of earlier studies. A total of 1,602 patients were seen at follow-up appointments in UK NHS homeopathic hospitals during one month in 2007. The study found that eczema is currently the most common referral to homeopathy by NHS doctors. Other commonly treated complaints were chronic fatigue, menopausal disorder and osteoarthritis.

In the UK there are over 400 GPs practising homeopathy who are regulated by the GMC and are members of the Faculty of Homeopathy. They treat around 200,000 NHS patients per year with homeopathy. Homeopathic medicines are very safe .The vast majority of adverse effects reported in clinical trials were temporary aggravations of symptoms or other mild and transient effects. Homeopathic remedies are cheap. The available evidence suggests that homeopathy has the potential to generate savings through reduced conventional prescribing and demand for otherservices.

In France, where homeopathy is an integral part of the healthcare system, a government report showed that the total cost of care per patient receiving homeopathic treatment was 15% less than the cost of treatment provided by conventional physicians.

Homeopathy doesn't interfere with conventional medicine and should be seen as a complementary treatment, not as an alternative. In fact, homeopathic and conventional treatments can work very well alongside each other. This approach also gives patients more treatment choices. NHS homeopathic doctors are medically trained as well as being members of the Faculty of Homeopathy. They are statutorily registered with the General Medical Council . They are bound to act within the competence of their profession and their level of training and qualifications in homeopathy.

Homeopathy has been under attack from a small number of scientists and science journalists. Unfortunately this has resulted in a polarisation of views on the subject.

One criticism is that the effect of high dilutions is implausible with no basis in real science. There is an increasing amount of laboratory research that is extending our understanding of how such dilutions work and scientists have admitted surprise at their own findings.

To summarise, homeopathy is a safe, cost effective complementary therapy which should be available to all in the NHS.

Dr Susan McAllion is a retired NHS homeopathic doctor and a past Treasurer of SHA Scotland.

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The Case Against Homeopathy

Dr Alex McMahon argues homeopathy is flying in the face of science, spending precious resources, undermining the principles of the NHS, and doing more harm than good to those most in need.

Samuel Hahnemann, who invented homeopathy, probably meant well when he devised his idea for the ailments of humanity at the end of the 18th century. Most people have heard of the 'like cures like' idea, and may be sympathetic. Most people probably know that homeopaths dilute their treatments to such a degree that there is not a single molecule of the original material left: and then turned into pills. This is not 'like cures like'. Hahnemann himself, if he was here to defend himself, may well argue that he was trying to be scientific and improve on dreadful treatments like bloodletting and purging that were common in his day. At the turn of the 19th century it may well have been a dangerous gamble to visit a physician: cure or kill. Unfortunately Hahnemann extrapolated his theory from a single experiment. He fell prey to the logical fallacy known as 'induction'. This problem was mainly mooted by David Hume around 1748. Although the lives of Hahnemann and Hume overlapped by around 20 years, this particular medical problem was only really solved in the 20th century by the devising of the Randomised Controlled Trial (see the James Lind library[1] for the history of fair testing of treatments).

Homeopaths often justify dilution with the notion that it equates to greater potency of their treatment. In this case it would be dangerous to go for a swim in the sea. Sceptics often stage mass suicide attempts by overdosing on homeopathic medicines to mock this idea. On the plus side, homeopathic treatments will be entirely free from side-effects. Having said that, you would have to be wary of homeopathic plutonium, although diluted arsenic seems safe. [2]

Homeopaths could easily test their treatments in Randomised Controlled Trials, which are occasional positive but mostly unconvincing due to a lack of vigour. [3] Unfortunately, although there are fortunes to be made in the High Street from untested homeopathic medicines, there is no motive to subject these treatments to formal testing as there is very little regulation. This is in sharp contrast to the punitive levels of regulation for pharmacologically active medicines. [4]

But is any harm done by this inoffensive quackery? The NHS provides expensive homeopathic hospitals and prescriptions. This money could be better spent. We are also undermining medical research and science in people's minds. Many people argue that it is only a placebo. Placebos are deception. It is not widely known that the so-called 'placebo effect' is hotly disputed[5] and is in fact a natural consequence of the phenomenon known as 'regression to the mean' where patients' symptoms get better simply due to the passing of time.[6] By displacing real medicine and health care, the NHS has to pay twice due to any subsequent harm caused by the delay in treatment. There are dangerous parallels to the anti-vaccination movement in both the developed and developing worlds. Misplaced middle-class concerns with the scientific method ultimately undermine the concept of universalism and institutions that help the poor and those with the greatest need.

[1]http://www.jameslindlibrary.org/

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Dr Alex D McMahon is Reader in Epidemiology, University of Glasgow

Depression is not a "must have accessory"

Gordon McKay urges us to have a proper conversation about mental health.

Isn't it about time those claiming to have mental health problems stopped making life so inconvenient for the rest of us and stopped whining and got on with their lives in the way that the rest of us have to? Apparently so in the eyes of the British media.

Two of the most recent widely covered reports on mental issues were following comments from media 'personalities' Jeremy Clarkson and Janet Street-Porter.

Jeremy Clarkson following on from his laugh a minute routine suggesting that striking public health workers should be executed in front of their families, said that 'Johnny Suicides' who threw themselves in front of trains caused great disruption for the public and that their body parts should be left for scavenging animals so as to prevent delays.

Janet Street-Porter in her devastating insight into the world of mental health claimed that depression is now a "must have accessory" and that if you suffer from poverty then you almost certainly will not be depressed.

While it sticks in the throat to excuse Clarkson's crass mental health comments I will do so on the grounds that he is a buffoon, and that if the public do not stop watching the television programmes he appears on, for which he receives large sums of money, then hell mend us when he regurgitates this venom.

What are not excusable are Street-Porter's comments, because unlike Clarkson's morally wrong comments hers are also factually wrong. One in six people in the United Kingdom are currently affected by a mental illness. The World Health Organisation indicate that one in four will have a mental illness at some point in their life and that by 2030 depression will be the leading cause of disease in the world.

Street-Porter implies that to a large extent, but not wholly, depression is a made up illness and by implication that the people least affected are working class women. Two recent reports of health in Scotland put these claims to the sword in very stark language. Audit Scotland's 2012 report "Health Inequalities in Scotland" show that more than twice as many females consulted GPs for depression and anxiety than males in 2010/11 and that those living in deprived areas have lower overall mental well-being and more GP consultations for depression and anxiety.

The second report in 2012 which was NHS Scotland's "Scotland's mental health" reported that the most common inequality in mental health was due to deprivation. Forty-two out of fifty indicators showed a direct link between socio-economic indicators and a poorer state of mental health. While not enough time has yet passed to show on-going trends it was confirmed that women at the starting point of 2009 were significantly more likely to suffer from depression than men.

The austerity measures of the UK Government make it likely that figures for depression amongst women in Scotland are going to increase when one considers that the number of economically active women fell by fifty thousand in 2012.

Oscar Wilde in the Picture of Dorian Gray wrote that "there is only one thing in the world worse than being talked about and that is not being talked about." It is certainly true of depression in particular and mental illness in general that acceptance, investment and treatment have suffered by a lack of willingness to talk about it. The effect of this has been to have a disproportionate effect on women and the poor. Being able to talk about mental illness is the first step towards prevention, let us hope that it will be a rational discussion because comments of the Clarkson and Street-Porter kind may mean that the conversations dry up. Starting a conversation about mental health is however only the first step in alleviating the problems. The next step is investment both in NHS mental health services and in the economy as a whole.

Gordon McKay is a mental health nurse and UNISON NEC member

Measures to tackle alcohol misuse

Richard Simpson MSP argues that we need more than just minimum pricing to tackle alcohol misuse.

Alcohol misuse and its consequence for health and community safety remains a significant challenge throughout the UK. The Sheffield model on which the debate around minimum unit price (MUP) has been based predicated a reduction in consumption of 3.8% from a ban on discounting in practice there was a reduction of only 1%. It is worrying for MUP that the model has been found flawed at the first test.

Increases in duty and VAT have led to an increase in price and will have contributed to the reduction in the UK consumption over recent years. Many other measurements are improving including deaths particularly in men down 15%, self reported hazardous drinking down by a quarter, and reductions in admissions and discharges from hospital. Scotland remains the nation with the greatest problem in the UK. It was clear at the time of the debate on MUP that whatever the merits of MUP many stakeholders were of the opinion that other measures were needed.

With the support of Labour colleagues I have consulted on fourteen measures which may form part of a private members bill. The responses have been generally positive or very positive. There are two strands to the bill. One is concerned with those whose pattern of alcohol consumption is getting them into difficulty. Many of them build on pilot work already undertaken.

Areas where there were diverse views many supportive but with some suggesting the need for further evidence and evaluation included:

- Restrictions on pre-mixed caffeinated alcohol products;
- Licensing Boards having the power to make bottle-tagging schemes a licensing condition;
- Fine Diversion being made available on a statutory basis;
- Arrest Referral Schemes for alcohol (as well as drugs) being a statutory requirement in each Community Justice Authority;
- Drink Banning Orders;
- Extending Drug Treatment and Testing Orders (DTTOs) to become Alcohol Drug Treatment and Testing Orders (ADTTOs).

The evidence on the risks of premixed caffeine alcohol drinks has strengthened since this was last proposed. The USA has now banned premixed drinks completely.

The use of Bottle Tagging to gather intelligence on the source of purchases involved in both underage drinking and proxy purchasing could help tackle underage drinking. There are some objections on the ground of cost to the licensee. However, this would not be a requirement on all licensees rather a power to make it part of the license if requested by the police.

Fine diversion into educational programmes has proved worthwhile in a Fife pilot.

Currently a very substantial proportion of offenders in short term custody have an alcohol element in their offence. Short term custody does not allow the Scottish Prison service to undertake work with prisoners so more diversion which does address their problem should be valuable. Arrest referral is only currently available in two sherrifdoms though some five do have such a referral mechanism for drug misuse. The bill would extend this to all eight sheriffdoms.

Drink Banning Orders in England show some benefit both in the individual behaviour and in community safety. Some of the new Police Commissioners are committed to extending their use. ACPOS support for this measure is particularly welcomed.

Increase diversion from custodial sentences into treatment, building on the Drug Testing and Treatment orders (DTTO) and Community Orders, is proposed with a specific order for Alcohol (ATTO).

One reference was made in the consultation response to the application of breathalyser locks being required by some US states following an offence. Drivers have to demonstrate that they meet the drink driving limits before a vehicle will start. This is not in the bill at present but may be worth considering

There are a number of general measures including clarification on the licensing conditions on the public health interest and protecting children; re-establishing the national licensing forum; strengthening the discount ban and restricting advertising. The full response to the consultation on the bill will be published as soon as we have the governments view.

Dr Richard Simpson MSP is Scottish Labour's Public Health spokesman.

Challenges facing Nursing

Matt McLaughlin says Think NHS Scotland – Think Nurses

Let's face it, everyone loves nurses. Whether it's a photograph of nurses on a 1980's picket line or imagery of a modern nurse, in a clinical environment, for many Scots if we are thinking about the NHS we think about nurses.

The last few months have been tougher than usual on Scotland Nurses. As the reality of budget cuts and short staffing began to bite over the winter, the service struggled to cope. Media sources were filled with horrific stories of service failure and the governments top men and women were spinning all over the place trying to convince us all that they were "managing" the seasonal upturns "effectively".

Of course good news doesn't sell papers so stories of nurses and midwives pulling double shifts to make sure that patient in their ward wasn't compromised, or the thousands, maybe hundreds of thousands of instances where a nurse, midwife or nursing assistant went the extra mile for a patient are and will remain unreported.

The challenge for Scotland nurses is not however one of image or confidence. The real challenge is openness. Not for nurses, the profession and its membership are very open and honest about the challenges that they face. Survey after survey of Scotland's nurses identifies major concerns every time they are undertaken. On the other hand politicians and decision makers continue to promote a version of reality that seems alien to our members and now it seems many patients. UNISON wouldn't go as far as to say that the NHS is in crisis, but it is under pressure and it needs urgent and open action soon.

The service simply can't go on pretending that there is not a problem. Successive surveys into nursing attitude and staffing levels have found that across the UK – never mind Scotland, nurses are worried about staffing levels. Indeed a UNISON survey in 2012 found that less the 10% of respondents felt that they were always able to deliver safe and companionate care.
Results of a recent Nursing Times survey (UK), supported an earlier UNISON survey carried out in 2009 in NHSGGC. The latest survey found that whilst 73% of respondents had completed an 'incident form' (to record a professional concern) only 24% ever received feedback from their manager or higher up.

Despite these and other surveys, nursing seems to remain fixed in a downward spiral. Everyone wants to talk about nursing, everyone wants their photograph taken with a nurse but no seems prepared to listen and even if they do look like they are listening - practical action seems a step too far!

There are a number of issues, big ticket issues in our NHS which will without doubt affect nursing, the profession and organisations like UNISON will without doubt steer a patch through them. However as we stand at this point in time, arguably the major challenge for nursing is not one of clinical direction or policy, but rather one of image and the major risks that are associated with continuing to be a political football.

To politicians and policy makers the message is simple. The cost of relying on nurses to support your latest political headline, is support for nurses and the NHS. Stop using the nurses as a political tool, and start listen to the service and develop policies and initiatives which support nurses and the wider NHS team.

Matt McLaughlin is the Secretary of UNISON Scotland's Nursing Sector Committee

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