Health Committee

6th Report, 2005 (Session 2)

Stage 1 Report on the Smoking, Health and Social Care (Scotland) Bill

Volume 2: Evidence
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Health Committee

6th Report, 2005 (Session 2)

Stage 1 Report on the Smoking, Health and Social Care (Scotland) Bill

Volume 2: Evidence
ANNEX C: ORAL AND ASSOCIATED WRITTEN EVIDENCE

11 January 2005 (1st Meeting, Session 2 (2005))

All parts of the Bill

Oral Evidence

Roderick Duncan, Bill Team Leader
Colin Cook, Substance Misuse Division
Mary Cuthbert, Tobacco Control Division
Eric Gray, Primary Care Division
Dr Hamish Wilson, Primary Care Division
Chris Naldrett, Primary Care Division
Richie Malloch, Workforce and Policy Division
John Davidson, Workforce and Policy Division
Dr Hamish Wilson, Head of Primary Care Division
Sylvia Shearer, Health Planning and Quality Division
Andrew MacLeod, Head of Health Planning and Quality Division
Adam Rennie, Head of Community Care Division 2
Diane White, Social Work Services Policy Division
Stephen Sandham, Regeneration, Fuel Poverty and Supporting People Division
Jim Brown CBE, Head of Public Health Division
Mike Baxter, Property and Capital Planning Division
Patrick McGrail, Community Care Division 2
Mike Stevens, Chief Scientist Office

22 February 2005 (5th Meeting, Session 2 (2005))

Part 2 (General Dental; Services, General Ophthalmic Services and Personal Dental Services) and Part 3 (Pharmaceutical Services)

Written Evidence

Scottish Consumer Council
British Dental Association
Optometry Scotland
Scottish Pharmaceutical General Council
Fife Local Health Council

Oral Evidence
Dr Iain Wallace, NHS Greater Glasgow
Mary Morton, NHS Highland
Catherine Lush, NHS Highland
Martyn Evans, Scottish Consumer Council
Joyce Shearer, Fife Local Health Council
Andrew Lamb, British Dental Association
Hal Rollason, Optometry Scotland
James Semple, Scottish Pharmaceutical Federation
Alex McKinnon, Scottish Pharmaceutical General Council
Dr Hamish Wilson, Scottish Executive Health Department
Eric Gray, Scottish Executive Health Department
Chris Naldrett, Scottish Executive Health Department

1 March 2005 (6th Meeting, Session 2 (2005))

Part 4 (Discipline) and Part 5 (Infection with Hepatitis C)

Written Evidence
Forth Valley Local Health Council
British Dental Association
BMA Scotland
Royal Pharmaceutical Society of Great Britain Scottish Executive
Scottish Haemophilia Forum
Skipton Fund

Oral Evidence
Stewart Scott, Borders Local Health Council
Margo Biggs, Forth Valley Local Health Council
Alex Matthewson, BDA Scottish Council
Dr David Love, BMA Scotland
Hal Rollason, Optometry Scotland
Angela Timoney, Royal Pharmaceutical Society of Great Britain
Dr Hamish Wilson, Scottish Executive Health Department
John Davidson, Scottish Executive Health Department
Philip Dolan, Scottish Haemophilia Forum
Dave Bissett, Scottish Haemophilia Forum
Frank McGuire, Scottish Haemophilia Forum
Peter Stevens, Skipton Fund
Keith Foster, Skipton Fund

Supplementary Written Evidence
Scottish Haemophilia Forum
Skipton Fund
Optometry Scotland
8 March 2005 (7th Meeting, Session 2 (2005))

Part 5 (Authorisation of Medical Treatment; and Joint Ventures)

Written Evidence
Alzheimer Scotland
ENABLE
Scottish Association for Mental Health
Royal College of General Practitioners (Scotland)
RCN Scotland
British Dental Association
EC Harris
COSLA
STUC
NHS Confederation
UNISON Scotland

Oral Evidence
Dr Alan Jacques, Alzheimer Scotland
Nicola Smith, ENABLE
Sandra McDougall, Scottish Association for Mental Health
Dr Mairi Scott, Royal College of General Practitioners (Scotland)
Pat Dawson, Royal College of Nursing
Robert Hamilton, British Dental Association
David Fox, Turner and Townsend Management Solutions
Howard Forster, EC Harris
Alex Macleod, Skanska
Alan McKeown, COSLA
Tim Huntingford, COSLA
Hilary Robertson, NHS Confederation
Susan Aitken, NHS Confederation
John Park, STUC
Dave Watson, UNISON Scotland

15 March 2005 (8th Meeting, Session 2 (2005))

Part 1 (Prohibition of Smoking in Certain Wholly Enclosed Spaces)

Written Evidence
Scottish Licensed Trade Association
Tobacco Manufactures’ Association
CISWO
British Hospitality Association Scotland Committee
COSLA
City of Edinburgh Council
Royal Environmental Health Institute of Scotland
ASH Scotland
AMICUS
STUC
UNISON
Oral Evidence

Paul Waterson, Scottish Licensed Trade Association
Stewart Ross, Belhaven Brewery, Scottish Licensed Trade Association
Christopher Ogden, Tobacco Manufacturers’ Association
Steven Stotesbury, Imperial Tobacco, Tobacco Manufacturers’ Association
Paddy Crerar, British Hospitality Association Scotland Committee
Ian McAlpine, Coal Industry Social Welfare Organisation (CISWO), Committee of Registered Clubs Associations
George Ross, Royal British Legion Clubs, Committee of Registered Clubs Associations
Alan McKeown, CoSLA
Gordon Greenhill, City of Edinburgh Council
Keith McNamara, Royal Environmental Health Institute of Scotland
David Mellor, Association of Chief Police Officers
Dr Rachel Harrison, ASH Scotland
Sheila Duffy, ASH Scotland
Andy Matson, AMICUS
Ian Tasker, STUC
Dave Watson, UNISON Scotland

Supplementary Written Evidence

British Hospitality Association Scotland Committee
ASH Scotland
STUC
COSLA

22 March 2005 (9th Meeting, Session 2 (2005))

All parts of the Bill

Written Evidence

Minister for Health and Community Care

Oral Evidence

Minister for Health and Community Care

Supplementary Evidence

Minister for Health and Community Care

ANNEX D: OTHER WRITTEN EVIDENCE

PART 1: Prohibition of Smoking in Certain Wholly Enclosed Places

Organisations

Against an Outright Ban – Petition 819
Asthma UK Scotland
Barnardos
Bellhaven Group
Blantyre Bowling Club
BMA Scotland
British Lung Foundation Scotland
Broomhouse Centre
CAMRA
Cancer Research UK Scotland
Carlton Clubs
Chartered Society of Physiotherapy Scotland
Children in Scotland
CPL Entertainment Group Limited
Diabetes UK Scotland
FOREST
Health Economic Research Unit
Howard League for Penal Reform in Scotland
Lynnet Leisure Group
MacMillan Cancer Relief
MacLay Group PLC
NHS Grampian
NHS Lanarkshire
NHS Tayside
Phillip Morris International Ltd
Punch Taverns PLC
RCN Scotland
Roy Castle Lung Cancer Foundation
Royal College of General Practitioners (Scotland)
Royal College of Physicians Edinburgh
Scotland CAN!
Scottish Beer and Pub Association
Scottish Wholesale Association
SmokeFree Liverpool
Tennent Caledonian Breweries
Tobacco Workers’ Alliance

Individuals

Anonymous
Anonymous
Anonymous
Mark Cadle
David Cattanach
Tony Collins
Margaret Ellam
John Heatherill
John and Winifred Hughes
Laura Lamb
Collette Lander
Kenneth MacArthur
Charles McCann
Sheila McQueen
Wendy Nganasurian
Andrew Pearson
Andrew Rose

344
Mike Thistle  
Louise Wilson  

**Part 2: General Dental Services, General Ophthalmic Services and Personal Dental Services**  

MDDUS  
RCN Scotland  
Which  
Andrew Rose  

**PART 3: Pharmaceutical Care Services etc.**  

BMA  
Lloydspharmacy  
RCN Scotland  
Elizabeth Calder  
Francis Flynn  

**Part 4: Discipline**  

Scottish NHS Confederation  

**Part 5: Miscellaneous**  

**Section 24: Payment to certain persons infected with hepatitis C as a result of NHS Treatment**  

RCN Scotland  

**Sections 25-27: Amendment of Regulation of Care (Scotland) Act 2001**  

RCN Scotland  

**Section 30: Authorisation of medical treatment**  

British Dental Association  
BMA Scotland  
Chartered Society of Physiotherapy Scotland  
The Law Society of Scotland  

**Section 31: Joint ventures**  

Partnerships UK  
RCN Scotland  
Universities Scotland  

**Section 32: Scottish Hospital Endowment Research Trust**  

RCN Scotland
ANNEX E: PROHIBITION OF SMOKING IN REGULATED AREAS (SCOTLAND) BILL

Hard copies of the Committee’s Stage 1 report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill (published 11 January 2005, SP Paper 263) and accompanying evidence are available from the clerks to the Committee upon request to health@scottish.parliament.uk or on 0131 348 5224.

ANNEX F: UNPRINTED MEMORANDA

W Hunter Watson
Scottish Parliament

Health Committee

Tuesday 11 January 2005

[THE CONVENER opened the meeting at 14:00]

Smoking, Health and Social Care (Scotland) Bill: Stage 1

The Convener (Roseanna Cunningham): I welcome everyone back to Parliament and wish them a happy new year. Let us hope that the work of the Health Committee is as successful in 2005 as it was in 2004.

Today, we will receive a briefing on the policy intentions behind the Smoking, Health and Social Care (Scotland) Bill. The bill team leader is Roderick Duncan, who will be accompanied by a variety of colleagues from the different divisions of the Health Department that have a policy interest in the bill. The bill has five main parts and we have arranged this afternoon’s session to follow that structure.

I ask Roderick Duncan to make a brief introductory statement. He will remain here throughout the evidence session to address general questions. However, if members have questions on specific subjects, we would be obliged if they would wait until the relevant Executive officials are before the committee. Roderick Duncan is accompanied by Colin Cook, who is the head of the substance misuse division, and Mary Cuthbert, who is the tobacco control division team leader.

Roderick Duncan (Scottish Executive Health Department): Good afternoon, ladies and gentlemen. I thank the committee for giving us this opportunity to present the contents of the Smoking, Health and Social Care (Scotland) Bill. My role as bill team leader is to co-ordinate the Executive’s activities as the bill moves through the parliamentary process. I do not have in-depth knowledge of the individual policy areas behind the bill, so I ask members not to ask me too many difficult questions about those.

My colleagues will address the detail of the bill, but I will start by providing a high-level summary of it. The Smoking, Health and Social Care (Scotland) Bill is wide in scope, with a range of provisions that address smoking, health care and social care. The smoking provisions introduce a prohibition on smoking in all wholly enclosed spaces to which the public or a section of the public have access. The health care provisions continue the process of modernisation of the national health service, specifically with respect to the provision of dental and pharmaceutical care services. They also introduce free eye and dental examinations for all. There are measures to update legislation relating to the listing of and disciplinary processes for family health service practitioners.

The bill contains a number of miscellaneous provisions. Among them are a scheme for payments to certain persons who are infected with hepatitis C and amendments to the Regulation of Care (Scotland) Act 2001, including provisions relating to child care agencies and housing and support services. There are amendments to the Adults with Incapacity (Scotland) Act 2000 and provisions to allow Scottish ministers to set up or participate in joint ventures. Finally, the bill contains provisions to end the non-departmental public body status of the Scottish Hospital Endowments Research Trust.

The Convener: I ask Colin Cook to make a short introductory statement on the part of the bill for which he is responsible.

Colin Cook (Scottish Executive Health Department): Part 1 of the bill deals with the prohibition of smoking in certain wholly enclosed public spaces. For some time, we have recognised that smoking is the most important preventable cause of ill health and premature death in Scotland. When the Executive published its tobacco control action plan back in January 2004—the first-ever action plan that was designed for Scotland—it made a commitment to a major public debate on passive smoking. The health evidence about the impact of passive smoking grows all the time. We added to that evidence during the consultation process the estimate of about 865 deaths per annum in Scotland among lifelong non-smokers from the four main diseases related to smoking.

Between June and September 2004, the Executive undertook its consultation, which generated more than 53,000 responses. That was supplemented by opportunities for the public to give ministers their views and discuss the issues on the internet and elsewhere. It was also supplemented by a series of research projects, many of which are covered in the documents that are before the committee. Those projects examined the health and potential economic impacts of introducing the policy.

Part 1 of the bill prohibits smoking in premises that are fully enclosed and to which the public or a section of the public have access. It does so to protect public health. The detailed provisions, including any exemptions that might be considered, will be prescribed in regulations subject to the affirmative procedure. However, given the health evidence that I mentioned briefly,
ministers have made it clear that they want the most comprehensive approach, which will include premises such as transport cafes, restaurants and large-scale public buildings such as hospitals. That takes into account the fact that 70 per cent of Scots do not smoke, that many who smoke want to give up and that evidence suggests that there is no safe level of exposure to tobacco smoke.

The bill provides for a ban on smoking in the premises that are prescribed in regulations as no-smoking premises by creating offences of permitting others to smoke in no-smoking premises; of smoking in such premises; and of failing to display warning notices in no-smoking premises. The bill also sets out powers for enforcement officers to enter no-smoking premises and creates an offence of failing to give a name and address on request by an enforcement officer.

Part 1 makes a significant contribution to the Executive’s overall effort to improve health in Scotland. Mary Cuthbert and I hope to answer your detailed questions.

**The Convener:** Committee members will be aware that we have much to get through this afternoon, so I ask members to keep it in mind that we will ask questions on part 1 until about half past 2. Nanette Milne has joined us. I ask members to indicate whether they have questions; they should not feel obliged to ask questions for the entire time—I am sure that the officials do not mind either way. Does nobody have a question? Somebody must have a question.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** We have questions on other parts of the bill.

**The Convener:** In fairness to the officials, they will be aware that the committee has taken much evidence that is germane to part 1, so that part will not take up as much time as it would have if we had approached the subject afresh. However, my filibustering has managed to elicit one question.

**Mr David Davidson (North East Scotland) (Con):** I thought that I would help you out a bit, convener. It may not be competent to ask or to answer this question, but why have many different provisions—each valued in its own right—been incorporated into one bill?

**Roderick Duncan:** Members may be aware that, in his statement to the Parliament in September 2004, the First Minister outlined the intention to introduce a health service (miscellaneous provisions) bill. When the smoking provisions were brought forward as a health measure, it was thought appropriate to include them in that bill. A large part of the Smoking, Health and Social Care (Scotland) Bill relates to smoking, but it also captures several other important health care and social care matters.

**Mr Davidson:** I did not receive an answer—that is obviously not appropriate. Do you have any idea why all the provisions have been grouped together rather than introduced as separate pieces of legislation?

**Roderick Duncan:** Each piece of legislation would be so small on its own that individual bills would not be justified. It was felt that it would be appropriate to bring all the provisions together into a single piece of legislation.

**The Convener:** I have a question for the two other officials. I was interested in the Scottish Parliament information centre’s briefing on the smoking ban, page 12 of which deals with deaths relating to environmental tobacco smoke. I am curious about the fact that three different figures are given for that. NHS Health Scotland and Action on Smoking and Health Scotland estimate that there are around 1,200 deaths a year in Scotland from passive smoking. A University of Glasgow study says that there are “865 deaths per year in Scotland among lifelong non-smokers from the four main causes listed”.

The third source says that, “including other deaths known to be related to smoking, up to 1000 deaths per year might be attributed to ETS exposure among lifelong non-smokers”.

Will the witnesses explain why we have that variety of figures?

**Colin Cook:** Each of those figures is defined differently. As you said, the figure of 865 deaths, which is probably the most often cited statistic, comes from work done by David Hole at the University of Glasgow. As the briefing states, that study looked at the relevant four main causes of death— ischaemic heart disease, stroke, respiratory problems and lung cancer. We need to bear in mind other smoking-related diseases, but the evidence base for those is less robust; nonetheless, some of the other figures include them. We are looking at those over a long period and, in the case of some diseases, the medical effects might take 20 or 30 years to come through. Different timescales and definitions come into play.

**The Convener:** There is a bit of rumbling around the table. Can we take from what you said that we have a variety of estimates and that the figures cannot be said to be more than that?

**Colin Cook:** Yes, but 865 deaths is the central estimate. Other factors also come into play—for example, deaths among ex-smokers who have continued to be exposed to environmental tobacco smoke over time. The 865 deaths were among lifelong non-smokers, but there are other
categories of people to consider. There are different estimates, but they can all be traced and matched. The evidence report that was produced attempts to do that.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I am not sure whether this is the right point at which to ask this question, which is about the wholly enclosed places. Hospital grounds, which are usually large, wide-open spaces, are non-smoking areas. I am also thinking about the concourses of railway stations, which are reasonably open, although they are roofed. Are they wholly enclosed spaces?

Colin Cook: We can refine the definition of a wholly enclosed space in regulations. We work on the assumption that it is somewhere with four walls and a roof. However, that will be picked up through regulations as the process continues.

Mrs Nanette Milne (North East Scotland) (Con): We have mortality figures for passive smoking, but are there any morbidity figures?

Mary Cuthbert (Scottish Executive Health Department): All the information is gathered on the basis of estimates and there are no available estimates that relate to passive smoking.

The Convener: Following on from Jean Turner’s point, I will ask about the kind of spaces that are likely to be covered by the legislation. We know from the Irish experience that some hotels, restaurants, cafes and pubs have devoted external spaces to smoking with the use of marquees, external heaters and what have you. Is it envisaged that that is likely to happen in a number of places in Scotland, where space is available?

Colin Cook: Clearly, the situation will be driven by the market, but one would expect similar things to happen as have happened in Ireland.

14:15

The Convener: There are no more questions. You have got off lightly, but that is because of the enormous amount of work that the committee has already done on the issue, not because there is not a great deal of interest in it. I thank the officials for coming.

As I said, Roderick Duncan will stay with us as we are joined by officials who deal with parts 2 to 4 of the bill. I invite to the table Dr Hamish Wilson, who is the head of the primary care division and who has an interest in all three parts. To deal with part 2, which is on general dental services, general ophthalmic services and personal dental services, we have Eric Gray, who is from the primary care division’s dental and ophthalmic services fraud and disciplinary team. To deal with part 3, which is on pharmaceutical care services, we have Chris Naldrett, who is the team leader with the pharmacy issues team in the primary care division. To deal with part 4, which is on discipline, we have Richie Malloch, who is the team leader of the general medical services team in the workforce and policy division, and John Davidson, who is also from the workforce and policy division’s general medical services team. I ask Dr Hamish Wilson to make a short introductory statement on parts 2 to 4.

Dr Hamish Wilson (Scottish Executive Health Department): With your agreement, convener, it might be best if I introduced each part separately, because, although the provisions are interconnected, they are also distinct.

The Convener: Okay. We will ask you to make three introductory statements. Perhaps you will deal first with part 2, on general dental services, general ophthalmic services and personal dental services.

Dr Wilson: Thank you. Part 2 deals with three main issues and it would be helpful to consider them in turn. The first is the partnership agreement pledge to introduce free dental and eye checks for all before 2007. Sections 9 and 10 make provision for the introduction of free dental and eye checks for all. The present legislation requires charges to be made for certain people for dental and eye checks, but sections 9 and 10 will remove that requirement.

Part 2 will also provide the potential for more comprehensive free oral health assessments and eye examinations. I will exemplify using the second of those. At present, the specific definition of a sight test involves refraction, which is used when a person needs glasses, whereas the phrase “eye examination” can be a much broader term that allows optometrists, for example, to provide an examination for an individual that may not involve refraction and hence the need for glasses. That is particularly appropriate for certain clinical conditions.

In relation to dental services, the consultation—to which I will return when I refer to section 11—revealed strong support for wider oral health assessment, not just the current dental examination that individuals receive from dental practices. We have used the term “oral health assessment” to describe that broader examination, which will allow dental practitioners to perform something that is much broader and more useful for patients than the current examination is.

The bill will remove the requirement to pay for eye and dental checks and it will provide for a broader range of examinations than are allowed for currently. It might be helpful if I stopped there and took questions on those sections, or would you prefer me to deal with all three issues now?
The Convener: I want to deal with the three parts separately. The first—part 2—deals with general dental services, general ophthalmic services and personal dental services.

Dr Wilson: I will carry on then, if I may, with the other two issues.

The next sections of the bill flow from the consultation that the Executive conducted in the earlier part of last year. The consultation paper “Modernising NHS Dental Services in Scotland” was issued, to which there were a large number of responses, and a number of meetings were held throughout Scotland. As a result of that, the proposals for changing primary legislation are quite limited. The response to the consultation was clear: the changes that professionals and members of the public were looking for could be implemented by methods other than primary legislation—for example, by changes to regulations and changes to the way in which dentists are paid. There is a specific dental remuneration system, which can be changed without amending primary legislation. On the face of it, the changes to primary legislation on dental services seem modest, but they are important. I will deal with them in the order in which they appear in the bill.

First, in section 11, there is a provision to make the dental charging regime simpler and more flexible. At the moment, a patient’s dental charge is linked to the dentist’s item-of-service fee. If a patient pays, they pay 80 per cent of that fee. That is how the legislation is currently framed; it does not give the detailed percentage but states the way in which the charge is calculated by reference to the item-of-service fee. By breaking that link, which is what the bill does, we will have the opportunity, through regulations, to have a more flexible and transparent system. Ministers have not yet taken a view on what that system should be, but the bill allows for a more flexible system than currently exists.

Section 12 will allow NHS boards to enter into arrangements for general dental services with dental bodies corporate as well as with dental practitioners. Dental bodies corporate are defined in the Dentists Act 1984, which is reserved legislation. It contains provisions for bodies corporate to provide general dental services under the NHS as well as privately. At the moment, arrangements can be made only with individual dentists, but the provision broadens the ability of NHS boards to make arrangements.

Section 13 is on a particularly important matter, which was raised forcefully during the consultation: the ability of health boards to provide financial assistance and support to persons who provide general dental services. That might include, for example, assistance with the cost of premises and information technology support to staff.

Section 14 will allow health boards to make arrangements with dentists for what we describe as co-management schemes—schemes that allow dentists to provide in the community services that might otherwise be provided in, for example, a hospital setting. The bill will allow such services to be contracted with local dental practices in the high street, which will be able to provide them to patients in the community. Indeed, dentists can provide an important service in relation to other treatments—two examples are migraine and snoring treatments, which are not normally associated with dental services.

Sections 15 to 17 are about the listing of those who provide dental or optical services. At the moment, people who are included on health board lists to provide such services are what we call principals—the main providers of service. Those who are not listed are called assistants and they support those professionals in providing services. Assistants are qualified dentists or optometrists but they are not listed. One of the post-Shipman recommendations was that all such individuals ought to be listed, whether the services that they provide are medical, dental, pharmaceutical—we will come to that later—or ophthalmic, so that individual health boards have responsibility for all the individuals on their lists. That is a clinical governance issue.

Mike Rumbles: You make it clear that part 2 of the bill will allow everybody to have free dental examinations and sight tests. When you say that part 2 will also allow the Executive at a future date to establish more comprehensive oral health assessments and eye examinations, do you mean that could be done by regulations? I just want to be absolutely clear that ministers will be able to come forward with those proposals not through a bill before the Parliament but through laying regulations before the committee. Is that right?

Dr Wilson: Yes.

Shona Robison (Dundee East) (SNP): In the financial memorandum, providing free dental checks has been costed at between £3.1 million and £12.4 million, based on a cost of £6.80 for one check. This exercise is running simultaneously to the awaited response from ministers to the “Modernising NHS Dental Services in Scotland” consultation, so it is quite possible that there will be substantial changes to the fee structure and to the fee level that could be paid to dentists for carrying out those dental checks, particularly as you have said that there is a desire to have wider oral health assessments than just the basic check. There is a likelihood that the figure of £6.80, on which the financial memorandum is based, could quickly become out of date as the fee structure...
and fee level change and as what dentists are expected to provide for the check changes. Is not the financial memorandum likely to become way out of date and substantially inaccurate quite quickly?

**Dr Wilson:** You are absolutely right. Because discussions with the dental profession on the potential for an oral health assessment and what that might mean are on-going, we do not have new figures for the financial memorandum, which was constructed a number of weeks ago. We have simply had to go on the figures that we had available at the time, so you are right to say that the cost could change.

**Shona Robison:** How will that be managed in terms of the progress of the bill?

**Dr Wilson:** As soon as we are aware of the changes that might flow from those discussions and from the decisions that ministers will announce, we will have to come back and make an addendum to the financial memorandum.

**Shona Robison:** I suppose that the problem is that, in some ways, the timing could not be worse. I have highlighted one aspect where the decisions made by ministers could have an impact on the financial memorandum or indeed on the contents of the bill, but there could be many such aspects. I take it that you are in close liaison with the officials who are working around what the ministers are about to announce.

**Dr Wilson:** Yes.

**Shona Robison:** Will you come back and have another session with us on the more realistic figures?

**Dr Wilson:** Yes. We were able to produce costs only on the basis of the information that we had at the time. In relation to the main service, in addition to the examinations, the bill does not have direct financial consequences other than those that are listed. Clearly, however, if any ministerial announcement includes additional resources for general dental services, that would have to be taken account of as well.

**Helen Eadie (Dunfermline East) (Lab):** I note from the SPICe briefing that remuneration for dental services across Scotland is set at United Kingdom level. One of my concerns, which I am sure other members will share, is that if there are negotiations going on at the London end of the spectrum, as happened in relation to general practitioners not so long ago, there will be a feeling in Scotland that not enough discussion and negotiation is taking place to reflect Scottish concerns on the issue. What measures are in place to ensure that Scotland is wholly and fully consulted on that point?

14:30

**Dr Wilson:** There are two aspects to that question. First, the remuneration set by the doctors and dentists remuneration review body for the UK relates to item-of-service fees and, traditionally, we have gone along with that body’s recommendations. Secondly, however, we have introduced in addition to the item-of-service fees and outwith the DDRB certain unique allowances and incentives to encourage practitioners to stay and practise in Scotland. In a sense, we have tried to have the best of both worlds by continuing certain aspects that have been introduced on a UK basis while introducing measures on a Scotland-only basis to meet the country’s particular circumstances.

One of the basic issues for ministers in considering the future is the extent to which we change the relationship with what happens south of the border. In England, they have already indicated that they will take a contractual route that is different from the one that most people in the consultation wanted us to take. The approaches taken in Scotland and in England and Wales are already diverging.

**Helen Eadie:** I understand that even as we speak negotiations on this issue are taking place at a UK level. How far have they reached with regard to Scotland?

**Dr Wilson:** Ministers hope shortly to announce the results of the response to the consultation, which will provide a set of proposals for the future of NHS dental services in Scotland. I am sorry, but I cannot provide a precise timescale.

**Kate Maclean (Dundee West) (Lab):** How do the bill’s provisions for free eye tests compare with those in the general ophthalmic services contract? There has been some criticism that they do not go far enough.

How can we ensure that people such as children who are entitled to free eye tests take them up? For example, it is reckoned that 20 per cent of school pupils have undetected sight problems. Moreover, what provision will there be for people such as those with dementia or learning disabilities who are more difficult to test and need more time for such examinations? I am concerned that, although free eye tests can have a real public health benefit, they have to be carried out properly or there will be no improvement.

**Dr Wilson:** For that very reason, the wording in the bill has been changed to allow eye examinations, which, subject to discussion with the profession, can be defined in a much broader way than the current sight test. After all, that provision was designed in 1948 for a very specific purpose and has not been altered much since then.
The Convener: Has the wording been changed to take into account Optometry Scotland’s concerns that confining the provision to a sight test would miss the point in many respects?

Dr Wilson: Yes. I believe that the SPICe paper specifically mentions Optometry Scotland’s view. Indeed, we are discussing with the organisation the potential through the eye care services review group of extending eye examinations to broaden the proposed provision into one that is more of a public health measure than the current provision is.

The other issues that Kate Maclean raised, which are important, are more to do with how we implement the changes. I wonder whether we should simply stick to the bill’s content for today. We will take the other matters away and consider them in the context of implementation.

Mr David Davidson: The British Dental Association and Optometry Scotland appear to challenge their members’ capacity to deliver the provisions on time. In other words, there are not enough bodies on the park to do that. Moreover, practitioners might be unwilling to participate unless they are forced to. How will you address that matter in the bill?

Dr Wilson: Legislation cannot address that issue in itself; it has to be a matter for discussion and negotiation with the two professions. Let me take them in reverse order. Optometry Scotland has said that opticians across Scotland have the capacity to deal with a policy of free eye tests for all. In comparison with other health care professionals, opticians are reasonably plentiful. I accept that the situation is quite different with regard to dentistry and that, as people around this table know well, there are severe pressures on dentists. We are in discussions with the profession about the content of the scheme, but believe that it must be set in the context of the whole modernisation process rather than being seen as an item on its own. If, through the modernisation process, we can encourage more dentists into the national health service and retain them within the NHS, we have a much better chance of delivering the oral health assessments that are mentioned in the legislation.

Mr David Davidson: Are you saying that Optometry Scotland says that it has enough people to do what it is currently doing and to take on an additional load?

Dr Wilson: Yes. That is what its representatives have been saying in the eye care services review, of which they are part.

Mr David Davidson: Will we be able to read the reports of that review group?

Dr Wilson: The intention is that a preliminary report will be given to ministers in the near future. I am sure that that can be made available to the committee as soon as ministers have seen it.

The Convener: There appear to be no more requests to question this panel of officials with regard to part 2 of the bill, so perhaps Eric Gray is no longer required and—no doubt much to his delight—he can go.

I ask Dr Wilson to make a brief introductory statement on pharmaceutical services, which are dealt with in part 3 of the bill.

Dr Wilson: I stress the fact that the bill is not about the detail of the new pharmacy contract that is being negotiated with the Scottish Pharmaceutical General Council, which is the representative body for community pharmacists in Scotland. However, the bill sets the legislative framework within which the new contract might be delivered.

I emphasise the fact that the legislation, as drafted, substitutes the term “pharmaceutical care services” for “pharmaceutical services”. That might seem to be a small change, but care is an important word because part of the negotiations with the profession—because of the requirements placed on the Executive in the partnership agreement—relates to the need to make the best use of the skills of community pharmacists. That issue relates to care, not just dispensing, important though dispensing is. Therefore, the provisions in the bill are meant to underpin a new set of arrangements for the delivery of what we are increasingly going to call pharmaceutical care services rather than pharmaceutical services. In summary, the key provisions in the bill enable the implementation of that new pharmacy contract. The bill underpins the new contract arrangements, the detail of which will be laid out in regulations, as is the case with the current contract.

The bill also introduces a duty on health boards to be much more proactive in identifying and providing or securing the provision of pharmaceutical care services for their respective areas. At the moment, the mechanism for the provision of pharmaceutical services is somewhat reactive. When people apply to come on to a pharmaceutical list, there is a process for considering that application and either accepting or rejecting it, and there is also an appeals mechanism. The intention of the legislation is to turn that process around so that health boards proactively plan the provision of services and secure that provision where it is needed.

The third element is about listing. I mentioned clinical governance in relation to dental and ophthalmic services and the issue is exactly the same in relation to pharmaceutical services.
Currently, lists that are held by health boards do not contain the names of the pharmacists who provide the services, other than those of the superintendent pharmacists who are in charge of particular outlets. The intention—again, a post-Shipman requirement—is to identify all the community pharmacists who provide pharmaceutical care services. They will be on the list and will be responsible for their own acts and omissions, and that will underpin the clinical governance requirements on the NHS board.

The final provisions will ensure that health boards have financial responsibility for the contractors that will be delivered through the community pharmacists who provide pharmaceutical care services, by ensuring that funding is seen as a core part of the health boards' budgets. At the moment, the budget for remuneration for community pharmacies is held centrally, and although health boards are formally accountable for it, they have no direct interest in or control over it. The intention is to change that, so with the planning of services goes the responsibility for funding them. Having said that, it is important to stress that essential services will continue to be negotiated and defined at national level and that there will therefore be consistency of remuneration for community pharmacies throughout Scotland. The only additions to that will be services that not every community pharmacy will be required to provide, which can be contracted locally. We will still have a national service, albeit that remuneration will be done accountably at health board level.

The Convener: Do members have questions? Why did I guess that David Davidson would be the first member with his hand up?

Mr David Davidson: I am still on the roll of the Royal Pharmaceutical Society of Great Britain, although I do not practise.

Dr Wilson says that there will be national negotiation on the basic fee structure for dispensing purposes and I presume that there will be such negotiation for some form of new establishment contract. Is he saying that health boards will decide which additional services each pharmacy can apply to deliver or will be asked to deliver? How will the funding for that operate?

Dr Wilson: Additional services will be defined. There are four essential services in the proposed new national contract: acute dispensing, which is what most people think of as a pharmacy service; a minor ailments service; a public health service; and a chronic medication service. Those will be national services and the tariffs, capitation fees and so on will be laid down centrally. Examples of additional services include services to residential homes and oxygen therapy services. As I said, additional services will be defined and, just as happened with primary medical services, there will be a national specification and a benchmark tariff. Health boards will be able to use those, but at the same time they will be able to flex them to fit particular local circumstances. It is likely that specific pharmacy contractors will provide those additional services; not every pharmacy will provide them, just as at the moment not every pharmacy contractor needs to provide oxygen therapy services. They are distributed around an area to make sure that there is sufficient coverage.

Mr David Davidson: Are you saying that from the patient's perspective, which is where we need to come from, people who currently enjoy additional services will continue to do so and the health boards will not be able unreasonably to withdraw services from any particular area of Scotland?

Dr Wilson: We expect the pharmaceutical plan, which is mentioned in the bill, to cover the full spectrum of services so that people can be satisfied that the full range of services is available to the whole population, albeit that additional services will not necessarily be available from every community pharmacy.

The Convener: No other member has indicated that they wish to ask a question on part 3 of the bill, so that is good news for Chris Naldrett, who can now head off, perhaps wondering why he came along in the first place. I thank him anyway, and I ask Dr Wilson to make a brief introductory statement on part 4 of the bill, on discipline.

14:45

Dr Wilson: I have mentioned the post-Shipman recommendations more than once this afternoon, and a number of measures in part 4 of the bill flow from them—not necessarily the most recent recommendations, which have just appeared, but those that appeared not long after the events.

In Scotland, we have an NHS tribunal, which is the national disciplinary body for family health service practitioners—that is, doctors, dentists, pharmacists and opticians. Following consultation, a number of measures to strengthen the protection of patients throughout Scotland are proposed in the bill.

The first of those is the removal of the tribunal's sanction of local disqualification. At the moment, an NHS tribunal can, in theory, disqualify someone nationally—that is, throughout Scotland—or only in the area or areas in which they provide services. It seems inappropriate that someone should be disqualified in one part of Scotland only to be allowed to practise in another part of the country. The consultation was clear that that should no longer be the case and, in fact, the NHS tribunal has not used the provision for many years.
The second measure is to add a third ground for disqualification to those that currently exist. That third ground is unsuitability by reason of “professional or personal conduct”. There have been circumstances in which the requirements that are currently placed on the NHS tribunal have not allowed it to consider the disqualification of individuals whose disqualification members of the public would, I suspect, think that the tribunal ought at least to consider. In common with our colleagues south of the border, we are introducing that third ground for potential disqualification.

The third measure is the introduction of an additional ground for suspension. The tribunal can already suspend individuals from practice—that is, not disqualify them, but suspend them for a period of time—and the agreement from the consultation is that we should add:

“that it is otherwise in the public interest to do so.”

There are circumstances in which, to protect patients, it is appropriate to extend the current grounds for suspension. I add that, as mentioned in the SPIce note, we will, through regulations, provide for NHS boards to be able to suspend someone locally, as it might be appropriate to take action quickly in specific local circumstances. However, national suspension is reserved to the NHS tribunal.

The fourth measure is to bring within the NHS tribunal’s jurisdiction all the additional categories of staff that I mentioned in connection with listing. As I mentioned, assistants who support the provision of, for instance, dental or pharmacy services are not covered by the NHS tribunal because they are not on a list. However, because we seek to list them through the bill, they ought to be covered by the NHS tribunal, and provision is made for that.

Finally, there are provisions that will ensure that the Scottish ministers can, through regulations, require that decisions that are made in other parts of the UK also apply to Scotland. It is important that, if someone is disqualified in England, Wales or Northern Ireland, they are also able to be disqualified north of the border, and regulations will allow that to happen.

The Convener: Thank you. I have a question about the Shipman inquiry, which has recently published a report. Does the Executive intend to introduce further measures in part 4 if that seems sensible as the weeks go by?

Dr Wilson: Part 4 would be the appropriate part of the bill in which to do that. As you know, the Shipman inquiry’s “Fifth Report—Safeguarding Patients: Lessons from the Past—Proposals for the Future” has become available only very recently. It is the most recent report and deals with issues that are not dissimilar to those covered in the bill. In fact, the direction in which the bill is moving is consonant with the fifth report’s recommendations, but if there are specific issues, we would bring them back to the committee.

The Convener: Do you anticipate anything additional coming up or do you think that, at the moment, you have gone as far as you can go with post-Shipman recommendations?

Dr Wilson: We are still in discussion with the other health departments about what measures might need to be introduced, but we could come back at stage 2 or stage 3 if we felt that there were significant issues that it was important to include in the bill, because that would be the opportunity to capture anything that comes out of the Shipman inquiry’s fifth report.

The Convener: I will have to demit the chair to my deputy convener for a few minutes, because I have a television interview that I have to do. I ask the committee and witnesses to accept my apologies.

Mike Rumbles: I welcome the more comprehensive nature of the bill’s provisions on disqualification by the NHS tribunal, but to put the matter into perspective, I ask the Executive officials to tell me approximately how many individuals have been disqualified by the system in the past five or 10 years.

John Davidson (Scottish Executive Health Department): There is about one case per year, but there has recently been an increase. There are two cases running at present, but we anticipate that the workload will increase, especially in relation to fraud cases.

Mr David Davidson: I ask the officials to clarify the situation with respect to suspension and disqualification. What is the relationship that the various health departments have agreed or are negotiating with the professions that have registration and statutory disciplinary systems of their own? In some cases, a professional body might not support the NHS view but, in others, the professional body might wish to suggest to the health service that it take action. Such bodies could do so simply by disqualifying somebody from practising. What is the new arrangement under all the changes that have been made in the past year?

Dr Wilson: That arrangement is closely tied up with the recommendations from the Shipman inquiry and what might happen as a result of the inquiry’s fifth report. It is largely focused on the General Medical Council, but will inevitably have implications for the other councils. The intent has always been to make the procedures as consistent as possible while recognising that the NHS and the professional bodies have distinct roles. The NHS has a specific role in relation to the safety of
NHS patients, while the registration bodies have a broader role. However, the health departments have always tried to make those roles as consistent as possible. As the committee knows, the structures north and south of the border are different, so the bodies that deal with the issues in different parts of the UK might be different, but the principles are still the same. Discussions have continued with the professional registration bodies to ensure that they do not envisage any difficulty with the arrangements, and they have been consulted as part of the process.

Mr David Davidson: Will a standard system apply over the four health departments in the UK to a professional body that covers the whole UK?

Dr Wilson: Yes. The process by which that happens might be different because of the different bodies that are involved, but the principles will be the same.

The Deputy Convener (Janis Hughes): That concludes the questions on part 4 of the bill. For questions on part 5, we will move on to a new panel of witnesses, apart from Mr Duncan. We are a little ahead of schedule due to the discipline of members and their short questions, so I suggest that we have a short break and reconvene at 3 o’clock.

14:52
Meeting suspended.

15:01
On resuming—

The Deputy Convener: We will now deal with part 5 of the bill, which contains miscellaneous provisions.

I welcome our next panel, which comprises a host of miscellaneous officials. Mr Duncan is still with us. Stephen Sandham is from the regeneration, fuel poverty and supporting people division of the Scottish Executive Development Department and Sylvia Shearer is from the blood transfusion services and rehabilitation equipment branch of the Scottish Executive Health Department’s health planning and quality division. Andrew MacLeod is head of the Scottish Executive Health Department’s health planning and quality division. Andrew MacLeod is head of the Scottish Executive Health Department’s health planning and quality division. Adam Rennie is head of community care division 2 of the Scottish Executive Health Department. Diane White is from the Scottish Executive Education Department’s social work services policy division training and development team and Jim Brown is head of the public health division of the Scottish Executive Health Department.

I invite Sylvia Shearer to make some opening remarks on section 24.

Sylvia Shearer (Scottish Executive Health Department): The Skipton fund commenced business in July 2004, following an expert group’s report. The scheme aims to make ex gratia payments to people who became infected with hepatitis C as a result of receiving blood tissue or blood products as part of their NHS treatment prior to 1 September 1991 and who meet certain criteria.

In order to minimise any payment delays to individuals, the payments have been made using common-law powers. To allow payments to be made over the longer term, it is necessary for our ministers to be given legal vires for establishing and being involved with the ex gratia scheme. The bill that is before members therefore makes statutory provision for those payments. To date, the fund has paid out just over £8 million to Scottish claimants and a total of 400 Scottish claims have been processed.

David Davidson asked originally why there are so many parts to the bill, and I think that that partly answers his question. This is our first opportunity to propose such legislation to the committee.

Mr David Davidson: My original question was not so much why there are so many parts to the bill, but why some parts of it are not stand-alone pieces of legislation.

The Deputy Convener: Members may now ask questions on section 24.

Mike Rumbles: I want to consider the necessity for section 24. Payments for what is, basically, no-fault compensation are being made under common law. I heard what you said about ministers thinking that it would be better to firm things up in statute, but I am concerned that if cases arise on other subjects that relate to the health service, people may be concerned about no-fault compensation for victims who have an issue through no fault of their own or the health service and the bill might be used to block any future extension of no-fault compensation.

We already have no-fault compensation for AIDS and hepatitis C victims. No immediate pressure is building for compensation for any other category of victims, but that could happen in the future. I do not want the provision to be used as an excuse for not providing such compensation. You confirmed that ministers are allowed to provide no-fault compensation under common law, so why is the provision necessary?

Sylvia Shearer: The bill is not intended to pave the way for other schemes. We see hepatitis C as a special case, as with AIDS and other particular circumstances. We do not wish to set a precedent.
Mike Rumbles: That does not answer my question. I understand that point of view, but if the common law allows the payment to the Skipton fund—as it does—why is the provision being introduced?

Andrew MacLeod (Scottish Executive Health Department): We are using common-law powers to make the payments under the budget resolution because that is allowable as a temporary measure. However, the legal advice is that we cannot make hepatitis C payments in the long term without a statutory provision to do so.

Mike Rumbles: You have had specific legal advice.

Andrew MacLeod: We have legal advice that that is necessary.

The Deputy Convener: Members have no more questions on the provisions on hepatitis C compensation, so we will move to the next sections. I invite Adam Rennie, Diane White and Stephen Sandham each to give a brief introduction on their interests, particularly in relation to amending the Regulation of Care (Scotland) Act 2001 and the registration of child care agencies and housing support services.

Adam Rennie (Scottish Executive Health Department): We deal with several distinct provisions. Section 25 concerns independent health care services and is a fairly technical measure. The Regulation of Care (Scotland) Act 2001 lists various care services that are to be regulated by the Scottish Commission for the Regulation of Care, which include an independent health care service as defined in section 2(5) of the 2001 act.

The scope of the 2001 act goes further than the original policy intention. For instance, if regulation were commenced under the definition in section 2(5) as it stands, that would make the care commission responsible for regulating services from a doctor or dentist that are provided under arrangements for a third party and private services of any description that NHS general practitioners provide.

Section 25 will give ministers the power to except services from the overall definition by regulations. That is in line with many other service definitions in the 2001 act, such as the definitions of a school care accommodation service, a nurse agency or a child care agency, all of which provide for ministers to make regulations to narrow the scope of regulation if that is thought appropriate. Consultation would take place on any proposed use of the power and the regulations would have to be laid before Parliament in the usual way.

If section 25 was technical, section 26 is extremely technical. Section 26 will rectify drafting of the 2001 act. Strictly speaking, section 16 of the 2001 act requires the care commission to proceed with action such as serving an improvement notice on a provider regardless of representations that the provider may make. That was clearly not the intention. The care commission should consider any representations from people who have been notified of its intention to do something, then decide whether to do what the person was consulted on. Section 26 will amend the 2001 act to ensure that the commission considers representations then decides whether to proceed. The same change will be made to provisions on the Scottish Social Services Council, for which my colleague Diane White is responsible. She will also speak on section 27.

Diane White (Scottish Executive Education Department): The change is the same for the Scottish Social Services Council, which maintains registers of all social service workers. As is the case with the care commission, if the council intends to impose a condition on registration, it will issue a proposal notice to the person involved. Even if that person makes representations, the 2001 act is drafted so as not to take those representations into account. Section 26 will make a technical amendment to ensure that any representation is taken into account before any final decision is made. The final amendment in section 26, which also relates to the Scottish Social Services Council, is a technical amendment to the drafting to ensure that it is clear that a potential registrant has a right to appeal to the sheriff against all decisions and proposals.

Section 27 will make a technical amendment relating to the codes of practice that are issued by the Scottish Social Services Council with the consent of Scottish ministers. The 2001 act makes it clear that any employer must take the codes of practice into account when they deal with a conduct issue regarding a social services worker. Section 27 aims to clarify exactly the circumstances and what information should be provided to the council when any registration matters are being dealt with. It also makes it clear that employers are expected to contribute to any registration process and any investigations that the council may undertake.

Adam Rennie: Section 28 deals with the registration of child care agencies and housing support services. As members can see, it is a fairly complex-looking provision. The proposed amendment is necessary to rectify a problem that we identified last year. I will give the committee some background information about how that arose.

When services that were not previously regulated by the care commission are brought within regulation, a procedure has to be set up to
phase that in. Regulation cannot simply be introduced overnight; if that were to be done, suddenly everybody would find themselves breaking the law. All services that are in operation at a particular date are deemed to be registered with the care commission for a specified period. During that period, service providers may apply for registration with the commission. Provided that they apply by the deadline at the end of that period, the deemed registration then continues for a further period, during which the commission determines the application. That procedure has been used for the commencement of various services. In particular, it was used for the commencement of the regulation of housing support services and child care agencies from 1 April 2003.

Due to the complexity of the services concerned, discussions between the care commission and the providers about the application arrangements took much longer than was anticipated. An especially difficult question was what precisely constituted a branch for the purposes of registration with the commission. During those discussions, the deemed registration period ran out, by which time very few providers had applied for registration. As a consequence, many providers were inadvertently acting illegally under the terms of the 2001 act. I hasten to add that everybody was acting in good faith—at the time, very few people realised that the change was taking place. That did not come to light in the Executive until it was too late to take action to extend the deemed registration period. Once the deemed registration period had finished, it was not possible to breathe life back into it.

In July, once we had discovered that and had worked out what to do about it, the Scottish Executive issued a news release urging providers to apply by the end of September 2004 and stating that the Executive would take steps at the earliest legislative opportunity to ensure that the registration status of the services concerned was brought within the law. At the same time, the Lord Advocate granted the providers who were affected an amnesty against prosecution for providing unregistered services, provided that they submitted an application for registration with the care commission before 30 September last year.

The provision in the bill implements the Executive’s commitment to bring the registration status of the providers within the law. The provision looks quite complicated, but basically it will ensure that, if a person was deemed to be registered from 1 April 2003 as a provider of child care agencies or housing support services, that deemed registration will not cease until 1 April 2006, provided that applications for registration were made before 30 September 2004. In effect, it puts something right.

My colleague Stephen Sandham, who is responsible for housing support services in the development department, will talk about section 29, which is related to what I have just spoken about.

15:15

Stephen Sandham (Scottish Executive Development Department): Grants are made by the Scottish Executive to local authorities, under the Housing (Scotland) Act 2001, towards the cost of housing support services for vulnerable people. Local authorities in turn pay grant to providers of those services. One of the grant conditions was that those providers who required to be registered with the care commission were indeed registered. The lapsing of the deemed registration due to the complexity of the registration process—which Adam Rennie discussed in relation to section 28—meant that payments were, in fact, made by local authorities after 1 October 2003 to providers who were not registered, in contravention of the grant conditions. When the problem came to light, action was taken by the Executive on 19 August 2004 to remove temporarily the requirement for providers to be registered with the care commission. That enabled us to continue grant payments to providers to ensure that crucial services continued.

The provisions in section 29 seek to correct the unlawfulness of the payments that were made between 1 October 2003 and 19 August 2004—recognising, as Adam Rennie said, that throughout that period providers were acting in good faith and in ways that, in every other respect, entirely met the grant conditions.

The Deputy Convener: Do members have any questions? No? The evidence was either too complicated or very comprehensive. I therefore thank Mr Sandham, Mr Rennie and Ms White for their contribution.

Jim Brown will make a short statement on the authorisation of medical treatment for adults with incapacity.

Jim Brown (Scottish Executive Health Department): Section 30 proposes changes to part 5 of the Adults with Incapacity (Scotland) Act 2000. Part 5 of that act gives a general authority to medical practitioners to treat patients who are incapable of consenting to the treatment in question. That is done through the issue of a certificate of incapacity. At the moment, only registered medical practitioners can issue certificates of incapacity.

Prior to the 2000 act, to treat a patient without consent, unless in an emergency, could be considered an assault. The general authority to treat that is conferred by the certificate of
incapacity does not extend to particular treatments specified in regulations—treatments such as electroconvulsive therapy or abortion, for which special arrangements apply. It also does not extend to emergency treatment to preserve life or to prevent serious deterioration in a person’s condition.

Guidance on the operation of part 5 of the 2000 act was set out in a code of practice. The operation of part 5, which started on 1 July 2002, gave rise to concerns, among general practitioners in particular, that the procedures and requirements that it set out were onerous and time consuming and that some streamlining was necessary. In addition, other professionals—in particular, dentists—were concerned that they were unable to treat patients attending their surgery, sometimes in pain, because a certificate was not already in place to allow treatment to take place. In consequence, those professionals had to seek out a doctor to issue a certificate.

Accordingly, a two-part consultation process was launched in 2003. The first part of the process sought views on a range of changes or improvements that might be made to the code of practice on part 5 of the 2000 act; the second part of the process took the shape of qualitative research, which was designed to examine the experience of the operation of part 5.

In the light of responses to the consultations—which were complemented last year by a meeting with key stakeholders—it was decided that two changes to the 2000 act should be proposed. First, it is proposed that, as well as medical practitioners, other health practitioners should be permitted to issue certificates of incapacity that are relevant to their specialism. The bill will therefore amend section 47 of the 2000 act to allow dentists, ophthalmic opticians and registered nurses to issue certificates of incapacity. There is also provision to extend the authority to sign certificates to other professional groups. That would be done by regulations, which, of course, would be the subject of consultation and would be laid before the Parliament. It is important to stress that the issue of a certificate will apply only to the particular specialism of the health professional group concerned. For example, a dentist could authorise only dental treatment.

The second proposed amendment to the 2000 act aims to extend the maximum duration of a certificate of incapacity from one year to three years in certain circumstances. The circumstances in which the extended period could be applied will be set in regulations to be the subject of consultation. It is envisaged that the longer-lasting certificates will be dependent on the nature of the illness from which the patient suffers. For example, if a patient were suffering from a progressive degenerative condition with no chance of improvement, it would be open to the certificate issuer to extend the certificate beyond one year.

In proposing the amendments to the 2000 act, the aim has been to help improve the operation of that important legislation while at the same time maintaining its principles and ensuring the continuing benefits and protection that it provides for that vulnerable group of adults.

The Convener: Thank you, and I am sorry that I was not here for the start of your statement.

Mike Rumbles: Jim Brown is right, the amendments to the 2000 act are extremely important for a vulnerable section of the community.

You propose to replace the words, "the medical practitioner primarily responsible for the medical treatment of an adult" with the words "any of the persons mentioned in subsection (1A)". You stressed the fact that health professionals will be able to issue certificates that are relevant to their specialism. However, the person responsible for anybody’s general health and treatment is their GP, so the GP should and does take an overall look at the individual.

I am a little concerned that we might be removing that responsibility and giving it to an awful lot of other people. The list of health professionals in the SPICe briefing includes GPs, other doctors, consultants and dentists—which is obvious if dental work is required. However, the list also includes hospital trusts, nurses, people in social work and the voluntary sector, health care providers, health care associations and academics.

Jim Brown: First of all, the ability of a general medical practitioner to issue the certificate remains. The other categories described in the bill—for example, dentists, ophthalmic opticians or registered nurses—are additions.

We are aware that concerns were raised in the consultation process about the ability of those health professionals to assess capacity. In other words, there was concern that what is needed before treatment can proceed and before a certificate can be issued is a rounded assessment of the patient’s capacity to respond or not respond to a particular treatment.

We are in touch with NHS Education for Scotland with a view to developing protocols and guidance for health professionals who are affected by the new legislation to ensure that they are equipped in every way to assess capacity to the maximum extent.
Mike Rumbles: We—rightly—recognise the expertise of registered nurses, in giving them more authority for example. However, does the legislation represent a move away from allowing the GP to make the overall assessment of capacity?

Jim Brown: I hope not. The provisions in the 2000 act on the assessment of capacity and what is said in the code of practice will still apply to those groups of professionals, so there is no dilution of the absolute requirement for a thorough assessment process to take place. All that is happening is that we are extending the range of professionals who are able to issue the certificate of incapacity, based on a thorough assessment of a patient’s ability to consent to treatment or otherwise.

Mike Rumbles: Can you give me an example of a situation in which it would be more appropriate for a registered nurse to make the assessment than the person’s GP?

Jim Brown: Nurses have a range of duties—applying dressings to a wound, for example. If a patient were to present at a doctor’s surgery and be incapable of consenting to any kind of treatment—even to having a dressing applied to remedy the situation—and if a certificate of incapacity were not ready, the nurse would have to seek the authority of the general practitioner to carry out the treatment based on a certificate issued by the GP. The change is really an attempt to improve the service rendered to the patient.

The Convener: I see that Mike Rumbles is hesitating. I shall allow David Davidson to ask a question now and we can return to Mike once he has had a think.

Mr David Davidson: Jim Brown talked about the development of protocols with NHS Education for Scotland. New breeds of prescribers—supplementary and independent—are beginning to come through. I am not convinced that they yet have the right training within the existing schemes. Will they be dealt with through the protocols or will they be included in the wording of any eventual regulations?

Jim Brown: Extending the provision would be a matter for consultation. The provision in the bill makes it clear that regulations would apply to

“a person who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfies such requirements as may be so prescribed”.

Those could include having certain qualifications, for example in the assessment of incapacity.

Mr David Davidson: So they could be covered by the legislation without much change?

Jim Brown: The idea is that, initially, additional groups would be given authority to issue certificates of incapacity, and that would be complemented by guidance on the assessment of incapacity, issued by the department and enshrined in and incorporated into a revised code of practice.

Mr David Davidson: I take as an example a supplementary prescribing registered pharmacist who goes into a care home to assess medication. Within certain protocols, such pharmacists can represcribe and change doses, which is treatment. Would they be included on the basis of a protocol or as of right? Currently, their training does not cover the situation.

Jim Brown: We would need to take that up with NHS Education for Scotland to determine what guidance should be issued to the field in that respect.

Carolyn Leckie (Central Scotland) (SSP): I think that what Mike Rumbles was getting at is similar to the concerns that I have. There is concern that there should continue to be holistic assessment of a patient to take into account all their circumstances and their background. I would be worried about inconsistencies in the assessment of incapacity, depending on which health professional happens to see a patient and in what circumstances they are assessed for incapacity related to mental illness. A patient might go into a maternity hospital because she is pregnant. What level of incapacity is to be assessed? I can see that there might be inconsistencies depending on who approaches the issue. Someone could be assessed as having an incapacity in relation to one aspect of health care, but in relation to another aspect, they might not.

There is a need for an holistic assessment. I am just a wee bit worried, because that kind of holistic assessment and individualised care takes time. In the care home situation that David Davidson referred to, it is quicker to mass prescribe than it is to take time with an individual patient. There are legitimate concerns about opening up the process and about patients being compartmentalised according to different conditions.

Jim Brown: I take that point keenly. That is one of the reasons why we seek to develop guidance that will assist in setting the parameters for the assessment of capacity—or incapacity, as the case may be.

Shona Robison: I thought that I knew where you were going until you used an example to highlight your point to Mike Rumbles. Unless I have picked you up wrong, I am now quite concerned that we could have a situation in which people who have not necessarily gone through specific training in assessing capacity find
themselves in the position of issuing certificates and making judgments. Will the protocol allow only people who have been through a clear training programme to carry out such assessments?

Jim Brown: It is certainly our intention that issuers of certificates should have that experience. The same issue arose in the consultation in relation to general medical practitioners—sometimes even doctors did not fully understand the assessment process. We are anxious to address that.

15:30

Shona Robison: Would there be a register of people who have completed the appropriate training and who are therefore qualified to carry out such work—with the appropriate support and with the requirement that they update their training and so on?

Jim Brown: Those are issues that we are considering at the moment.

Mike Rumbles: Pursuing that point, I can see where the Executive is coming from, and I can see the purpose of the proposal. My concern is that no system is perfect and that things will go wrong. I am worried that the proposal might open the door to more things going wrong than might otherwise have been the case. The proposals are as a result of the consultation that took place, and I notice that the SPICe briefing on the miscellaneous provisions says that most of the respondents in the consultation

"were health professionals and medical and health organisations, rather than patient interest groups concerned with adult incapacity."

How many responses did you get from patient interest groups or groups concerned with adult incapacity? I want to know what sort of balance we had. I can understand the medical profession—in the widest possible sense of that phrase—wanting the changes; I am concerned about the other side of the coin.

Jim Brown: The written consultation attracted 148 responses, notwithstanding the fact that more than 1,000 consultation documents were issued. Responses were received from 28 GPs; 10 other doctors; 17 dentists; 10 hospital trusts; seven nurses; 11 social work respondents; nine voluntary sector respondents; and 56 others, representing a diverse cross-section of organisations and individuals, including health care providers, health care associations, national representative organisations for health care providers, interest groups, academics, medical protection societies and individuals.

Mike Rumbles: We can pursue that as the bill goes through.

The Convener: Yes. I can see exactly where you are going with that.

Dr Turner: I can understand why, if somebody who needs to see a dentist because they have a terrible abscess has to wait for a GP to give them a certificate, they would want to get that sorted out. However, I can see problems arising with continuity of care. If a patient has other health problems and is on other medication, that complicates the issue a bit. Dentists and ophthalmic opticians have quite a bit of training. In health centres or private companies who carry out procedures, there is more throughput, because we do not have the work force. We are considering a whole lot of different ways of providing service. Not everybody will have the same standard of assessment. We agree that the process is even difficult for GPs.

I am more worried about the proposal now than I was when I first read it. We should be safeguarding the patient and safeguarding GPs, who should be at the hub of the wheel—everything should come back to them. One begins to wonder whether this is the beginning of a dilution of the service to patients. The GP might not know everything that is going on, and that is a worry.

The Convener: There are a range of concerns among committee members about section 30. I appreciate that it might not be easy for the Executive officials to respond to all those concerns at the moment. However, they might want to flag up back at the office the possibility that the proposals will run into trouble if some of the issues are not resolved—at least to the committee’s satisfaction—before we get to the more vital parts of the bill.

Jim Brown: We will do that.

The Convener: Is that a fair assessment of the situation?

Members indicated agreement.

The Convener: I thank the officials for their evidence; they are free to leave.

We move on to evidence on the final sections of part 5, for which Roderick Duncan continues to sit on the sidelines. The officials who have been invited will deal with joint ventures for facilities and services. They are Mike Baxter, who is the property and capital planning division team leader; Dr Hamish Wilson, who is back again; and Patrick McGrail, who is from the joint future team in community care division 2. Mike Stevens, who is the deputy director of the chief scientist office, will deal separately with joint ventures, intellectual property and the Scottish Hospital Endowments Research Trust.
I invite Dr Hamish Wilson to give a short introduction on joint ventures for facilities and services.

Dr Wilson: I will keep my comments brief. I introduce the provisions from a primary care perspective because they flow from several national reviews of the various methods by which improved facilities—particularly premises—can be secured to support better delivery of primary and community care services, especially when several agencies are involved, such as health services, local authorities and GPs.

Methods exist to secure premises in the community—for example, through public capital, third-party investment in property that is leased to occupants or investment by practitioners—but following a review, it was felt that there was a gap in opportunities in Scotland. That was reinforced by experience from south of the border, where provisions were introduced a short time ago to allow Scottish ministers’ counterparts and the equivalent NHS bodies to form or participate in joint venture companies to provide such facilities and services.

The bill is intended to add to the armoury of organisations in Scotland to support the delivery of better facilities in the community. It also allows us to learn from the experience of the approach in England. We will not necessarily follow slavishly the precise methods that have been used south of the border, but we can at least gain from the experience there in the past couple of years.

The provisions are fairly straightforward. They allow the Scottish ministers and, hence, NHS bodies to form or participate in joint venture companies to provide facilities and services in the same way as can local authorities, which already have such a power.

Helen Eadie: The proposals are interesting. The SPICe briefing on the miscellaneous provisions refers to

“the proposed structure of joint ventures as companies limited by share capital”.

You will be aware that a key policy objective of the Scottish Executive is to develop co-operatives and a co-operative development agency. Will that aspiration be considered so that joint ventures could be not only companies limited by share capital, but companies limited by guarantee? That would encourage mutual development throughout Scotland.

Mike Baxter (Scottish Executive Health Department): In producing the proposals, we undertook much research into the different vehicles that could fulfil what we are trying to achieve, which is a co-ordinated and strategic approach to premises development, rather than the individual approach that the techniques that are available to most organisations have developed.

Given the scale of possible development, we need to recognise that the development of new and different models would incur cost and have time implications. There might also be an effect on market acceptance by funders and private sector partners and on their willingness to engage in untried and untested models.

The proposals do not take a one-size-fits-all approach. A range of opportunities is available to the NHS and local government to develop premises and we do not suggest that we want to stifle that. We want to provide something that acts as a conduit to bringing the organisations together. If the NHS or local government made proposals, we would be happy to consider them, but no specific alternative models were proposed in the responses to the consultation that we undertook.

Shona Robison: How would the model differ from the public-private partnership model that is already in operation for joint ventures? The SPICe briefing on the bill’s miscellaneous provisions says:

“Section 31 of the Bill proposes to allow Scottish Ministers to”

do a number of things, one of which is to

“invest in, provide loans to or provide guarantees to companies providing ... facilities and services”

for those who provide health and care services. How would that work? Will you give us an example?

Mike Baxter: On the first point, the powers that we seek are a consequence of the fact that ministers do not have powers to enter joint ventures for provision of health services. That is the vires issue that brings us here. The public finance initiative model that we have is simply a contractual vehicle between the private and public sectors; the joint venture approach differs from that significantly in that there is a long-term investment for the public and private sectors in the joint venture as a vehicle to deliver premises. That is quite a departure from what has happened previously—

Shona Robison: I am sorry to interrupt, but local authorities already have the powers to enter joint ventures. Would the bill bring health boards into line with them?

Mike Baxter: Yes, it would. Although public-private partnerships are the easiest model to look to, the power would also provide the opportunity for public bodies to work together and to form joint ventures. Therefore, the health service and local government could work together to form joint ventures, which they cannot currently do. Local
authorities have had the powers for some time and have used them in different ways.

On the second point, there are a number of ways under the bill in which ministers and NHS boards could invest and take a financial interest in the joint venture company, such as by providing financial guarantees—the investment of cash and share capital—or by putting land into the deal as a capital investment. The drafting of the bill is reflective of the different types and methods of investment in the joint venture company.

**Shona Robison:** Where would the risk lie?

**Mike Baxter:** Because it is a joint venture, the risk would be shared, which is the real dynamic in the joint venture. With the traditional acute services PFI schemes, a large amount of the risk is in the construction, whereas in the joint venture models that we are considering the risk will be spread more over the longer term in the residual value of the property after 15 or 20 years. It is a different animal altogether.

**Carolyn Leckie:** I am interested in the risk, so will you be more specific about that? You made a comment about making the joint venture more attractive to private participants, which obviously means less risk, increased chances of profit and more secure income for them. I would be interested to hear you expand on the detail of that. What are the calculations and the attractions for the private sector?

What you said about no specific alternatives having been proposed by respondents to the consultation contradicts the SPICe briefing on the bill's miscellaneous provisions, which says that "A number of alternatives ... were suggested".

Will you comment on that and tell us more specifically what the alternatives were?

On the consultation, the briefing says that the majority of respondents were positive and about 10 per cent were negative. However, some respondents were from the private sector and some were from, for example, trade unions. Will you tell us what the balance was? Of the positive comments, how many were made by the private sector and the employers' side? Were the negative comments from all the trade unions?

**Mike Baxter:** I will take your last question first. The answer is yes, and the trade unions’ objection is essentially a philosophical one to the involvement of the private sector in provision of health care.

15:45

I turn to the first question about risk. The risk to which I referred was the development of a model that is untried and untested. Given the size of the joint ventures that we are talking about, we are not talking about the creation of many such companies throughout Scotland. A necessary critical mass is required to make such a venture commercially viable and attractive. Therefore, we have limited bites at the cherry in trying to propose something that is novel or different.

According to the consultation responses, the alternative models that were proposed are currently available to local authorities and other parties. The point was that those models were not available to the NHS.

**Carolyn Leckie:** I will follow up on the risk question because I would like you to be more specific about the positive conclusions of respondents to the consultation, which came primarily from the private sector. The private sector is motivated by profit and I imagine that the attraction for that sector comes from what it expects the returns will be. Will you be specific about why the private sector likes the proposal?

**Mike Baxter:** It likes it because it proposes a long-term partnership. We are not reinventing the wheel with individual procurement; we are trying to establish something that has long-term flow as regards premises development. We are not looking at any measures in isolation.

The proposal has attractions for both the private and public sectors. From a financial planning point of view, it allows us to consider our infrastructure, how we replenish and develop it in conjunction with other public sector partners and the availability of private capital.

At the moment, the vast majority of primary care and GP premises are privately owned and developed. It is a question of how we can actually bring those kinds of developments together with other NHS and local authority developments, look at services more strategically, reduce the risk of duplication and increase efficiency in use of public resources. At the end of the day, whether we are paying for leases on such premises or investing in companies, we are talking about public money.

**Carolyn Leckie:** It is an ambitious claim that your proposal would be more efficient for the public purse. Is there evidence to support that? What calculations have been made and can they be made available?

**Mike Baxter:** We still have detailed work to do on the financial structure of the companies and our possible options. We looked at the experience of the joint venture development model south of the border and the results are certainly encouraging in terms of value for money and how different strands of public resources can be brought together and made to work more effectively.
When we looked at joint ventures and how they developed in England initially, there was a primary care and health focus. That has evolved substantially over the past couple of years and we now have projects that have taken on a focus on regeneration or on education and training. That is all about bringing different strands of money together to deliver more effective services.

Carolyn Leckie: I am interested in the English examples, so I would appreciate your being specific about those you mention. Are you talking about diagnostic and treatment centres?

Mike Baxter: No. I am talking about NHS local improvement finance trusts; the regeneration example that I quoted is the NHS LIFT project in St Helens, in respect of which there has been a significant impact on urban regeneration in deprived areas. There are also examples in Liverpool.

The Convener: If some of that information is available on paper, I invite you to let the committee clerk have a copy and we will make sure that everybody gets hold of it for comparison.

Dr Turner: The matter of joint ventures has provoked most thought—there are so many questions because we did not have enough examples. Would you consider a joint venture like some of the initiatives that occurred after the sale of hospital land? NHS or public money could go into a venture with that of other companies.

A private company can be formed and registered at Companies House. It is quite cheap to do that and it makes it difficult for the public to ascertain what is going on: I have had difficulty finding minutes for such a company. Eventually, after about a year, I discovered that minutes are produced, but that they are not verbatim—they are précised for public view. I was told that minutes are not necessarily kept in a library. I worry about accountability for how money is spent.

Flexibility is another issue. I worked in a health centre that was built in 1982, but by 1990 it was not fit for purpose under a new contract because it was not big enough. To enter long-term contracts is probably comfortable for businesses, but how does that maintain the flexibility that the NHS needs? We do not know where we will be 20 years from now. Different techniques and ways of working will apply because medicine is always changing. I would like examples of how entering a joint venture will deal with that.

In my area, the local authority does not seem to have control over one initiative, although it does over another. Ministers probably have more control over the private company. The situation is extremely difficult to understand. Could I have some answers? If you cannot provide them now, perhaps you could provide them in writing.

The Convener: That was an open-ended question.

Mike Baxter: There are two sides to accountability. For financial accountability, any flows into or out of an NHS board or local authority must be accounted for. Interaction with a joint venture company will take two forms. The share capital investment that we envisage will be recorded on an NHS board’s balance sheet. Lease payments to rent parts of or whole premises will be identified as lease expenditure. The accounting regulations provide a basis for identifying the financial flows into and out of an NHS board in relation to a joint venture company.

As for the flexibility argument, I agree that—as with all capital or infrastructure developments in the health sector—change and how we plan for it are huge issues. Bodies can engage in the joint venture model at different levels. One way to engage is as a shareholder in the joint venture. Another is by being the lessee of part of a building or buildings. The model that we are examining is a lease plus agreement, which would run for 15 years or less with opportunities for break points. Some flexibility is built into the model, but I accept that flexibility is a huge issue across the board for the NHS.

Dr Turner: I take it that the purpose is profit for the NHS.

Mike Baxter: The profits of a joint venture company are shared among shareholders.

Dr Turner: Are the share proportions clear?

Mike Baxter: Yes.

Dr Turner: We should be able to access such information easily.

Mike Baxter: Yes.

The Convener: Members have no more questions for Mr Baxter, whom I thank for appearing.

I invite Dr Wilson to give a brief introduction—I am sorry; I am repeating myself. I invite Mike Stevens to give an introduction on joint ventures, intellectual property and the Scottish Hospital Endowments Research Trust.

Mike Stevens (Scottish Executive Health Department): Section 31(2) also deals with companies, but for the purpose of income generation. Ministers have a range of powers to generate income for the NHS. Those powers were extended to NHS bodies through a power of direction in 1989 and include developing and exploiting ideas and exploiting intellectual property. However, ministers are not empowered to establish or participate in companies in exercising those income-generation powers. That can be a limitation on exploiting intellectual
property when the creation of a small spin-off company to attract external finance is the most appropriate and—sometimes—the only way to exploit ideas.

In addition, the Executive’s growth and innovation grants are available only to businesses that have a base in Scotland. They are not available to public sector bodies such as the NHS or universities, but many of the companies that they support have emerged from the university science base. Section 31 will extend the powers that are available to ministers by allowing them to create companies and participate in their running, but solely for the purpose of generating income. Ministers intend to extend the power to NHS bodies and, in order to ensure that it is used only when appropriate, they propose to prescribe and regulate carefully the circumstances in which it may be used through a power of direction.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The SPICe briefing note on the bill’s miscellaneous provisions says that NHS bodies in England and Wales have been able to gain additional income as a result of their intellectual property. Will you give some examples of how intellectual property has boosted their income?

Mike Stevens: The big benefit is the ability to exploit a particular innovation by collaborating with a private company. It could be that a particular device has been invented in the NHS in Scotland, but if no private company can share in its ownership, the device will sit on the shelf. However, if a device is invented in the NHS in England or Wales, where the power was introduced in 2001, a private company can be set up. The private finance would pay for development of the device and ownership would remain joint with the NHS.

Mr McNeil: That is the potential, which we are trying to understand. Are there any clear examples in which the NHS has been able to maximise the benefit or gain from intellectual property?

Mike Stevens: There have been no approvals yet of the establishment of companies in England, but the Department of Health’s commercial directorate is considering one proposal. I referred earlier to the power of direction; in England, that power calls into the Department of Health all such proposals, which are carefully scrutinised.

Carolyn Leckie: I have some technical questions to ensure that I understand what section 31 means. At the moment, if a technique is developed in the NHS, the fact that it has been developed there means that it is owned and shared by the NHS, which can—as a public body and if it is given the investment—choose to develop the technique further and spread it across the NHS. Section 31 seems to me to say that that is not an option because there is not enough funding and that, therefore, if the NHS can collaborate with a private company to develop an idea, the intellectual property will be shared between the part of the NHS that is participating—which might be an individual hospital, GP surgery or laboratory—and the private sector company. That intellectual property could then be sold within the NHS as a whole, which I would have difficulty with. Is that what section 31 means?

Mike Stevens: Yes. At present, if the innovation is a device, the NHS purchases it anyway. We are saying that if the NHS has the capacity to share in ownership and to profit from the development of a device, it will be able to do so through section 31.

Carolyn Leckie: My point is that there are ideas within the NHS that do not attract NHS funding but which nevertheless belong to the NHS. However, you are talking about such ideas being part-owned by the private sector, which has not developed them but is involved because you want its money because no public money is available. The ownership of such ideas might be transferred from the NHS to the private sector and then sold back to the NHS.

Mike Stevens: The proposal is that the intellectual property would be shared, but only if there was no NHS investment. If the NHS was prepared to invest, it would own the intellectual property outright.

Carolyn Leckie: That is my understanding of section 31.

Helen Eadie: The SPICe briefing note on the miscellaneous provisions states:

“Future financial benefits as a result of the power are difficult to predict, but nonetheless are expected.”

Can anyone give us any ballpark figures of what we might expect in a year?

16:00

Mike Stevens: In a year, we could expect very little, based on the English experience. I can give you some figures for the number of innovations that have been looked at in England and Scotland. In England each year, the NHS considers approximately 500 innovations that might be worthy of further exploration and selects 100 for further development. It is pursuing 24 licensing deals in total. In Scotland, 200 new ideas have been looked at. They have been refined to 35 that are suitable for potential further development, subject to funds being available. Scottish Health Innovations Ltd, which has been set up to manage NHS intellectual property, holds equity in one company, and nine further exploitation proposals are under consideration. Any one of those proposals could generate £20,000 or £200,000, but at this point it is very much a guess.
The Convener: Were there any objections to the proposal to make the Scottish Hospitals Endowment Research Trust stand alone?

Mike Stevens: No.

The Convener: I just wanted to clarify that that proposal is not controversial.

I thank all the officials for coming along. I thank Roderick Duncan in particular for sticking it out, although perhaps it was not too onerous.

I remind committee members that next week’s committee meeting will take place in Stonehaven, albeit without my presence. The meeting will be under the capable convenership of my deputy convener, Janis Hughes. I will see committee members in the last week in January.

Meeting closed at 16:01.
The Scottish Consumer Council welcomes the opportunity to comment on this bill, and will focus on Parts 2 and 3, which deal with dental, ophthalmic, and pharmaceutical care services.

1 Free dental examinations and oral health assessments, and free eye examination and sight tests

The SCC welcomes this proposal as removing the initial barrier to treatment for people who may otherwise be deterred from receiving services because of fear of the cost. However, there remains a real concern about how whether it will be possible in practice to deliver on this commitment. The shortage of dentists providing NHS services is well documented, not least by the recent report to the Health Committee.

For this policy commitment to result in a real improvement in access to services for consumers will require:

More effective use of the dental team, particularly professions complementary to dentistry (PCD)
Guidance on how frequently such checks will be available (in light of evidence that 6 monthly dental checks are not clinically necessary for all patients)
Clear information for consumers about what they are entitled to, and what is included. For example, at present it is standard practice to provide a scale and polish at the same time as carrying out a dental check. However, as this will probably remain chargeable, consumers need to know that it is not necessary to have a scale and polish carried out.

2 Proposals to allow changes in the dental charging regime

The SCC welcomes the proposals in the bill which would allow changes to charges for dental treatment. The current charging regime does not allow consumers to have any clear idea of what the charge of treatment is likely to be, and the level of charges (80% of NHS costs) are a disincentive to those living on a lower income to seek treatment, and are regressive in nature. The SCC believes that any new charging scheme should be based on ability to pay, and should be simple enough for consumers to understand. As the Bill is enabling, there is no indication about whether charges will be based on treatment received or on a flat rate basis. Again, there will need to be clear information available for consumers on any changes to the charging scheme.

In general, the SCC position is that there should be a more thoroughgoing review of patient charges within the NHS, as there is currently inconsistency between different parts of the NHS, for instance in relation to how older people are treated, and exempt groups.

The SCC supports the breaking of the link between the payments made to dentists and the fees charged to patients.

3 Proposals to give NHS boards a more pro-active role in planning, funding and delivering dental services

The SCC welcomes this proposal. It is important that NHS boards are able to proactively address the needs of their local community for dental services. Linked to this are the proposals that NHS boards can contract with corporate bodies, and that they can provide assistance and support to those providing dental services. Again, while these are positive moves, they will not in themselves be enough to tackle the shortage of NHS provision in parts of Scotland. Action taken at national level will continue to be important in encouraging dentists to undertake NHS work, and to work in areas where there is a shortage of NHS provision.

It is important that the value of preventative work is recognised in any new contract with dentists, and that the contract encourages all the members of the dental team to play a full part in meeting the needs of Scottish consumers.
4 Provisions enabling a new contract for pharmaceutical care services

The SCC supports the parts of the Bill which will facilitate the implementation of a new contract for pharmaceutical care services. This is clearly required by the policy developments set out in The Right Medicine and Modernising NHS community pharmacy in Scotland.

5 Proposals to give NHS boards a more proactive role in securing or providing pharmaceutical care services in board area

The SCC supports NHS boards having a more proactive role in relation to pharmaceutical care services. In fulfilling this role, and in contracting with providers, we would hope that boards will recognise the importance of access in the widest sense, encompassing opening hours and flexibility of service, for example, as well as geographical location.

While pharmacy is rightly considered as an integral part of the NHS, it is important to bear in mind that pharmacies operate as businesses providing a service to consumers. The SCC has supported the arguments made by the OFT in relation to control of entry, that competition can provide a useful incentive to improve services, for example providing out of hours services, or home deliveries to patients. NHS boards should be wary of intervening in the market in a way which would deter this kind of healthy competition between providers. Boards should encourage provision in locations which will improve access, including, where appropriate supermarkets, as well as places like railway stations and airports.

SUBMISSION BY THE BRITISH DENTAL ASSOCIATION

Part of Bill: Part 2, sections 9-10

Main Objective: Free dental and eye tests

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

We agree in principle with the main objective of this part of the Bill, but have serious reservations about the ability of the service to meet patient expectations. The BDA believes patient charges are a matter for Government decision.

If not, why not?

Not applicable

Are there any other comments you would like to make?

With regard to the policy intentions outlined in Part 2 of the Bill, the BDA has serious reservations on two grounds;(a) funding and (b) workforce.

The funding of the Scottish Executive’s free dental checks pledge is of major concern to the BDA. In its response to “Modernising NHS Dental Services in Scotland”, the BDA favoured the development of a fully funded, comprehensive oral health assessment as part of basic oral healthcare provision. The existing dental examination Item 1(a) in the Statement of Dental Remuneration is insufficient to determine the needs of patients and to identify and discuss and agree with them the care regimes they should receive as part of a modern dental service.

Dental workforce shortages in Scotland will also affect the ability to deliver this initiative. Evidence to support this statement is contained in the NHS Education for Scotland 4th Workforce Planning Report “Workforce Planning for Dentistry in Scotland” published in June 2004. The Report states that in 2003 “Potential gaps in service provision may be identified by comparing the supply and utilisation model projections and the principal results suggest a current shortfall of 215 General Dental Practitioners.” The BDA is concerned that the anticipation of free dental checks may raise
patients’ expectations of accessing NHS dentistry. Where there are existing access problems the public will become even more dissatisfied.

The Scottish Executive has based its costs for the implementation of this initiative on the current system and “on an increase of up to 25% on the numbers of people who currently pay for dental check-ups.” The BDA finds it difficult to see how this increase in numbers of patients will be realised, especially with current evidence showing the numbers of patients being de-registered in some areas. Evidence of a downward trend in adult and child registrations is contained in the Scottish Dental Practice Board’s Annual Report of 2003/2004, figures that the Scottish Executive recently presented to Parliament.

In the report commissioned by the Scottish Parliament Information Centre for the Health Committee published on 1st February doubts about the likelihood of meeting the pledge on free dental check ups were raised. It was reported that “only 3.5% of primary care dentists stated they intended to increase the amount of time spent treating NHSScotland patients over the next two years (see section 5.12.1)”. “62% of retired dentists could see no incentive to induce them to return to providing NHSScotland dental services and thus plans to increase provision of services by encouraging retired dentists to return to practice are unlikely to be successful (see section 5.12.3).”

“A significant increase in NHSScotland provision, required to meet pledges to make free NHSScotland check-ups available to all by 2007, and improve access to dental services, is more likely to succeed where the incentives on offer appeal to the greatest proportion of dentists. This is unlikely to be achieved with the type of incentives currently available”.

In addressing workforce shortages, the Scottish Executive must also recognise and take action on the funding of under-graduate and post-graduate education and training.

In 2000, a recommendation was made by the Scottish Advisory Committee on the Dental Workforce (SACDW) to standardise the output of the two dental schools in Scotland by setting an output target of 120 dental graduates (70 from Glasgow and 50 from Dundee), over the 5 year period 2000-2005. (Reference: “Workforce Planning for Dentistry in Scotland – A Strategic Review”).

The Scottish Executive Health Department has set a revised output target of 134, which is reflected by an intake target in 2004/2005 of 151.

The BDA believes that without significant investment in the two dental schools in Scotland, then this increase in intake will be difficult to support. The BDA understands that some of the education and training of dental students is likely to take place in a primary care setting (outreach). However, once again, this will require major investment in facilities and staff training and recruitment.

The BDA acknowledges that the proposed increase in Professionals Complementary to Dentistry (PCDs) may help to free up dentists’ time (although it has not been made clear as to how these numbers are to be increased). This is more likely to be the case if PCDs have enhanced roles within the dental team - a trend that will be facilitated under the planned new regulatory regime for PCDs. However, we note the Section 60 Order (under the Health Act 1999) that is required to amend the Dentists Act 1984 so as to enact this change has been delayed by six months and the GDC now expects the PCD reforms will not be implemented until 2006.

Moreover, an article published in the British Dental Journal (Vol.198 No 2 Jan 2005 page 105), showed the majority of registered dental hygienists in Scotland do not work in wholly NHS practices, but in either wholly private practice or in mixed NHS/private (39% and 41% respectively). One of the authors is Dr J R Rennie, Postgraduate Dental Dean and Deputy Chief Executive of NHS Education Scotland.

Part of Bill: Part 2, sections 11-17

Main Objective: Changes to dental and ophthalmic services
Do you agree with the main objective of this part of the bill? Yes/No

Response: The British Dental Association (BDA) has laid out its written evidence so that it correlates to the individual sections of Part 2, as numbered above. For this reason, we have not provided a “Yes” or “No” response at this part of the questionnaire as there are a number of nuances in the policy objectives.

If yes, why? (refers to above)

Section 11 – “Charges for certain dental appliances and general dental services”

Response: The BDA agrees with the separation of patient charges and Item Of Service fees in order to make the system more flexible. We therefore agree with the main objective here.

The BDA believes the current system of charging is too complex and difficult for dentists and patients alike to comprehend. Any new system must be transparent and easy to understand, with the main drivers being clarity about patient charges; clarity about NHS availability; distinction between NHS and private treatment; and clarity about trust and accountability. Any replacement system must be easy to operate and avoid unnecessary bureaucracy.

The BDA believes patient charges are a matter for Government decision, but the Scottish Executive should clearly state the rationale behind applying patient charges. Currently, we conclude there is no such rationale and patient charges are inconsistent across the health service, leading to a lack of clarity with regard to NHS dental charges.

There is evidence to suggest that patient charges are a barrier to accessing dental care. Indeed, the introduction of patient charges for dental services in 1951 was undertaken in an attempt to suppress patient demand.

Separation of patient charges from, and simplification of the item of service feescale, should also help to address the “treadmill” effect referred to by the Scottish Executive in the Policy Memorandum and increase clarity and reduce bureaucracy.

NHS dental charges should be consistent with other NHS charges; they should also be consistent across a single primary care dental service. This would link in with the policy intention to integrate Salaried General Dental Services and Community Dental Services. However, this would raise questions over the infrastructure within the salaried services to collect patient charges and to process transactions.

We question whether it is right that general dental services dentists should carry bad debts if patients do not pay. It is more appropriate that Health Boards should assume debt recovery once general dental practitioners have made reasonable efforts to recover the debt.

Section 12 – Arrangements for provision of dental services

Response: The BDA recognises Scotland’s diverse oral health needs and believes it is not possible to have a successful, single system that will suit everyone in all parts of Scotland. It should also provide proper incentives for dentists and discourage the “treadmill” work pattern that is referred to in the Bill.

The BDA calls for voluntary entry and exit contractual arrangements, and supports the policy objective of the Bill to develop these on a national basis, but with flexibility to take account of local needs. The essential role of the profession in developing these contracts should not be overlooked and it is vital, therefore, that the BDA is fully involved in developing these agreements at both national and local level.

It is essential that Health Boards are fully engaged in the dental agenda and are held accountable for supportive service delivery. However, the BDA is concerned that the very recent research commissioned by the Health Committee highlights deficiencies in the availability of basic type
information at health board level. The type of data the BDA feels is required, but is not currently available at health board level, includes:

- Access levels for special needs patients
- Demand for access to general dental services
- Demand for access to hospital dental services
- Recruitment and retention levels of dental staff
- Availability of appointments
- Distances being travelled by patients

If the policy objective contained within the Bill is to be achieved, then devolving responsibilities to Health Board level will therefore require immediate development of comprehensive local databases to identify the oral health needs of the local community. The data should also inform the planning and delivery of services, by showing the level of available dental workforce, and identifying gaps in provision.

We support the extension to bodies corporate of the ability to provide general dental services and look forward to the necessary changes in the Dentists Act to allow for this.

Lastly under this section, in its response to the Review of Primary Care Salaried Dental Services, the BDA saw merit in the integration of the Salaried General Dental Services and the Community Dental Services, as is also outlined in the policy objective of the Bill. It should be noted, however, the Review’s remit did not include terms and conditions of service.

Section 13 – Assistance and support: General Dental Services (GDS)

Response: The BDA believes high quality oral healthcare should be provided in fit-for-purpose premises that would allow access to all members of the population, including those with special needs, to all NHS primary and consultant-led secondary and specialist care and emergency services. These clinics would be sited within the communities they serve.

Local funding by health boards to facilitate provision of these premises would be welcomed by the BDA. Such financial support might include, amongst other things:

- The provision and management of premises, with rent at lower rates to practitioners
- The continuation of practice improvement grants
- Direct funding provided in return for a level of NHS commitment
- Provision of funding to the dentist towards continuing professional development of the staff in their practice
- Support for equipment and materials

The current range of GDS allowances have been welcomed, but they do not address the fundamental problems of the current system. The research previously referred to ("Access to Dental Health Services in Scotland") reported that no incentive to increase NHSScotland commitment was favoured by the vast majority of practitioners. The most frequently endorsed incentive was a significant increase in the fee per item of treatment (55% primary care dentists). Moves to a salaried contract or a capitation arrangement were far less popular. Only 3.5% of primary care dentists stated that they intended to increase the amount of time spent treating NHSScotland patients over the next two years.

Section 14 – Provision of certain dental services under NHS contracts

The BDA believes patients should be able to access high quality NHS oral healthcare in both the primary and secondary care sectors in all parts of the country. However, access to secondary care services in Scotland is patchy and throughout the country there are very long waiting lists to access secondary care.

In particular, problems exist in remote and rural areas, where consultant-led services are, firstly, limited and, secondly, patients have to travel long distances to access this care. The BDA has called for a substantial increase in the number of specialists, whether hospital- or practice-based, in
all the dental specialities. There are particularly acute problems in Highland, Grampian and Argyll where imminent retirements and actual resignations, together with failure to recruit have had a severe impact on services. We therefore see some merit in the Bill’s intention to allow health boards to make arrangements with dentists to undertake functions that will complement the work of hospital departments.

The BDA would support the development of properly funded systems that would encourage specialist services to be delivered more locally. The development of clinical networks utilising existing consultant services, together with “dentists with specialist interests” would be one way of providing such care. The use of clinical networks would support the provision of oral healthcare in the primary care sector, particularly in the remote & rural areas.

Dentists with special interests (DwSIs) already exist through the clinical assistant programmes within hospitals, but the provision of such posts is patchy throughout Scotland. The impact of dentists with special interests receiving adequate and focused training to complement their experience is of paramount importance to safeguard patient safety and the BDA would support moves to provide this.

Section 15 – Lists of persons undertaking to provide or approved to assist in the provision of general dental services

The BDA supports the listing of vocational trainees, assistant dentists and locums for the purpose of clinical governance and improving patient safety. Such listing should also allow for health boards locally to retain information on practitioner numbers, which, in turn will allow for better planning of delivery of local services. Some allowance needs to be made for patient care to continue in the case of illness or death of a single-handed practitioner.

Whilst the BDA recognises that it might not be appropriate to have an upper age limit for removal from a dental list, we do believe that greater emphasis must be placed on developing a service structure that does not encourage dentists to seek early retirement. In Professor Newton’s report it was stated that 62% of retired dentists could see no incentive to induce them to return to providing NHSScotland dental services and thus plans to increase provision of services by encouraging retired dentists to return to practice are unlikely to be successful. According to the findings of the “Toothousand Project”, a survey of General and Community Dental Practitioners carried out by the Scottish Council for Postgraduate Medical and Dental Education, two thirds of GDPs planned to retire early. Half of this group planned to reduce their clinical hours in the years before retirement. The “piecework” nature of the GDS was cited as one of the main reasons; furthermore, a third of GDPs identified stress as a reason for early retirement.

Section 16 – Lists of persons performing personal dental services under Section 17c arrangements or pilot schemes

We support the ability to develop Personal Dental Services in Scotland and agree the same conditions should apply for listing arrangements.

Are there any other comments you would like to make?

The BDA is concerned that the Bill has been announced without any response from the Scottish Executive to “Modernising NHS Dental Services in Scotland”. It is therefore almost impossible for the BDA to give an informed opinion on the dental section of the Bill without the availability of the Ministerial response. Because of this lack of detail, we are unable to provide comment on the Bill’s objective that it will improve the oral health of the Scottish population.

This lack of detailed policy intention is coupled with a lack of funding information. The BDA has been seeking for some time now details of the annual spending review and how it might relate to the modernisation of dental services in Scotland. This information is crucial in order to take forward this agenda. However, no such information has been published to date.

As we have stated earlier in our response to Sections 9-10 of the Bill, dental workforce shortages in Scotland will also affect the ability to deliver this initiative. Evidence to support this statement is

In the BDA’s response to “Modernising NHS Dental Services” we set out our recommendations for a way forward for improving oral health and a shift towards a preventive based service.

The funding of general dental practices is mostly from item of service fees. This system generates the “treadmill” effect which the Scottish Executive mentions in the Bill.

The BDA believes that if NHS dental services are to be truly modernised, then financial provision needs to be made to facilitate a preventive approach to dental care. This allows general dental practitioners to spend more time with patients discussing their oral health, their general health and agreeing individual management regimes. This increased time commitment must be recognised and appropriately remunerated. The current range of GDS allowances have been welcomed. However, the eligibility criteria of these are almost totally based on levels of GDS earnings, which is “output” based rather than “outcomes” based, thus compounding the “treadmill” effect.

As long as the current system does not recognise this time and focuses mainly on funding reparative and restorative work, modern dental services will not be delivered. Examples of where additional support might come from would be direct support for premises and infrastructure that would include things such as equipment and materials, as well as direct reimbursement for some staff costs.

The impact of the current NHS system requires dentists to work at a pace that is increasingly difficult to sustain in order to provide appropriate dental care. The result is that many dentists have had to withdraw from the NHS and seek support for running their practice through the provision of dental services on a private basis. In doing so, it also enables them to allocate greater time to their patients, which they are unable to do by working under the current NHS system.

The Scottish Executive has confirmed that since 1999, 93 practices in Scotland have ceased to provide general dental service, ie NHS treatment. In many cases, this has been as a result of dentists choosing to retire early.

Many dentists (practice owners) have found it difficult, if not impossible, to sell their practices as “going concerns”. The current criteria of the Scottish Dental Access Initiative does not allow for funding to be allocated towards the purchase of established practices. The BDA believes that if the criteria were expanded in this way, it would help address the problems associated with practice closures, not least continuation of care for patients.

SUBMISSION BY OPTOMETRY SCOTLAND

Smoking, Health and Social Care (Scotland) Bill – Stage 1 Consultation

Optometry Scotland (OS) is grateful for the opportunity to comment on this important legislation.

OS is the representative body for registered Optometrists and Dispensing Opticians in Scotland, and includes delegates from each of the Area Optometric Committees in Scotland, plus representatives from all the main national optical bodies, including The Association of British Dispensing Opticians, the Association of Optometrists, the College of Optometrists, the Federation of Ophthalmic and Dispensing Opticians, and the Scottish Committee of Optometrists. We are also an integral part of the Scottish Executive Health Department’s (SEHD) Review of Eyecare Services in Scotland that plans to report to Ministers on the optimum mechanisms for delivery of eyecare in Scotland in March this year. OS also has representation on the working group set up by the Centre for Change and Innovation (CCI) to establish model pathways in ophthalmology.

Our comments here relate to Section 10 of the draft Bill and those parts of the Financial Memorandum relating to ophthalmic services. In general terms, OS welcomes the long-overdue
consideration that is being given to eyecare in Scotland and is happy to support the general thrust of the move towards better delivery of service. What we do not welcome, however, is the simple widening of access to a GOS sight test, the so-called “free eye checks for all”. To put it bluntly, such a change would be seen as being implemented only for political purposes since it would confer no health gain on the people of Scotland and, therefore, OS could not endorse such a proposal.

It is important, therefore, that both the GOS sight test and eye examination referred to in the Bill should be defined at the earliest opportunity. If OS is to endorse the changes outlined in this Bill, it is also absolutely essential that, if access to GOS eyecare is to be granted to everyone, the Eye examination and Sight test should be inextricably linked, fully resourced and introduced together. Any proposal that does not actually produce a health benefit for the people of Scotland would not sit comfortably in a Health Bill.

To elaborate, in the absence of any agreed definition for the eye “examination” referred to in the draft Bill, we believe that merely extending the current NHS GOS Sight Test would be an ineffective and profligate exercise. Many sections of society receive a GOS sight test already though, due to its restrictive nature, it is not always appropriate to their needs and symptoms. To extend this facility to the other sections of the population that currently do not receive free eye care – those aged between 19-60 in work and in generally good health – will not make best use of limited resources.

Accordingly, we would suggest that negotiation on a new GOS contract with Optometry is started immediately. This will establish what is expected from a GOS eye examination, when a GOS sight test may be included in that examination, and when repeat procedures are advisable. This will open the door for more comprehensive and extended eyecare programmes such as those currently under consideration by the SEHD Review of Eyecare Services.

Our final major point at this stage regards the financial resources which the Financial Memorandum indicates will be required to extend the GOS Sight Test and Examination to all. We must point out that the sums detailed are wholly unrealistic and inadequate, a comment we have already made to both the Finance Committee and the SEHD. We do appreciate that the figures in the Bill were produced from out of date information and understand that the SEHD have informed the Health Committee that a new budget for Optometry services will be added to the Bill as figures become available. Until a new contract has been agreed it will be difficult to give an accurate estimate of costs.

At the request of the SEHD, The Review of Eyecare Services in Scotland is currently considering fundamental changes in the level of responsibility optometry should have for eyecare in the community. The Centre for Change and Innovation is designing new and innovative pathways for ophthalmology that will make extensive use of the services of optometrists at a level far in advance of that for which the current very limited GOS contract was designed. It is likely that the current fee structure for optometrists will change markedly in the light of recommendations expected from the Review.

We shall restrict our main comments to the above at this stage, conscious that further details can be provided when OS attends to give oral evidence to the Committee on 22nd February. We attach a list of more detailed points as an annex to this letter which the Committee may wish to consider now or at a later stage.

Suffice to say that OS’ aspiration is for the people of Scotland to enjoy a world-class, fully integrated and multi-disciplinary eyecare service, and we believe that this Bill, suitably amended, allied with professional developments elsewhere would go a considerable way to delivering it. The Scottish Parliament has, we believe, the opportunity here to reduce the incidence of preventable eye disease and take a significant step towards the elimination of avoidable visual impairment and blindness in Scotland. However, the Bill as presently drafted is unlikely to achieve this goal.

Hal Rollason
Annex to Optometry Scotland letter to the Health Committee dated 10th February 2005

Summary of Additional and Supplementary Points

1. Optometry Scotland supports the opportunity this Bill affords to provide the people of Scotland with a high quality integrated community-based eye care service led by optometrists working in close conjunction with GPs and ophthalmologists. Simply widening access to the current GOS Sight Test would confer no health gain on the people of Scotland and OS could not endorse such a proposal.

2. This service can only be provided on the basis of a newly defined contract between the SEHD and optometry. This contract will allow for a “needs driven” service based on presenting signs and symptoms allowing optometrists to provide appropriate care and management. This contract must also allow for additional procedures to be carried out leading to refinement of diagnostic accuracy. The present GOS contract was introduced in 1948 for a different set of priorities to those we face today. The restrictive nature of this old arrangement does not fit with modern eye health issues faced by modern day optometrists.

3. OS accepts that private surcharges cannot be made for work contained in the new NHS contract. However, it would be sensible to accept that certain procedures might fall outwith the new contractual arrangement for the service that the NHS provides.

4. It is widely accepted that 5-7% of all GP visits are “eye related”. GPs generally welcome the support of optometry, recognising the optometric profession has the appropriate training and equipment to manage safely the many and varied eye problems regularly presenting in the community.

5. OS believes that this new contract must allow for an effective direct referral from optometry to the HES. Such efficient lines of communication will result in reduced time for the patient journey, avoid unnecessary GP consultations and reduce the administrative burden on primary care support staff.

6. Currently, 40% of patients presenting to a hospital eye outpatient clinic are discharged without treatment despite having waited up to 18 months for their consultation.

7. The proposals put forward by OS for the new contract will allow these patients rapid access to a competent clinician within their local community equipped to carry out accurate diagnosis and institute suitable management.

8. The new contract that this Bill facilitates should recognise optometrists as the principal providers of primary eyecare. The profession has just committed to compulsory CET and professional development. OS warmly welcomes the fact that this Bill enables an extension to the responsibility of optometry and we believe the profession has demonstrated it is prepared to accept the need to comply fully with the Code of Conduct and Clinical Guidelines laid down by the College of Optometrists and the enhanced clinical governance and audit which will follow.

9. OS believes the timing of this Bill is fortuitous:
   a) Optometry is the focus of the SEHD-led Review of Eyecare Services in Scotland.
   b) The Centre for Change and Innovation (CCI) will shortly conclude its deliberations on the pathways for ophthalmology and, in each of these, optometry acts as the core profession for patient management.
   c) Optometrists have just been granted additional exemptions under the Medicines Acts which will enable the profession to treat a range of external eye diseases. Supplementary prescribing rights have been agreed for optometrists and independent prescribing rights are expected to be granted within the next two years.
10. The aspiration of OS is that the convergence of the Bill and these ongoing developments will enable patients easy access to an expanded community-based primary eyecare service. This could lead to the establishment of a fully integrated multi-disciplinary eyecare service which would mean the Scottish Parliament had legislated for a world-class service, thereby reducing the incidence of preventable eye disease and taking a significant step towards the elimination of avoidable visual impairment and blindness in Scotland.

11. The uniform development of such a high quality eyecare service in every community would reduce the problems of health inequality and could only have a positive impact on hospital waiting times and lists.

12. OS is confident that MSPs recognise the benefits described above can only accrue to the people of Scotland if the implementation of these proposals is appropriately resourced and funded.

13. OS believes this Bill is the most exciting development in eyecare since the inception of the NHS in 1948 and looks forward to working with the SEHD to ensure this piece of legislation realises its full potential.

SUBMISSION BY THE SCOTTISH PHARMACEUTICAL GENERAL COUNCIL (SPGC)

SPGC is the body empowered by community pharmacy contractors to negotiate and make representation on their behalf with SEHD, on all matters of terms of service and remuneration for contractors’ NHS work. SPGC represents Scotland’s 1150 community pharmacies and 700 different community pharmacy contractors. SPGC also runs the central checking unit, providing the only independent audit of prescription pricing in Scotland. SPGC also answers queries from its members on all aspects of NHS services and works to increase the profile of community pharmacy with other stakeholders and political decision makers.

Part 3: Pharmaceutical Care Services (PCS)

Part 3 makes a series of provisions to support pharmaceutical care services. It places requirements on Health Boards to plan provision of pharmaceutical care services and deals with the contract for provision of such pharmaceutical care services. It also addresses the listing requirements for persons performing pharmaceutical care services and makes provision for assistance and support for pharmaceutical care services.

Main Objective: Giving Health Boards responsibility and powers to provide pharmacy services

Do you agree with the main objective of this part of the bill? Yes

SPGC supports the underlying policy intention to modernise the delivery of NHS community pharmacy pharmaceutical care services, as part of the wider process of implementation of new arrangements for modernising NHS Primary Care Services in Scotland.

SPGC agrees with the general intention of the Bill to allow for legislation to underpin the new pharmacy contract and legislation giving Health Boards increased powers and responsibilities in the provision of pharmaceutical care services, by making provisions for amendment of the National Health Service (Scotland) Act 1978 (the 1978 Act).

SPGC supports the Scottish Executive’s policy document “The Right Medicine”: a strategy for pharmaceutical care and the Scottish Health Plan “Our National Health: a plan for action a plan for change”.

SPGC agrees with the collective agenda for modernising and redesigning pharmacy services with the overarching aim of improving levels of patient care, through better use of the key skills of community pharmacists and their support staff but would like to stress that the dispensing and supply of medicines is still recognised as an important and valuable part of community pharmacy’s role.
However, while SPGC agrees in principle with the proposals contained within the Bill, there are a number of areas of concern on which we would like to make representation and seek further clarification.

As the accompanying Regulations, which contain the fine detail of the proposals, are not yet available for consideration, a number of concerns similar to those already raised and expressed within SPGC’s original response to the consultation paper, “Modernising NHS Community Pharmacy in Scotland”, still exist. SPGC does appreciate that these concerns may be allayed when the detailed regulations and accompanying directions are available.

If yes, why?

Smoking, Health and Social Care (Scotland) Bill

Part 3: Pharmaceutical Care Services

Section 18 Health Boards’ functions: provision and planning of pharmaceutical care services. This section inserts two new sections, 2CA and 2CB, into the 1978 Act.

Section 2CA Functions of Health Boards: pharmaceutical care services

Subsection 1 of the new 2CA requires Health Boards to provide pharmaceutical care services or to secure the services by others. This gives Health Boards a new obligation to provide service themselves, in contrast to current legislation that only permits them to secure provision by others.

Subsection 2 of this new section enables a Health Board to secure provision of pharmaceutical care services by others and to do so by means of such arrangements as they think fit. The main new arrangement is a pharmaceutical care services contract, which replaces the current Section 27 pharmaceutical services contract of the 1978 Act.

Subsection 3 places a duty on Health Boards to publish prescribed information about the pharmaceutical care services that they secure provision of by others, or provide themselves. This applies to Part 1 of the 1978 Act as well as section 2CA.

Subsection 4 creates an obligation on Health Boards to cooperate with each other in discharging their functions connected with every aspect of pharmaceutical care services.

SPGC supports the principle that Health Boards will be expected to meet all reasonable requirements as they see necessary to provide or secure the provision of pharmaceutical care services as respects their area. We understand that this requirement may extend to the area of another Health Board and may also be performed outside their area and that Health Boards will now have a new obligation to provide services themselves, if those services cannot be secured from others.

SPGC still has concerns as to the process and methodology whereby this might be achieved and would emphasise that any such process be fair, equitable and transparent. It is important that while Health Boards will be allowed to make pharmaceutical care service provision as they see fit and in particular make contractual arrangements with any person, they try first to secure any such service from within the Scottish community pharmacy network. There is a concern here that this allows for the possibility of some pharmaceutical care services being delivered by the ‘Managed Service’. SPGC believes there is a distinct danger in not being able to achieve the key principles of ‘The Right Medicine’ if delivery is attempted by a mixture of supported, salaried and managed service provision, which is left to the variable whim of a Health Board.

SPGC agrees with the requirement on Health Boards to publish prescribed information about pharmaceutical care services and sees that as being a vital part of an inclusive and engaging process.

SPGC agrees with the intention under Subsection 4 to create an obligation on Health Boards to cooperate with each other in discharging their functions in connection with every aspect of
pharmaceutical care services and sees that as reflecting the increased emphasis on patient care that is intrinsic within The Right Medicine and the New Pharmacy Contract.

Subsection 5 allows regulations to be made that will define “pharmaceutical care services” for the purposes of the 1978 Act. The regulation will set out types of services that are and are not pharmaceutical care services for this purpose.

Subsection (6), allows the regulations made and defined for the provision of pharmaceutical care services under Subsection 5 of the Act, to classify what services are to be defined as essential or additional pharmaceutical services.

SPGC believes that the approach to introduce a pharmaceutical care service contract in a planned and proactive manner can only benefit patient care in the longer term.

SPGC would like to emphasise that any regulations pursuant to the Bill should clearly detail and require that those pharmaceutical care service elements deemed core to the new pharmacy contract, classified essential and agreed nationally, are adopted, recognised and accepted by the Boards as being to national service frameworks, standards and tariffs. SPGC believes that any agreed core service elements of the new pharmacy contract must be delivered across all community pharmacies in Scotland to ensure consistency of quality pharmaceutical care thereby avoiding post-code inequality. This is in keeping with the Scottish Executive’s stated intention that the public should have full access to the full range of essential pharmaceutical care services irrespective of domiciled in Scotland or not. SPGC would suggest that it is not in the best interests of patients if sections of the “managed service” were allowed to provide a partial pharmaceutical care service within a PCS plan.

While SPGC agrees that Boards should be empowered to meet their local care requirements, it should not be at the diminution of the nationally agreed core contract services. Pharmacy is a small contractor profession and as such is concerned about the possibility of a nationally agreed pharmacy contract agenda being undermined in the desire to fulfil a local needs requirement. It is only through a consistent across the board introduction of core pharmaceutical care services that community pharmacy will succeed in delivering improved levels of quality care to patients as envisaged within “The Right Medicine”: a strategy for pharmaceutical care.

Subsection (7) provides that any directions to be issued by Scottish Ministers must be published in the Drug Tariff.

SPGC believes that there should be a full and comprehensive revision and updating of the Drug Tariff to reflect the changes to pharmaceutical care services within a modernising NHS in Scotland.

Subsection (8) makes it clear that arrangements, which a Health Board may make for the provision of pharmaceutical care services, may provide for the delivery of these services from a location outside of Scotland.

SPGC strongly suggests that any proposals allowing Health Boards to make provision for pharmaceutical care services to be performed outside Scotland, should involve a process whereby the procurement of that service is first sought from within the existing Scottish community pharmacy network. Any such procurement from outside Scotland should be a last resort to be pursued only after all other avenues have been exhausted.

SPGC however, does appreciate that there may be limited circumstances where it would be more convenient or practical for a patient to have services provided in this way.

SPGC would also make representation that in the circumstance where a Board sought to provide NHS pharmaceutical care services themselves, a fair and reasonable process of service procurement would be undertaken before any such stance was finally adopted and that this again would be a last resort approach to the procurement of such a service.
SPGC would urge that the community pharmacy network is recognised as the provider of choice. Community pharmacists in many ways already deliver added value. However in future there will be considerable opportunity to provide even more in terms of access and service delivery.

2CB Functions of Health Boards: planning of pharmaceutical care services

Subsection 1 provides Ministers with the broad regulation and direction-making powers that will prescribe the arrangements by which Health Boards will prepare, publish and keep under review, plans that will enable them to discharge their duty under section 2CA(1).

Subsection 2 gives examples of what the regulations under Subsection 1 may cover and includes identification of what pharmaceutical care services are required in a Health Board's area, whether there is convenient access and where provision of these services is considered inadequate. It also includes the periods in which Health Boards are to prepare, publish and review their pharmaceutical care services plan and the consultation process by which the PCS plan is prepared and made available to the public.

Subsection 3 gives the Scottish Ministers power to publish in directions what criteria ought to be considered in the identification by the Health Boards of the matters in subsection 2a in preparing a PCS plan e.g. the directions might require Health Boards to compare the location of NHS community pharmacies and GP surgeries relative to size and proximity of populations and their pharmaceutical care service needs.

SPGC supports the proposal to allow for regulations, which provide for the provision of a pharmaceutical care services plan. A more proactive approach to the provision of pharmaceutical care services can only ultimately be to the benefit of Scotland's patients. The use of a planned holistic approach should make it possible to resolve objectively any specific local under-provision. Great care must be taken with reference to the setting of review and revision frequencies and to the duration of any such plan, so that as well as achieving the Health Board's pharmaceutical care service requirement, nothing is done that could potentially reduce the current, well-recognised benefits of the existing community pharmacy contractor network. It is extremely important that the regulations do not introduce anything, which will reduce the recognised benefits, effectiveness and stability of the current community pharmacy network. The use of the word convenient in relation to access as proposed in the Bill could be seen as potentially ill defined and open to conjecture, it would be better to consider the use of the word 'adequacy' within the PCS plan but with the use of a set of clearly defined criteria.

Point 1b implies continuous review. It is important that any agreed plan is reviewed with a sensible and realistic frequency.

SPGC supports the principle of moving towards a formal planning mechanism or framework to place the provision of pharmaceutical care services, as long as the benefits of the current control of entry regulations can be retained in line with the Scottish Executive’s response to the Office of Fair Trading report. SPGC does appreciate that a mechanism based on a response to clearly identified need rather than speculation can only be to the benefit of patient care.

With reference to the preparation of a pharmaceutical care services plan any consultation process should be involving, engaging and transparent, with all key stakeholders being allowed the opportunity to make positive contribution to the construction of the plan.

SPGC strongly suggests that clear guidelines, needs assessment criteria and preparation methodology for any such pharmaceutical care services plan should be clearly laid down on a national basis, so that each Health Board is required to take the same consistent approach in relation to service needs assessment. The regulations should clearly detail what PCS plans should provide and how they will be prepared, implemented and maintained. This should be done following a strict nationally agreed set of criteria.

There is a danger that too wide a set of criteria is introduced with reference to the definition of access to pharmaceutical services. It is extremely important that in any attempt to address
convenient access issues on a local basis, the attempt is not carried out in such a way that any items agreed nationally are devalued or lost.

The expertise and capacity within Boards is variable. Therefore it would be beneficial and indeed desirable that additional locally agreed services be defined through service specifications and tariffs benchmarked to a nationally agreed formula. Health Boards could then enhance those local services further, as and when required. Maintaining minimum local service specifications and tariffs to a national agreement would ensure consistency of pharmaceutical care across the whole of Scotland. Consideration should also be given to accompanying these changes with a national accreditation scheme for delivery of pharmaceutical care services.

Section 19 Pharmaceutical care services contract

The policy intention is to introduce the legislative changes required to allow the implementation of the new community pharmacy contract.

This part of the Bill inserts 2 new sections 17Q and 17V into the 1978 Act (in place of existing sections on pharmaceutical services). These new sections govern the terms and content of the new pharmaceutical care services contracts and who may provide or perform pharmaceutical care services under such contracts and contain regulation-making powers to set out the detail of the rights and obligations under the new contracts.

Section 17Q of the Bill refers to the general content of the contract.

Subsection 1 allows a Health Board to enter into a PCS contract with a contractor to provide pharmaceutical care services in accordance with the provisions of part 1 of the 1978 act.

Subsection 3 sets out the parameters for services to be provided under the contract, remuneration for their provision and other matters.

Subsection 4 allows the contract to cover a range of services such as those that are provided in other primary and acute care settings and for such services to be delivered at a location outside the Health Boards geographical area.

SPGC recognises that one of the main policy intentions proposed within the “Modernising NHS Community Pharmacy in Scotland” consultation document was a requirement to resolve instances of under-provision of pharmaceutical care services. SPGC would agree and fully support this policy intention.

SPGC seeks clarification that the previous proposal for the use holding contracts has been removed. SPGC remains concerned that the new process for the granting of any such contract for pharmaceutical care services is still not clear. Will the current criteria of “necessary and desirable” be replaced by a new set of criteria or will they remain in place but be more objective in nature?

SPGC is concerned that a completely new process might be introduced for assessing the need to grant a new contract within a PCS plan, where instances of under-provision are identified. SPGC would strongly advocate that any new process for assessing the need for a new contract must be robust, transparent and unambiguous with a nationally agreed set of objective criteria and guidelines. Care must be taken to ensure that the key benefits of a system based on necessary and desirable criteria are not lost.

SPGC firmly believes that any pharmaceutical care services contract should encompass all four core essential elements (Chronic Medication Service, Acute Medication Service, Minor Ailments Service and Public Health Service) of the new contract without exception.

SPGC would be very concerned if any such new contract assessment process did not include provision for minor relocations. We maintain using the minor relocation facility allows for improved standards of premises and this can only ultimately benefit patient care.

Currently Health Boards and the NHS rely on pharmacy contractors investing their own money in premises, staffing, cost of stock etc. Therefore, careful thought must be given to appropriate
funding to encourage contractor investment when addressing any instances of under-provision in deprived and rural areas.

It is difficult for SPGC to make appropriate representation on this key issue, without having the detail of intent, which will be contained in the Regulations and supporting Directions. Until a draft of the actual Regulations is available, this whole issue around contracts remains a major concern for SPGC.

Within the Bill it is suggested that the National Appeals Panel would not have a remit in the future to make deliberations on contract disputes, which could infer that there is no expectation for any such contract disputes to arise. SPGC appreciates that any instances of under-provision will be identified within a pharmaceutical care services plan. However we are concerned that there may not be the opportunity for a contractor to apply for a new contract in an innovative and creative manner if the PCS planning process is too restrictive. It is essential that any PCS planning process will allow for community pharmacy contractors to fully participate and engage in a positive spirit of partnership working with Boards and other stakeholders.

A pharmaceutical care services contract may include services, which are not pharmaceutical care services. SPGC would have concerns that unless any such services are specifically confined within a healthcare remit, that this could pose contractual difficulties in the future. Point 4 provides for non-pharmaceutical services to be covered and allows all services covered to be provided in any suitable location, where it is to meet all reasonable needs. This may allow for pharmaceutical services being provided in GP’s surgeries or at Health Board clinics in rural areas or in areas of deprivation. SPGC would strongly advocate that this should only happen after every attempt to secure such services from community pharmacy contractors has been exhausted.

SPGC would make representation that any pharmaceutical care services contract, which will by definition be negotiated at a local Health Board level, should allow for the Executive’s intention that the new contract will be agreed at a national level.

A pharmaceutical services contract will require the contractor to provide pharmaceutical care services of such description as may be described. SPGC would seek confirmation that this applies only to the collective core essential components part of the contract.

The new section 17R makes it compulsory for a PCS contract to require the contractor to provide pharmaceutical care services of such description as may be in regulations under the section, the intention being to set out in regulations that providers must provide certain essential services.

SPGC agrees with this intention.

The new section 17S sets out the persons with whom a Health Board may enter into a PCS contract.

Subsection 1 allows a Health Board to enter into a PCS contract with a registered pharmacist or a person lawfully conducting a retail business in accordance with section 69 of the Medicines Act 1968.

Subsection 2 enables regulations to set out the effect on the contract of a change in the membership of a partnership contracted to provide pharmaceutical care services, the intention being to allow the membership of a partnership to change without requiring a new contract to be entered into merely because a change in partnership has taken place.

SPGC has concerns around how a Board will define practising and non-practising pharmacist status and would suggest that this should be done with due reference to RPSGB guidelines and thinking.

With reference to the proposed compliance with agreed standards, quality parameters and the achievement of benchmarked performance levels, SPGC is concerned that Health Boards will have such powers as to set their own at a local level rather than through an agreed national set of standards and performance criteria.
Health Committee, 6th Report, 2005 (Session 2) – ANNEX C

SPGC believes that the appliance supply and advice service sits naturally within a total package of pharmaceutical care and that this service should be incorporated within the essential core part of the new pharmacy contract. Recent definition suggests that Health Boards will not be able to enter into PCS contracts with businesses providing only appliance supply and this can only be to the benefit of patients, as supply should not be divorced from the provision of pharmaceutical care and advice.

Section 17T - deals with the payment to be made under PCS contracts.

Subsection 1 enables Ministers to give directions as to payments to be made under the contracts.

Subsection 2 makes it compulsory for a PCS contract to require payments to be made in accordance with the directions then in force.

Subsection 3 gives examples of the matters for which directions may provide and Subsection 4 requires Scottish Ministers to consult before giving any direction under Subsection 1.

SPGC seeks further detail about the process whereby global sum allocations will be based on a possible future weighted capitation.

It is extremely important that the essential core services are paid by the Health Boards to any nationally agree remuneration scale.

SPGC accepts that Scottish Ministers must consult with representatives of persons to whose remuneration the direction would relate. SPGC currently fulfils this role and looks forward to undertaking its new obligations arising from the legislation.

New section 17U allows regulations to be made identifying the requirements that must be included in all PCS contracts.

Subsection 2 gives examples of the issues that the regulations may cover e.g. manner in which and the standards to which services are provided, the persons who may perform services, contract variation and enforcement and the adjudication of disputes.

Subsection 3 provides for regulations made under subsection 2CA to set out prescribed circumstances in which a contractor must accept a person to whom services are to be provided and in which a contractor may decline to accept such a person or may terminate responsibility under the PCS contract for the person.

Subsection 4 provides that regulations varying the contract terms may include provision as to the circumstances in which a Health Board may so vary the terms or to suspend or terminate any duty under the contract to provide services of a prescribed description.

SPGC would like to emphasise the importance of clearly defining and detailing the premises standards that will be required within a PCS plan and it is vitally important that any premises standards criteria are set following national guidelines, which are not open to different interpretation across the Boards. The issue of premises being able to meet the required standard is extremely important and will potentially be one of the more difficult areas to address. Clarity is required as soon as possible in this key area so that when satisfying an identified patient need becomes the key driver, premises issues do not become the stumbling block to the delivery of new pharmaceutical care services.

SPGC is concerned that the monitoring of quality and standards and right of entry, premises inspection and enforcement by the Health Board could create cross responsibility issues with the Royal Pharmaceutical Society of Great Britain. SPGC questions whether or not this regulatory function should be shared in the future. Community pharmacy contractors could potentially become the victims of an unnecessarily bureaucratic system.

There is concern around the regulations in relation to suspension and termination of a contract and clear definition of the circumstances under which this course of action might be taken is sought.
Under 4a, the Regulations may make provision as to the circumstances in which a Health Board may unilaterally vary the terms of the contract. The extent and meaning of the word unilateral in this circumstance requires further clarification. This could easily be taken out of context and applied more generally and SPGC has concerns around how any such unilateral decision would be reached and also about the rights and payments to the suspended person. The potential to allow for unilateral variations to any process is of grave concern to SPGC.

New Section 17V

Subsection 1 creates a regulation making power to set the national procedures for internal dispute resolution for the proposed PCS contracts. It may also provide for this to be referred to Scottish Ministers or a panel of persons appointed by them.

Subsection 2 creates a regulation making power to enable the parties to a PCS contract and parties who are already providing pharmaceutical services under a PCS contract to opt to be treated as a health services body for any purposes in the existing Section 17A of the 1978 Act. Section 17V instead provides for either party to an NHS contract to refer any matter in dispute to the Scottish Ministers for determination.

Subsection 3 provides that if a PCS contractor or potential provider elects to become a health service body under subsection 2, section 17a of the 1978 Act applies with appropriate modifications.

Where a business opts for its PCS contract to be an ordinary contract at law, it will have the option of asking the courts to resolve any resultant contract disputes.

Section 20 Persons performing pharmaceutical care services

This section inserts a new section 17W into the 1978 Act.

Subsection 1 provides for regulation- making powers governing the ways in which persons performing pharmaceutical care services are listed. The regulations may prevent registered pharmacists from performing pharmaceutical care services for Health Boards unless their name appears on a list held by the Health Board.

An obligation to be on the list of a Health Board before performing services in that Health Boards area remains even if the services are carried out as a part of a contract with a neighbouring Health Board.

Section 17W ends the current arrangements whereby the Health Board’s pharmaceutical list contains the names of persons or businesses with whom the Health Board has made arrangement to provide pharmaceutical services and under which only the principal providers of those services are listed and thereby subject to terms of service requirements. The need to list contractors for “terms of service” requirement is no longer necessary as arrangements will be governed by the terms of arrangements which Health Boards enter into with persons to secure the provisions of pharmaceutical care services under Section 2CA.

The new listing requirements will apply to all registered pharmacists wishing to perform pharmaceutical care services i.e. whether contractors or employed or engaged by contractors.

Subsection 2 of Section 17W sets out particular issues that may be included in the regulations e.g. how the list will be drawn up and maintained, what criteria an individual will have to meet to qualify to be on the list, the process by which decision on applications will be made and mandatory grounds under which a Health Board would have to reject an application.

SPGC agrees that the intention of making non-principals accountable and principals more accountable for their actions is sound and improves clinical governance. The Health Board list therefore will be maintained as a control mechanism for all pharmacists undertaking PCS in the Board area and not for control of entry purposes as is the case now. This brings community pharmacists into line with the other healthcare professional groupings and ties in to part 4 of the Act (Discipline).
SPGC would stress that any proposed listing arrangement should incorporate a fast tracking registration facility to allow for sudden emergency situations such as absence or illness. It is vitally important that continuity of pharmaceutical care services is maintained.

SPGC is concerned how any selection or de-selection process sits with any RPSGB process and believes that there could be possible areas of conflict here in the future. SPGC would have extreme difficulty with any Health Board selection and de-selection process which might occur without due reference to the procedures and guidelines of the Royal Pharmaceutical Society of Great Britain. There needs to be clear demarcation with reference to responsibilities and remits between NHS Scotland and RPSGB, the regulatory body.

SPGC would advocate that there should be a registration process with one Board and then automatic adoption to other nominated Boards.

SPGC believes that in order to minimise bureaucracy there should be a facility to allow for the whole process to be administered through a national register. The use of National Services Scotland to maintain Scotland’s pharmaceutical list would make sense but more clarity is required around the process for Boards and Contractors access to check “PCS performer status”. The process must be made as simple as possible so as to avoid any potential resource and cost issues arising out of a system that could become over complex.

SPGC has concerns around selection criteria for entry to any such list and the possible methodology used for removal. Selection criteria must be agreed nationally to a set of robust and unambiguous guidelines. SPGC would maintain that even if a nationally agreed set of criteria were to be adopted then acceptance or otherwise of an individual may be subjective and the quality of decision-making may as a result still vary across the different Health Boards. This is of grave concern to SPGC.

Section 21 Assistance and Support: primary medical services and pharmaceutical care services.

This section inserts a new section 17X into the 1978 Act, making new provision to pharmaceutical care services and does this by replacing the existing 17Q which is an existing provision for primary medical services. The new section 17X extends the provision of assistance and support to the pharmaceutical care services. The terms, on which such assistance and support are given, including terms as to payment, are a matter for the Health Board.

SPGC strongly suggests that a set of national guideline criteria is vital for ensuring equal opportunity in any assessment process for the allocation of assistance and support.

Within the regulations, this could make provision for replacement of the existing essential small pharmacy scheme with reference to instances of under-provision in rural or areas of social deprivation.

Final Statement

SPGC supports the key intentions proposed within the Bill. However we do have concerns regarding a number of issues, which can only adequately be answered within the fine detail of the Regulations and Directions.

SPGC would wish to be called to give oral evidence if the opportunity was forthcoming and would express a strong desire that Part 3 of the Bill, Pharmaceutical Care Services, be given due time and consideration as it paves the way for the future development of the community pharmacy profession in Scotland. Community pharmacists welcome the opportunity to deliver enhanced levels of pharmaceutical care to the patients of Scotland within a modernising Scottish NHS.
SUBMISSION BY FIFE LOCAL HEALTH COUNCIL

NATIONAL STANDARDS FOR DENTAL SERVICES

“RAISING THE ISSUE... NATIONAL STANDARDS FOR DENTAL SERVICES”

Acknowledgements

Fife Health Council would like to thank all those who assisted in this event, in particular, the participants themselves and Marjory Barquist and Lorraine Briggs from the Care Standards & Sponsorship Branch of the Scottish Executive Health Department (SEHD). Fife Health Council was also pleased to welcome Mr Neill O'Shaughnessy, NHS Quality Improvement Scotland, who attended as an observer of this “Raising the Issue...” event.

Summary

The issues discussed at this “Raising the Issue...” event were extremely wide ranging and interesting and much of the feedback provided a useful insight into the patient experience of dental services, for both NHS and private treatment. It was clear from the group discussions and the question and answer session which followed, that patients and the general public want to be involved in decisions about the planning and development of their NHS services.

In essence, participants welcomed the development of a set of standards which applied to both NHS and private dental services. From the discussion which took place, it was clear that, if regularly monitored, the standards would lead to an improved service and patient experience. Accreditation was an issue which came up on several occasions as an area which Participants felt worthy of promoting within the dental profession.

Identified throughout the group discussions were suggestions for improvements to access to information for patients. In this context, a significant number of participants mentioned the need to clearly explain the finer detail of de-registration rules and the procedure for agreeing a patient’s care and treatment. As could be expected, a significant part of the discussion covered dental costs and, in particular, what some participants considered to be confusing fee structures.

The care environment within dental practices generated significant debate, not only in terms of the difficulties associated with older style dental practice premises, but also the requirements of the new Disability Discrimination Act.

Finally, but by no means least, participants stressed the need to consider the dental standards from a children’s perspective. It was advocated by participants that training in how to deal with children and, more specifically, how to address their psychological needs within a dental setting was worthy of inclusion in the dental standards.

1 Introduction

Fife Health Council is the statutory representative of the general public in the NHS in the local area. One of its priorities is to represent the interests of the people of Fife, encourage public involvement in the planning and delivery of health services locally and support existing public involvement mechanisms.

Another area is to seek new and innovative ways of involving the public in the health service planning process and, in November 2001, Fife Health Council secured funding from the Scottish Executive to take forward a new initiative entitled “Raising the Issue...”.

In essence, the overall aims of the project are to:

• create new and unique opportunities for public involvement via the establishment of a series of events where members of the public are invited for an in depth discussion on a chosen subject;
promote public awareness of the role of Fife Health Council as an organisation tasked with promoting public involvement and a patient focussed NHS; and

produce a detailed report of each event and take forward, wherever possible, issues raised by the public.

This ninth in the series of “Raising the Issue…” events sought to attract input from the public to discuss the draft National Standards for Dental Services developed jointly by the National Care Standards Committee (NCSC) on behalf of Scottish Ministers and by NHS Quality Improvement Scotland (NHS QIS).

2 Background

The Regulation of Care (Scotland) Act 2001 extended the scope of care services to be regulated. The Act also set up the Scottish Commission for the Regulation of Care to carry out the regulation of services. In carrying out its work, the Care Commission must take account of the relevant national care standards developed by the NCSC on behalf of Scottish Ministers. One of the new services to be regulated under the Act by the Care Commission is private dental services.

Dental services providing NHS care are already subject to regulation. The dental practice premises are inspected. In addition, checks are made on a sample of patients to make sure treatments have been carried out as claimed, and have been done satisfactorily. At the moment, there is no consistent monitoring of dental care provided in the Salaried Primary Care Dental Services. It has been recognised that there is a need for national standards and consistent monitoring of them across NHSScotland. Responsibility for developing the standards was given to NHS QIS.

Two different bodies therefore are responsible for setting standards: NHS QIS for the NHS and NCSC for the private sector. At first these two bodies worked separately and developed draft standards for dental services in their own sector. Most dental practices in Scotland provide both NHS and private dental services, so it was decided to develop a set of standards applying to both NHS and private dental services.

As firm believers and advocates of the view that involvement of service users is not just a regulatory obligation but should be part of every day good management and high quality service provision, Fife Health Council has always been keen to support public consultation and so we entered into this discussion with the enthusiasm which it rightly deserves. Fife Health Council is also of the view that consulting and involving service users and finding out what the general public want from their NHS services should not be seen as an extra chore for the service providers but as a means of carrying out their work efficiently and effectively.

Through this event, we asked participants to specifically consider the draft standards for dental services which had been issued for public consultation, from the point of view of the person using the service, in particular how the standards meet the common set of principles, namely:

- Dignity
- Privacy
- Choice
- Safety
- Realising potential
- Equality and diversity

3 Event Format

This “Raising the Issue…” event was advertised in local newspapers and publicised with a large poster campaign. People interested in taking part were invited to contact the Health Council via a freephone number. In addition, Fife Health Council specifically invited former “Raising the Issue…” participants and representatives from local voluntary organisations and specific interest groups. There was no set criterion for involvement and, for a variety of reasons, the maximum number of delegates had to be restricted.
The event, which was ultimately subscribed to by 45 individuals, took place in the Dean Park Hotel, Kirkcaldy on 14 September 2004 and was facilitated by representatives from Fife Health Council. Participants had benefit of a presentation from a representative from the Scottish Executive’s Care Standards and Sponsorship Branch. Participants were then invited to join one of three discussion groups. Each group was tasked with discussing five of the fifteen draft standards:

Group A

- Standard 1: Choosing your dental service
- Standard 2: Before your appointment
- Standard 3: Your visits
- Standard 4: Assessing your needs
- Standard 5: Deciding and agreeing your care and treatment

Group B

- Standard 6: Receiving your care and treatment
- Standard 7: The quality of your care and treatment
- Standard 8: Ongoing care
- Standard 9: Expressing your views
- Standard 10: Confidentiality and information held about you

Group C

- Standard 11: The dental team and service management
- Standard 12: Medical and other emergencies
- Standard 13: Control of infection
- Standard 14: Your care environment
- Standard 15: Children and young people

4 Results & Discussion

This section summarises the wide ranging factors found to be pertinent to those who took part in the discussion. Participants considered whether the draft standards were clear and easy to understand, and, more importantly, what, if anything, had not been covered.

Standard 1: Choosing your dental service

The group agreed how important it was that patients have a clear statement about accessing accurate, clear and easy-to-understand information. This draft standard detailed all information patients should have easy access to. It was, however, considered that some mention should be made of where this information should be available, i.e. GP surgeries, Libraries, etc. As the standard stood, participants felt that it could be interpreted that information would only be available at source, i.e. the dental surgery.

The general consensus was that this draft standard should also cover the de-registration of patients after a fifteen month period without treatment. It was agreed that dentists should ensure their patients are aware of the rules regarding de-registration, should be warned prior to de-registration and reminders of check-ups should be standard practice. Mention in this section could also be made of the obligation of dentists to inform patients when any service change is implemented, e.g. change of dentist or if a dentist decides only to take private patients.

Standard 2: Before your appointment

Members considered that some mention is made with regard to arrangements for emergency cover when a dentist is absent, on holiday or ill. Preparing for appointment should also include information on any allergies a patient may have, as well as any medications the patient is taking.
Standard 3: Your visits

Participants considered the nine points contained within this draft standard were to be commended. The group suggested the following amendments to aid readability:

- under item 7, the term “third person” is clarified – would this also cover an appointment with the hygienist?
- item 2 touches on inaccessible service for reasons of disability, however, it was felt that special mention should be made for the deaf and those patients with sight problems;
- one participant felt that footnote 3 should be incorporated within the text.

Standard 4: Assessing your needs

The group considered this standard should have more emphasis on patient’s allergies to medicines and how patients with, say, a heart murmur may require varied medicine dosages. Continuing with the health theme, it was felt that to ensure continuing care, patient’s dental records should follow the patient on a care pathway, including a change of dentist.

Participants wondered what the practicalities were of assessing the patient’s current state of health. For example, how time consuming was it for the practitioner and also whether a dentist was qualified to make what appears to be a medical assessment.

Two minor amendments were suggested:

- in 1, line 3, suggest adding “will” before “receive”, “you will receive help, if needed”;
- in 3, line 2, suggest changing “possibly” to “possible”, “signs of possible serious illness”.

Standard 5: Deciding and agreeing your care and treatment

It was agreed that this draft standard was comprehensive and covered all aspects of deciding and agreeing care and treatment. Notwithstanding, the group considered it should also include patient’s rights to access a second opinion.

Although this section covered adequately that patients should be provided with details of the cost of individual treatments, the group agreed that dental rates should be displayed somewhere in the premises.

Standard 6: Receiving your care and treatment

The group considered the first point to be confusing and wondered how a dentist could tell a patient what could happen without carrying out an examination first. This, therefore, requires clarity. If this means the patient will be told what will happen during the examination, then this should clearly say so. Some of the group felt the use of the word “told” was inappropriate and felt “advised” was more suitable.

Regarding codes of practice when a referral is required, the group felt this should include making it clear to patients that the arrangements could take time, i.e. patients should be advised of waiting times for referral to, for instance, a dental hospital.

The group considered the item relating to a patient having an acute condition or signs of serious disease that need urgent referral should contain more detail, with a clarification of what was considered “urgent”.

Standard 7: The quality of your care and treatment

“It is easy to say what should be done, to actually get that to happen is a very different matter” ....a participant
The group commends recommending a peer group review, however they felt there also should also be some kind of public involvement.

Regarding a patient’s right to request information about the review process and its results, the group felt it was highly unlikely that a patient would be aware that such a process existed. It was agreed how important it was that the information be displayed and updated as regularly as reviews are carried out, displaying information on changes of practice and improvements in the care and treatment.

Some participants considered the last item under this draft standard regarding laboratories used for diagnostic tests being accredited failed to get its message across adequately, with one participant suggested changing “makes sure” to “ensures”.

It was also considered helpful if mention was again made of the NHS Complaints procedures to re-affirm a patient’s right to complain if unhappy with treatment.

Standard 8: Ongoing care

The group felt that the expression “an explanation about what your responsibilities are”, in item two, sounded rather patronising. They felt this item should be removed altogether or replaced with one which mentions the provision of information on oral health.

Participants wished to see more information in item 5, i.e. “can you disagree with treatment?”, and “can you ask for a second opinion?”. An example was given as a patient being advised to have an offending tooth out if that patient was not convinced that this was the right treatment.

One participant felt that item 8 should not start with “You know that” and a phrase such as “You will be asked….” was more appropriate.

The group were in agreement that, in practice, item 9 was not possible and should be removed.

Standard 9: Expressing your views

The group felt that the term “opportunity” should be replaced with something more definitive, i.e. that there is a complaints/comments procedure in place and a standard form was available and easy to complete.

It was agreed that this Standard as a whole should put the onus firmly on the service to seek the patients’ view. It was not, however, considered to be “user friendly”. Most members of the public it seems are unaware of how to make a complaint, although service providers have a duty to inform their patients of their rights.

Standard 10: Confidentiality and information held about you

Hopefully one day we will carry a swipe card that will state our history, medication being taken etc.”….a participant

The group agreed that the issue of confidentiality was already covered by current legislation, however, it was considered very important and merited reminding both patient and dentist about the finer detail.

Continuity of Care is stressed as important within the dental team, however, no mention is made of continuity within the draft standard if a patient changes dentists during a course of treatment.

One participant questioned whether this section should differentiate between electronic and paper records and if patients understood the difference. Equally, under the Data Protection Act 1988, patients have access to manual and electronic records and participants felt that this information should be included in this draft standard.

This section should highlight the point that patients have the right to access to their records.
One participant felt that footnote 6 describing patient care records should be incorporated in the text of the draft standard.

Standard 11: The dental team and service management

The group felt it would promote better communication and relationships between the dental team and patients if a board showing photographs and qualifications of the dental team was prominently displayed. It was felt that this would not only assist patients in identifying staff but also alleviate any doubts as to their ability to practice, particularly if their respective credentials were displayed. One member felt it would be embarrassing to ask about Disclosure Scotland checks, although having this information freely available within the practice would eliminate the need to ask for it.

Nonetheless, it was agreed how important the Disclosure Scotland checks were and some participants considered that this should be included in this draft standard under its own item number.

One participant considered that footnote 7 should be incorporated into the text as number 1, with subsequent items re-numbered accordingly. It was also suggested that item 6 be re-written to read “Your dental service should work effectively as a team. It should also communicate effectively with other professionals”.

Standard 12: Medical and other emergencies

“If you plan/organise for the worse scenario then you can cover everybody” ….a participant

As in standard 11, the group felt patients should be made aware of the protocol for dealing with emergencies, particularly that resuscitation equipment was available. They also felt that the Code of Practice including emergency care should be prominently displayed along with the details of the staff qualified to use the equipment and details of audits and equipment checks should also be freely available.

Whilst the evacuation of premises is included in this standard, it was felt that this should also stress the need for clear emergency exits and disabled access. Mention of the Disability Discrimination Act should also be included in this section. The group also felt there may be an issue around staff’s ability to move and handle people with a disability and suggested that the importance of training in this discipline should be included.

It is suggested that the safe storage of drugs is included in this draft standard.

One participant felt that footnote 9 should be incorporated in the text.

Standard 13: Control of infection

“You would expect the premises to be clean wouldn’t you?” ….a participant

The group was unsure of any incidence of MRSA infection within dentistry, however, with such an important issue within the NHS as a whole, all agreed that dental surgeries should follow the same rules and regulations that apply to hospital staff under any Infection Control Policy. Participants agreed that signs above sinks, “please wash your hands”, etc. should be standard policy and dentists should change gloves for every patient treated, with other comprehensive procedures in place to ensure a clean environment.

Standard 14: Your care environment

As mentioned previously, it is recommended that reference is made to the Disability Discrimination Act, particularly with access to toilet facilities and waiting areas.

The group discussed at some length the problems associated with inadequately sized waiting areas, particularly in older premises, again, this could be considered under the Disability Discrimination Act.
The risk management programme should stress the need to think about the “worst-case scenario” and then ensure the necessary equipment is in place.

The group considered that the suitability of access and equipment was paramount to ensure a comfortable, secure care environment for patients. Therefore, the importance of easily accessible premises with disabled car parking as a minimum requirement was considered worthy of mention.

Standard 15: Children and young people

“I think a child’s first visit to the dentist is crucial” ….a participant

The group considered this standard would benefit from including some recognition and understanding of how children view a dentist and how important it was to alleviate any fear from the time of a child’s first visit. The importance of talking to the children directly, not through the parent, to build a good relationship was seen as crucial and was advocated. Training in how to deal with children and young people should be undertaken by all the dental team as psychology plays such a large part in building a relationship.

It was also felt that the age of consent should be stated in the draft standard, not just a mention of the Age of Legal Capacity Act which could perhaps lead to complications.

One participant suggested the final item in this Standard should read “all team members with access to children must obtain an enhanced disclosure check from Disclosure Scotland. They may work with children under supervision until this check is completed. The situation of team members for whom disclosure checks have not been secured must be reviewed every six months”. If this final item was altered as suggested, or in a similar format, footnote 11 could be cancelled.

In general

All three groups wondered what kind of regulatory system would be checking these standards. Perhaps, accreditation should be promoted regularly and dental practices encouraged to apply.

Several participants mentioned the need for a glossary of abbreviations to be included in the standards. In addition, few questions also arose, such as:

• how will a patient be able to obtain this document? (Final Standards)
• are all dentists aware of the content of the document?
• who will monitor their response to this document?
• document doesn’t say it is available in other formats (Braille, etc.)?

One participant felt that the general information about dentistry could have been more comprehensive.

Most participants considered the draft standards well thought out and sensible, although it was felt that the document itself did not address the main issue of why most dentists were refusing adults NHS cover.

Several participants recommended that serious consideration be given to look into fee structures, particularly for initial consultations, which one participant described as “ludicrous”. This participant also felt that a patient’s major worry was cost of treatment and find it difficult to grasp the difference between NHS treatment and private, even though it was written down in black & white. The fact that NHS treatment charges of up to £372 for adults makes it at times impossible to differentiate. This participant stressed the importance of this aspect of the ethics of the standards to be set.

“Will the introduction of these Standards increase costs to NHS Patients or Patients?” ….a participant
One participant thought it was very important that the standard of dentistry remains at a high and safe level and acknowledged the difficulty remaining for some areas in getting NHS dentists to be available to the general public.

Another participant felt strongly that, because National Insurance contributions were set up to provide all aspects of healthcare, these National Standards should also include GPs, who were also beginning to close their lists.

Another participant felt that the section “Payment for dental care and treatment” (p5) needed to be re-written as the categories were not fully elaborated.

Another participant requested continuity, for instance, on page 30 the first bullet point, quite correctly refers to “her or him” whereas the fifth bullet point refers to “they have”, which preferably should read “he or she has”.

Finally, the majority of participants agreed that the draft Standards were on the whole clear and easy to understand. All participants were eager to contribute and offer suggestions for issues not covered in the draft Standards. However, it is acknowledged that there has to be a limit to the information contained within the final standards when produced to make it easily accessible and easily understood for both patients and dental staff alike.

This report will be shared with the participants themselves, senior officers within the Scottish Executive (Health Department & the Involving People Team), NHS Quality Improvement Scotland, Fife NHS Board, Fife Primary Care Operating Division, Fife Acute Hospitals Operating Division, Fife’s Local Health Care Co-operatives, Scottish Health Councils and the Scottish Association of Health Councils (SAHC).
On resuming—

**Smoking, Health and Social Care (Scotland) Bill: Stage 1**

The Convener: I thank everyone for coming along. I think that the witnesses realise that the committee is doing something a little different today in that we are having a round table discussion rather than our usual approach of having panels of witnesses slot in and out for questioning by members. This is the first time that the committee has tried such an approach and we are a little uncertain about how it will work. We hope that it works well and that everyone will join in the spirit of the approach, which is about engendering livelier cross-participation than can happen when members simply question witnesses.

The witnesses were sent a note that introduces the process with the papers for the meeting and I hope that they have had an opportunity to read the note and get their heads round the new way of working. The committee papers included background briefings from the Scottish Parliament information centre on parts 2 and 3 of the bill, along with submissions from a number of the witnesses—the committee has received other submissions, too.

I will ask the Executive officials to outline briefly—they must be really brief, because we are quite pressed for time—the main provisions of the parts of the bill with which we are dealing. I will then go through those parts of the bill section by section and invite people to comment. That will not preclude cross-discussion and at some point during the discussion on each section committee members will want to ask questions. We will try to get through the work as well as we can. It will not be necessary for every witness or committee member to comment on every section that we discuss; some sections might be completely uncontentious, so people should comment only if there is something that they want to contribute. I invite the officials to refresh members’ memories about parts 2 and 3 of the bill and then I will start the process and see how we get on.

Dr Hamish Wilson (Scottish Executive Health Department): I will be as brief as I can be. Three main areas are covered by part 2. First, the implementation of the partnership agreement pledge to introduce free dental and eye checks for all before 2007 is covered by sections 9 and 10. The provisions also allow for more comprehensive oral health assessments and eye examinations than current legislation permits. The second main area is dental services and in that context the
main provisions relate to the dental charging regime and the opportunity that we have to separate the dental charge from how dentists are paid, which will allow us to make the charging system more flexible and transparent. Section 12 extends the arrangements for the provision of general dental services to include bodies corporate—currently, arrangements can be made only with individual dentists. Section 13 allows health boards to provide assistance, including financial assistance and support to persons who provide general dental services and section 14 allows health boards to make arrangements with general dental practitioners to enter into what we call co-management schemes in relation to functions that are complementary to the work of hospital departments.

The final sections of part 2 deal with the listing of dental and ophthalmic contractors. Currently only those whom we describe as “principals” are included on health boards’ lists, but in future it is intended to include in lists for dental and ophthalmic services people who assist with the provision of those services—so the bill extends the provisions for listing. That is a clinical governance issue for health boards. Those are the main provisions of part 2.

**The Convener:** Will you also describe part 3?

**14:30**

**Dr Wilson:** Part 3 relates to community pharmacy services in Scotland. In general, the provisions are intended to underpin the implementation of a new community pharmacy contract, which is currently under discussion with the profession in Scotland. Section 18 introduces a duty on health boards to plan and then provide or secure the pharmaceutical care services that are required for their areas. Section 19 describes the contractual arrangements under which pharmaceutical care services will be provided or secured. Section 20 strengthens the clinical governance arrangements in the community pharmacy sector, as I described in relation to dental and ophthalmic services, by extending the listing arrangements to encompass everyone who performs pharmaceutical care services. Section 21 empowers health boards to provide assistance and support to those who provide pharmaceutical care services. Finally, paragraphs 11 and 12 of schedule 2 provide powers to transfer resources for pharmaceutical care services to health boards’ unified budgets.

**The Convener:** Thank you. We will start by considering sections 9 and 10, which deal with free dental and eye checks. I invite the patients’ representatives to comment: they are Martyn Evans, from the Scottish Consumer Council; and Joyce Shearer, from Fife local health council.

**Martyn Evans (Scottish Consumer Council):** Should I be brief?

**The Convener:** Very brief.

**Martyn Evans:** We welcome the proposals, which will reduce the initial barrier to treatment for people. However, we have concerns about how the proposals can be implemented, which is not the direct concern of the committee. We would like there to be a greater emphasis on the use of professions complementary to dentistry in delivering the policy. In the context of the evidence of the Audit Commission, we are not convinced that six-monthly dental checks are universally necessary. We are concerned that aspects of the current process of dental checks, for example additional work such as scaling and polishing, which are not part of the dental check but form a significant part of a dentist’s income, should be clearly defined, so that users know what they will pay for and what will be free in future.

**Joyce Shearer (Fife Local Health Council):** In a nutshell, I will focus on four key areas. First, access must be based on need rather than the ability to pay—

**The Convener:** Could you ensure that you speak directly into the microphone? If you do not do so people will have difficulty hearing you.

**Joyce Shearer:** Secondly, and linked to access, accommodation, by which I mean the places in which checks are carried out, must be fit for purpose. Thirdly, patients are very much concerned with accountability and whether robust standards and procedures are in place in relation to assessment and treatment. Finally, in relation to credibility, the regulation of the professions is foremost. The professionals who carry out the examinations must be registered and have recognised qualifications.

**The Convener:** I invite comments from the witnesses from the professional bodies: the British Dental Association and Optometry Scotland.

**Andrew Lamb (British Dental Association):** On free dental checks, in our response to the consultation, “Modernising NHS Dental Services in Scotland”, we supported the principle of a properly funded oral health assessment as part of basic oral health care. We are pleased that the bill uses the words “oral health assessment”. It is important that we understand exactly what will be delivered as part of the pledge and that we fully define “oral health assessment”. It is also important that patients have access to a dentist who can deliver the assessment.

We also have concerns about funding. The properly funded health assessment will require more than just a quick look at a patient’s oral tissue; it will require an assessment of the
individual patient’s needs, and the ability to talk through with the patient their particular problems and to focus on a preventive approach. The time that is required to allow dentists to take such an approach is not available in the current system. One of the reasons why dentists are moving into the private sector is so that they can deliver a preventive approach. Dentists need time to be able to do that. We are concerned that, given the continuing problems of access to dentistry, the bill might raise expectations in patients’ minds that cannot be delivered.

It is important that the oral health assessment is not considered in isolation from the general overall principles of “Modernising NHS Dental Services in Scotland”. Without a ministerial response to that, we are talking about the oral health assessment and free dental checks in a detailed policy vacuum. It is a bit unfortunate that we are in that position, because the oral health assessment cannot be taken in isolation and must be part of the overall package.

Three questions arise. What does the oral health assessment consist of? How will it be delivered by the workforce? How will it be funded?

The Convener: No members have questions on those specific issues, so we will go to Mr Rollason of Optometry Scotland.

Hal Rollason (Optometry Scotland): I thank the committee for the opportunity to address it. As chairman of Optometry Scotland, I state that we broadly support the bill. Press coverage last week, which might not have been entirely positive, highlighted our concerns. We understand that the terms “sight test” and “eye examination” are used to meet existing demand.

One of the reasons why dentists are moving into the private sector is so that they can deliver a preventive approach. Dentists need time to be able to do that. We are concerned that, given the continuing problems of access to dentistry, the bill might raise expectations in patients’ minds that cannot be delivered.

That will produce considerable health gains to the nation by introducing improvements in the eye care that is available to the public; the earlier detection of more eye disorders; better preventive eye care, which leads to a reduction in visual impairment; and a meaningful step towards the long-term goal of eliminating avoidable blindness.

Those measures will provide immediate access to a health professional who can assess, diagnose and treat or refer as required, and that service will be available in every community in an easily accessible and convenient environment, which will ensure equality of eye care throughout the country. Such measures will also achieve a significant reduction in inappropriate referrals to hospital eye departments. The combination of enhanced community-based care and the reduction of inappropriate referrals to out-patient departments will have a considerable impact on the time that people wait for hospital appointments. The measures will also reduce hospital waiting lists and waiting times. They will produce substantial savings in real terms for secondary care by helping to ensure that only people who need to be in hospital eye departments are sent there and by reducing the number of wasted out-patient appointments. They will also help to eliminate most of the 5 per cent of GP appointments that eye-related issues take up.

I work in the east end of Glasgow, in an area that has major health problems, according to every report that is published. The people in the east end become quite upset when they read such reports. I admit that I have a passionate and personal interest in improving health care in my area. Procedures that can provide health benefits somewhere such as Shettleston can work throughout the country.

The Convener: Health boards are also represented. From Greater Glasgow NHS Board we have Dr Iain Wallace and Highland NHS Board is represented by Catherine Lush. I ask them to make opening remarks.

Dr Iain Wallace (Greater Glasgow NHS Board): Greater Glasgow NHS Board supports the principle behind the proposals. It is difficult to gauge the unmet need and therefore the demand that will result from the bill and to know how we will deliver the service by the due date in places with access difficulties. We need to be mindful of the costs that are associated with providing the service against those of existing and proposed commitments.

Catherine Lush (Highland NHS Board): NHS Highland also broadly supports the initiative, but the access difficulties that we in Highland are experiencing with dental services mean that the initiative must be taken in tandem with every opportunity to develop the team approach and to maximise the use of professionals who are complementary to dentistry. The initiative will compound demand when the service is creaking to meet existing demand.

The Convener: I will ask members for their questions. I believe that Mike Rumbles wants to ask about Optometry Scotland.
Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I welcome Optometry Scotland’s broad welcome for the bill. However, when I read some of its written submission, I was quite exercised. I will focus on one paragraph, which mentions the “simple widening of access to a GOS sight test, the so-called ‘free eye checks for all’.

The submission continues:

“To put it bluntly, such a change would be seen as being implemented only for political purposes since it would confer no health gain on the people of Scotland and, therefore, OS could not endorse such a proposal.”

However, SPICe tells us that Optometry Scotland estimates that “65% of patients are currently eligible to have GOS sight tests.”

Mike Rumbles: Is it the logic of the submission that if there is no health gain for 35 per cent of the population, there is obviously no health gain for 65 per cent of the population—because the only difference is that the individual pays for the test? I would like some clarification about that because the submission makes a stark point.

Hal Rollason: That is precisely the point. There would be no new tests done if people got them free rather than paying for them.

Mike Rumbles: That is not my question. Your submission says that there will be “no health gain”.

Hal Rollason: That is because there will not be any more tests done. That is what is behind that statement.

Mike Rumbles: So you are not saying that there will be no health gain. Surely it does not matter whether an individual pays for the test or not. There is health gain with sight tests.

Hal Rollason: There is health gain with the sight test. At the moment, it tends to be opportunistic health screening that occurs within a sight test.

Mike Rumbles: So when the written submission says that there will be “no health gain”, it is not correct.

Hal Rollason: Our submission really says that there would be no health gain because there would be no new sight tests performed as the result of some people getting it free.

Mike Rumbles: But you are admitting that there would be health gain.

Hal Rollason: There is health gain in any sight test or eye examination.

Mike Rumbles: Right. Thank you. That is just what I wanted to hear.

Kate Maclean (Dundee West) (Lab): I did not see that article because I was otherwise engaged. However, my understanding is that even people who are currently eligible for free sight tests do not necessarily take them up. For instance, 20 per cent of school pupils have undetected levels of visual impairment.

The standard GOS sight test that is available at the moment is not a proper eye examination. If the bill introduced the right to such a test it would not necessarily lead to earlier detection of eye disorders or reduce future instances of visual impairment or blindness. Therefore, I conclude that unless the Executive ensures that the eye examination is a proper one, there will be limited health benefits for people. In that case, because there are people who currently do not take up the free eye tests to which they are entitled, it would be better for public health to target the money at those people, rather than to spread it so thinly that there is no significant health benefit. Is that correct?

Hal Rollason: There is a significant number of people in any category, such as drivers who do not pass the sight standard for the driving test, or people with diabetes who do not take up the diabetic check. There are all sorts of at-risk groups that do not currently have proper care. We are really promoting health care. The idea of the eye examination came about during discussions with the Scottish Executive. We could target a proper, health-based examination that is appropriate to the patient’s symptoms.

Kate Maclean: So in your opinion, the groups that are most likely to get a health benefit from having proper eye examinations are the very groups that would probably not take up sight tests. I do not think that anything in the bill suggests that the sight test is compulsory, so those groups would need more assistance than just the availability of free sight tests.

14:45

Hal Rollason: There is certainly an education message that we have to get across to the effect that when someone goes for a sight test, it is based on legislation that came along 60 years ago that was largely designed to get specs for people who had come out of the war and were starting to work in offices. That is what the legislation that we work with at present was designed for.

We need legislation that acknowledges the fact that eye problems and general health problems can be detected in a routine eye examination or health examination. Those are the most important issues that we must focus on. Every day, I see somebody who comes in complaining about flashes and floaters, which might mean a retinal
detachment. It could be a child or an old person. They could be having migraines, which would be the common result. In any case, such complaints have to be investigated to ensure they are not something more serious. It does not matter whether the problem is cataracts, diabetes, glaucoma, possible retinal detachment, tumours, high blood pressure or hardening of the arteries—we look at a huge range of conditions every day, which need to be investigated in a more appropriate and thorough manner.

**The Convener:** Do any of the health board representatives have any comments to make on the issue of targeting? There are big sections of the population that appear never to access some of the services to which they are entitled.

**Dr Wallace:** We currently have that difficulty in targeting particular areas of deprivation with respect to breast-screening services, for example. We might reflect that money could be targeted at those areas. However, there is not always sufficient evidence about how we can reach out into the communities concerned to get people to take up the services. We might need to pilot initiatives to access such evidence.

**The Convener:** Is either of your health boards actively considering potential targeting mechanisms for eye and dental checks?

**Dr Wallace:** There is something called the Glasgow integrated eye service, which deals with the redesign of eye care. It is the interface between primary care and secondary care that is the issue, rather than targeting specific groups within the population.

**The Convener:** What is the situation in Highland?

**Catherine Lush:** I cannot comment on the optometry side of things, but we are trying to ensure that all children can access dental services. As for adult patients, we are dealing with the waiting lists and we are targeting our services there.

**The Convener:** Would it be the health boards that would do the targeting, even for optometry?

**Dr Wallace:** Yes.

**Martyn Evans:** The complexity of the charging system is a barrier to people taking up services, particularly in dentistry. We did a large piece of work on access in two primary care services. It became quite apparent through our talks that people thought that costs were higher than they were. People did not understand what the costs were, because they were not clearly displayed.

If we could take simplification measures, we might get increased take-up. The relationship between the charges to the patient and the costs to the practitioner is critical from the consumer’s point of view. If the cost can be simplified, take-up can be increased. Then, there need to be discussions with the professions, which must establish what they are being paid for—what time they will be paid for to do what. That is a professional discussion. As I understand it, a dentist gets paid £6.80 for a dental inspection. That does not seem a lot of money for a reasonably thorough inspection, so there might be a case for increasing that amount. However, that is a separate matter from making the patient pay for that inspection.

**Andrew Lamb:** It is in fact £7.08 now—not a significant increase. The problems in dentistry are similar to those in optometry. The system was designed 57 years ago to deliver particular things that were relevant at the time. Dentistry has moved on and we must focus much more on the prevention of dental disease than on the management of the disease once it has occurred. Most of the problems that patients will encounter in the oral tissues—tooth decay, gum disease and oral cancer—are preventable. Time needs to be spent with the patient to identify the risk factors among individuals and to deliver a proper oral health assessment.

By and large, all the costs of running a dental practice come out of the dentist’s income. One or two allowances have been introduced in Scotland, which have been helpful, but most of the costs of running dental practices come out of the income that is derived from the patients or from the NHS. It costs about £120 an hour to run a dental practice, so you can see how much time can be spent for £7.08. It is that time that requires to be funded—it is that time that dentists are prepared to give to their patients, and they are prepared to move into the private sector to deliver that type of health care.

A simple dental check-up is not what is required. What is needed is a proper oral health assessment that takes into account the patient’s general health and matters such as their diet—including their intake of sugary foods and fizzy drinks—and whether they smoke. If they smoke, they should be provided with smoking cessation advice or passed on to someone who can deliver such advice. Like optometrists, dentists are in a good position to identify conditions such as diabetes. All such work is part of the general health game and dentists must be part of that process.

**The Convener:** I will allow Mike Rumbles to come back in briefly.

**Mike Rumbles:** The bill is enabling legislation—all that it will do is extend the scope for the provision of free dental checks and free eye tests. It is clear that that is the case and that, when the
bill has been passed, the Scottish Executive will produce proposals on dental checks and eye examinations. Is it the professional view of the witnesses, as representatives of professional bodies, that the more people who can take advantage of professional examinations in the fields of dental health and eye care, the better we will all be? Do they agree that if everyone could have such access, that would be a marked improvement?

The Convener: Please be brief.

Andrew Lamb: In our written submission, we said that the British Dental Association supports that. There is no question but that removing the barrier of a patient charge will help patients to access dental care, although the problem is whether there is dental care to be accessed. You are right about the bill being enabling legislation.

Hal Rollason: There is not an access problem in optometry, because there are enough optometrists. There are more than 1,000 optometrists—850 full-time equivalents in about 850 practices—working in Scotland, so there is plenty of access. I welcome the idea of a new eye examination that is appropriate to people’s needs and symptoms.

Mike Rumbles: For everyone?

Hal Rollason: Yes.

The Convener: Shona Robison wants to take up some of the access issues.

Shona Robison (Dundee East) (SNP): I have two questions. In its submission, the BDA says that because of the lack of detail it is “unable to provide comment on the Bill’s objective that it will improve the oral health of the Scottish population.”

That is a powerful statement. It is unusual for the committee to receive evidence that strongly questions a bill’s fundamental objective and its ability to deliver its intention. Do you think that the mistake has been that the lack of ministerial statements about the Executive’s intention has left a policy vacuum that makes it difficult to assess whether the bill will achieve its objective? It would be interesting to hear the Executive’s response on that general point.

I have a more specific question. You talk about access, funding and the workforce. As things stand, will the Executive be able to deliver free dental checks in any form, whether simple or comprehensive? Given the barriers that exist, do you think that that commitment can be met?

Andrew Lamb: I think that that commitment cannot be met. It is important that the oral health assessment—I am pleased that the phrase “oral health assessment” is in the bill—is part of the overall modernising NHS dental services package but, as yet, we are not clear about what the Executive will do in that regard.

Shona Robison: At the moment, you do not think that that objective can be met.

Andrew Lamb: The British Dental Association does not believe that that objective can be met.

Shona Robison: Can we hear from the Executive?

The Convener: Wait a second. Helen Eadie has a point on the issue in question.

Helen Eadie (Dunfermline East) (Lab): My point follows on from what you said about the existence of a policy vacuum. Will you expand on that and on how you would like dental policy to develop?

Andrew Lamb: There are several issues. First, we must keep dentists who are working in the NHS in the system. That requires a fundamental review of the way in which NHS dental services are configured and delivered. That is what we are waiting for from the Scottish Executive. I have already emphasised the need to take the preventive approach. There is certainly still a need for repair and replacement of missing teeth, but we need to emphasise the preventive approach. Access to a comprehensive oral health assessment will certainly help to improve the oral health of the people of Scotland, if they can get access to such a service. However, there are workforce shortages and there has been question after question in the Scottish Parliament about such shortages—I do not need to advise MSPs of that fact—and about difficulties in accessing NHS dentists. Indeed, in some parts of the country, it is difficult to access any dentist, so there is a serious problem, but it is a complex one.

We have heard about the role of PCDs. It is important to examine that role; that is all part of modernising NHS dental services. However, the comprehensive oral health assessment has to be delivered by the dentist. The dentist has to determine the treatment or management needs of the patient, but if some time can be freed up by the dentist not doing some of the other work that a PCD could do, that will improve the access problems significantly. That is one element of the issue.

We have already heard about the need for a six-monthly check-up. As part of an oral health assessment, it is important to determine the appropriate time to recall a patient. The appropriate time might be three months or it might be two years. If more patients move from six months to a year or two years, perhaps that will also free up some time. That is why we need to consider the whole package. Mr Rumbles asked a simple question, and if a patient can access an
oral health assessment, that will improve the oral health of that patient.

The Convener: Nanette Milne and Duncan McNeil want to ask questions, and Martyn Evans would also like to comment.

Mrs Milne: To some extent, my question has been answered already. Research has shown that the incentives that have been used so far to attract dentists back to the NHS or to keep them working in the NHS have not really worked. Do you agree with that research?

Andrew Lamb: Yes.

Mrs Milne: Have you anything to add to what you have already said about attracting dentists back in or keeping them in the health service?

Andrew Lamb: No. The incentives have worked spasmodically and only in some areas. The Scottish Executive has tried, but it recognises that they are short-term solutions—we call them sticking-plaster solutions. You have to look at the whole package. Rather than incentivising dentists with golden hellos, the whole package of the way in which NHS dentistry is delivered must be appropriate and must suit the needs of dentists and patients. It is the patients who come first, and the dentists want to deliver proper oral health care.

There is no doubt that if the system is right, dentists will stay in it. What concerns me is that many dentists are opting out of dentistry completely when they reach their 50s. Our written submission refers to the fact that two thirds of dentists seek early retirement and a third of them do so because of stress. That is down to the treadmill of the current system of NHS dentistry. We are talking about dentists retiring, on average, at 57. If you kept them going for another three, five or seven years, until they are 65, that would help the access issue. Keeping those dentists in the system is important and is easier to achieve at this point than trying to recruit people from outside. The system must work well. It must keep the people in and it must allow them the time that they need to spend with their patients to deliver modern 21st century dentistry.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Your submission raised the issue of transferring practices and the need for some subsidy to enable new dentists to come in. Would an incentive there increase the likelihood of dentists retiring early? I shall let that question stick to the wall.

As you know, at our previous meeting we discussed a study that was carried out. You mentioned professionals complementary to dentistry. We are talking about how we will be able to deliver the services in the future, and the report said that a dental therapist could increase a dentist’s output by 45 per cent and that a dental hygienist could increase a dentist’s output by 33 per cent. Your submission seems to make the grudging recognition that professionals complementary to dentistry “may help”. Will you assure us that the profession is totally committed to working in that wider team? Will you give us examples of what the profession has done to engage in and develop that process?

15:00

Andrew Lamb: We certainly welcome the inclusion of professionals complementary to dentistry as part of the team and support the principle that they should be allowed to work in all areas of practice. As I have said, dentistry has changed since the 1940s—it has become much more complex. The dentist should be required to identify the patient’s oral health needs—which we have already discussed—and to carry out more complex procedures. More straightforward procedures can be undertaken by hygienists and therapists, and we would certainly welcome their inclusion in the dental team. However, dental teams should be led by dentists, who should determine patients’ needs. The nation’s oral health will certainly be improved by the provision of proper diagnosis and treatment planning and prescription to professionals complementary to dentistry.

I would like to pick up on the issue of the Scottish dental access initiative, which has made available funding to allow dentists to set up practices in Scotland. The problem with that initiative is that it has not supported existing practitioners—I think that Duncan McNeil alluded to that. Practitioners who have been committed to the NHS for some time have been unable to access funding, but somebody coming in from outside could set up a practice 200yd down the road and access up to £100,000. The problem with the initiative is that it requires people to commit themselves to substantial work in the NHS for seven years. It is not inappropriate for the NHS to want payback for investment, but in the vacuum of not knowing what the NHS will look like next week let alone in seven years’ time, it is not surprising that the initiative has not been taken up. However, the profession as a whole certainly supports moves towards team working that includes professionals complementary to dentistry and the use of hygienists and therapists in appropriate circumstances.

Mr McNeil: But you see dentists as being the gatekeepers to the whole process.

Andrew Lamb: Absolutely—they must be.

Mr McNeil: Dentists deciding what would be appropriate would be the ideal. From that point of
view and in the light of the massive problems that there are in getting access to a dentist, what has your professional organisation done in the past year or so with the Scottish Executive and others to develop from the basis of the dentist being key and the team concept?

Andrew Lamb: Some of the things that we would like to see happening require legislative changes. The section 60 order has been delayed by the Westminster Parliament for another six months and proposals that would like to come into place cannot do so until that legislation has been enacted. However, we are certainly discussing the future of NHS dentistry with the Scottish Executive and we are considering how professionals complementary to dentistry can be included within the modernisation framework. It might be more appropriate to ask the Scottish Executive about that matter.

Mr McNeil: As a representative of a profession who has something to say about the roles that people will fulfil, you have some responsibility to develop such roles as well as the professional organisation. We all have the public’s interest at heart.

Andrew Lamb: We are in discussions with Governments throughout the United Kingdom on how professionals complementary to dentistry—

Mr McNeil: Is there anything specific that you have done to bring about team working?

The Convener: I remind Duncan McNeil that the committee has discussed the section 60 order that has been referred to. You might want to refer back to what was said, as some things cannot be done until it is brought into place. I say that as a matter of recollection.

Mr McNeil: I am making the point that the difference between the British Dental Association’s written submission and the other submissions that we are considering today is that the other submissions show development and a willingness to see things change and they give some vision of people’s future roles. Although the dentists’ submission dwells on a lot of the problems, I do not think that it goes beyond them to give a vision of what dentistry will be like in the future.

Andrew Lamb: I reassure you that we will discuss the matter when we enter into discussions with the Scottish Executive over the modernisation of NHS dental services. The profession is training dentists and PCDs in a common environment, and the training arrangements for PCDs are now much closer within the training institutions. Undergraduate dental students are being trained in the same environment as PCDs, so that the young graduate will understand what the PCD can do. We are also looking at how the PCDs can operate within the primary care sector. It is all part of the overall package and, I am afraid, it involves some changes through a section 60 order.

Martyn Evans: The question is whether there is a capacity to deliver, now that the commitment has been made. Mr McNeil made my first point about professionals complementary to dentistry, which is in Professor Tim Newton’s paper on access to dentistry. We made that point at the beginning and it is very important.

My second point is that there is a treadmill, at the moment. Because of the fee payment structure, dentists have to see their patients more often and have to do work that is not clinically necessary. The bill will alter that fee structure. We do not know what the structure will be, but it will be de-linked from patient charges. As we said at the beginning of our evidence, that is an important and progressive measure.

My third point concerns something that has not been mentioned—the local commissioning of services. Local commissioning, which is referred to in the bill, will allow a more flexible approach to be taken towards dental services and might well impact positively on the capacity to deliver. At the beginning of our submission, we say that we welcome the removal of the barrier of cost to looking at the initial inspection of teeth and eyes. We think that that is necessary but not sufficient to deliver access to services. There is a capacity issue, but we think that other things in the bill will help to create the capacity to deliver.

Kate Maclean: I have a brief question about the capacity to deliver. Andrew Lamb said earlier that, although under the current system everybody has a six-month check-up, that would not be necessary. People could have a three-month check-up or a two-year check-up, depending on circumstances. Would that be complicated to introduce? Would it affect the capacity to deliver the legislation?

Andrew Lamb: It is not complicated to introduce that; it requires the oral health assessment. It is a matter of identifying the risks to individual patients and determining, through consultation with the individual patient, when it is appropriate to recall them. As time goes on and a dentist gets to know the patient better, that period could be extended if the dentist knows that there are no risks involved—or it might have to be shortened. It is all part of the oral health assessment.

We will address in the next section the other issues that the patients’ representative has raised. However, dentists are not carrying out unnecessary treatments; there is plenty of treatment out there that needs to be done, without dentists carrying out unnecessary treatment. The problem is in providing the care that the patients need. If dentists could spend more time in
assessing the patients’ needs and perhaps preventing tooth decay by giving them dietary advice and so on, they might not take the current preventive approach, which is to cut a cavity because they are not sure whether something is going to become more significant if it is left for any length of time. If there was a proper review period, they would be able to decide whether a cavity needed to be cut. At the moment, the system does not allow dentists to take the preventive approach that is required. That situation needs to be changed, and we hope that the Scottish Executive will deliver that type of change in its programme.

The Convener: One or two questions have been indirectly put to the Executive official. Dr Wilson, I do not know whether you want to make any comment or whether you want to leave that until the final round-up session with the minister.

Dr Wilson: Certain points would be best dealt with in the final discussion with ministers. Nevertheless, I confirm that ministers have recently said that a response to the consultation on the modernisation of NHS dental services will be produced very shortly.

My only other point is that the bill’s provisions on oral health assessment and eye examinations were intended to underpin the discussions to which Andrew Lamb and Hal Rollason have referred. The intention behind the bill is to move us forward and not to leave us stuck in the NHS’s origins, as both representatives have said.

The Convener: We have covered many of the issues that I had expected would arise when we dealt with sections 12 to 14. As a result, instead of going through the whole process again, I ask whether anyone has any further comments on these sections, which deal with various changes to the provision of dental services.

Joyce Shearer: At the moment, parents are responsible for their children until they leave school. However, the number of people leaving school is huge. If, as one of the witnesses has said, those people had their dental assessment just after they left school and before they entered adulthood, dentists would be able to carry out more preventive work instead of having to deal with people who wait until much later in adulthood to visit them with problems that have arisen much earlier. The bill could target specific age groups. For example, university freshers weeks provide wonderful opportunities for examining young people’s oral health before they set out on a career pathway.

The Convener: Do the health board representatives want to comment on sections 12 to 14?

Dr Wallace: No.

The Convener: So you simply stand by your previous comments on targeting.

Dr Wallace indicated agreement.

Martyn Evans: We welcome the assistance and support that health boards will be able to give dentists. For example, in our study on access to primary care services, dentists were the least physically accessible. Indeed, 75 per cent of the dentists whom we reviewed were located up a flight of steps. The dental profession will have to address a whole raft of legislation. This particular provision will lead to a reasonable public investment in more accessible services. We are also in favour of co-locating services, but we think that the bill represents a significant start.

Andrew Lamb: We welcome the removal of the link between patient charges and payments to dentists. As a result of the proposed legislation, a greater percentage of practices’ income will not be derived from patient charges. We also welcome some direct reimbursement for premises, equipment, materials and so on.

Allowing health boards to determine the provision of oral health care services would provide a useful means of delivering that care to areas that suffer from such problems. In that respect, I hope that that there will be a Scotland-wide policy that can be locally implemented.

We have not yet mentioned access to secondary care, which is an area where local health boards could come into their own. One particular way of delivering specialist services could be extended into the primary care sector. The use of clinical networks and dentists with special interests in the primary care sector would benefit both patients, as it would give them access to services that they perhaps do not have at the moment, and dentists. One of the problems of recruiting particularly young dentists in so-called remote and rural areas is the sense of isolation and lack of support from their peers and the secondary care sector. As a result, working in a clinical network, which the local health board could set up, would be of benefit.

That said, Professor Tim Newton’s report has highlighted the lack of information that is held by health boards. If the proposed legislation is going to work, health board chief executives and chairpersons must be aware of the dental agenda and the strategic need to deliver dental services in their area. It is important that the Scottish Executive engage at a high level with health boards. Down the ladder, there is a problem with delivering dental services within the available funding. However, we must still engage with key people in health boards to ensure that they understand that dentistry is an important aspect of health care delivery in their area. That will be
crucial if we are to deliver dental care in the so-called remote and rural areas. It will be helpful to allow health boards to support dental practices in some way other than through fees alone, and separating the dentist’s income from what the patient pays is another way to do that.

15:15

Catherine Lush: I support the concept of flexibility for boards. Within NHS Highland, we have already enjoyed an element of flexibility in contracting with general dental practitioners to provide emergency dental services, which has been beneficial for patients in that they have been able to access care locally. Some flexibility at board level will be an important catalyst for change in service delivery.

I flag up the issue of premises. My vision for the future modernisation of dentistry is that dental services will be delivered in much larger teams. I expect dentists to continue to head up the teams, but we will make much better use of professionals complementary to dentistry, who will need premises. The dental therapists and dental hygienists will need to work in surgeries, so the challenge is not only to create the workforce and skill it up, but to ensure that we have the premises for the workforce to work in. We in NHS Highland are beginning to look at that, because we consider it to be a major challenge for the next 10 years. We need to have a premises strategy to ensure the sustainability of services.

On access to secondary care dental services, if significant numbers of patients cannot access primary care dentistry, they also cannot access secondary care support and advice. Dentistry is different from medicine, in that most people have a general medical practitioner. General medical practitioners make some direct referrals to hospital dental services, but a huge group of patients cannot access secondary dental services, so the creation of an intermediate skill layer in primary dental care is essential, and I support the BDA in that.

Dr Wallace: I was not going to say anything, because I agree with all that, but the co-management schemes that section 14 allows and the flexibility to have personal dental services, community dental services and GDS working together with salaried GPs are important. Our experience in Glasgow with sedation services and services for the elderly is that such flexibility is beneficial in targeting particular groups.

The Convener: I see that Hal Rollason from Optometry Scotland wants to speak, but the sections that we are discussing are about dental services.

Hal Rollason: I was going to make some comments about access, which is highly important in optometry and dental services. We consider access all the time. It comes back to the idea of education and of advertising the fact that services are available.

The Convener: That exhausts our discussion on sections 9 to 14. We move on to sections 15 to 17, which extend the list of those covered by disciplinary procedures to other dental and ophthalmic service professions. I invite the patients’ representatives to comment at the start of the discussion.

Martyn Evans: The Scottish Consumer Council approves of the extension. We think that it is sensible to have provisions on fitness to practise and to have all those who are practising on a list. We approve of the idea that somebody who is debarred from practising locally should be barred from practising in other areas—if a practitioner is a danger to patients in one area, they might be a danger to patients in other areas. We also approve of the disclosure requirement for new entrants to the list and want to know why those who are on the list currently will not be subject to the same disclosure requirement, as it is in patients’ interest to know that there is nothing for them to be concerned about in relation to a person’s fitness to practise.

All in all, sections 15 to 17 make it clear who will be subject to the NHS disciplinary procedures. At the moment, only principals are on the list and so are subject to the disciplinary procedures, so extending the list makes great common sense.

The Convener: Ms Shearer, is there anything that you want to add?

Joyce Shearer: Not really, except that the length of time that disclosures take can disrupt services.

The Convener: What are the views of the professional bodies? Are you content with the proposals in the bill in this regard?

Andrew Lamb: You have our written submission and we are content with the proposals.

Hal Rollason: Our only comment was that the proposals should happen in the least bureaucratic way possible so that extra expense will not be incurred.

The Convener: Martyn Evans asked why the requirement does not extend to existing list members.

Martyn Evans: As I read it, there is a requirement for someone coming on to the list to make a disclosure, but that is not a requirement on someone who is already on the list.
The Convener: Will the Executive official clarify whether that is a fair reading of the bill? If so, why was the provision drawn up in that way?

Dr Wilson: I will come back to the committee on that.

The Convener: Thank you. Are the health boards happy that what is proposed is workable?

Dr Wallace: We certainly support the proposals because they introduce greater accountability for the professions. There will need to be a modest increase in administration to work the lists.

The bill uses the phrase "standards of performance and patient care", which raises questions about whether there is expected to be a proactive system of appraisal for all NHS contractors and whether that means that we will pick up on complaints or detect under-performance. I would prefer that, but it would cost the boards more to fund it.

Catherine Lush: I agree with everything that has been said. It is important that we respond to patients, who are looking for increased accountability. I see the proposals as an important part of that.

The Convener: Those sections appear to be relatively uncontroversial, with the single exception of the issue that Martyn Evans raised on which the Executive official has agreed to come back to the committee.

We move on to section 18, which deals with pharmaceutical care services. The representatives from the dental and optometry bodies can now leave and we will have a changeover of witnesses.

I welcome Mary Morton, the acting chief pharmacist in NHS Highland; Alex MacKinnon, who is the head of professional services development at the Scottish Pharmaceutical General Council; James Semple, the chairman of the Scottish Pharmaceutical Federation; and Chris Naldrett, team leader of the primary care division in the pharmacy issues team of the Scottish Executive Health Department. Eric Gray, also from the Scottish Executive, gets a bit of a break.

We will go through the process again. I invite the patients' representatives to make any specific comments on section 18.

Joyce Shearer: I have one issue to raise about prescribing practices. A doctor can obviously prescribe—

The Convener: Mrs Shearer, you will really have to speak directly into the microphone because people are not picking up what you are saying. Try not to turn round and look at me; I know it is difficult because I am really easy to look at.

Joyce Shearer: The point I want to raise is about prescribing. If someone goes to an optician, the optician cannot prescribe an antibiotic. The patient has to go back to their GP, so their journey is disturbed. Equally, there seems to be a discrepancy between what a dentist and a doctor can prescribe. I would like to think the bill would address prescribing issues, to lessen the patient's journey because of trips back to their GP, in particular from the optician.

The Convener: That will be difficult, because this section is to do with pharmaceutical care services. A question about prescribing perhaps ought to have been directed to the dentists and the optometrists, but they have gone now. I do not know whether others can comment, or whether we can find a way to return to the issue.

Martyn Evans: I have a comment on the more proactive role that health boards will now have in planning pharmacy provision in their areas. We were much more supportive of the Office of Fair Trading report "The control of entry regulations and retail pharmacy services in the UK" than were the pharmacy profession and others. It had some partial answers to the lack of competition and some of the access issues. We welcome the increase in planned provision that is in the bill.

We would like greater clarity on the national standards that might be applied possibly not in the bill, but in the regulations that follow. The first example that we gave in our written submission was services in supermarkets, which the Office of Fair Trading report found were open longer than community pharmacies—79 hours compared with 50 hours. We would also like clarity on national standards for pharmacy services in places such as railway stations and airports. Both those examples are being dealt with in the English context.

Overall, under the current system, provision is unplanned and is based on the existing services that pharmacies provide. The bill represents a move towards more planned provision, which is welcome. It perhaps does not go as far as we would like it to, but we welcome it.

The Convener: Does the Scottish Pharmaceutical Federation want to comment? Obviously, the issue is pretty important for your business.

James Semple (Scottish Pharmaceutical Federation): Sure. Would you like me to comment specifically on that point or generally on the bill?

The Convener: You can comment specifically on section 18, then pick up the point that Martyn Evans raised.

James Semple: On section 18, we broadly support the proposed legislation. We are happy that the Executive has not gone down the route
favoured by the National Consumer Council, which was the OFT route of having a free market. The best idea is for health boards to maintain the ability to plan services properly and to put them where they are needed, not just where the nearest honey pot is to which all contractors will rush to make money.

On services in supermarkets and railway stations, within a planned system there would be an ability to put services where there is an appropriate need, so that would not be a problem.

Alex MacKinnon (Scottish Pharmaceutical General Council): The Scottish Pharmaceutical General Council welcomes the opportunity to give oral evidence. As a member of the team that is negotiating the new contract, we fully support the policy intention of modernising NHS community pharmacy services. We fully support “The Right Medicine: A strategy for pharmaceutical care in Scotland”.

This is all about improving patient care. We fundamentally support the overarching aim of improving patient care through better use of pharmacists’ key skills. The proposals represent a major service redesign and a major change in the way in which community pharmacists work. They will move from providing pharmaceutical services to providing pharmaceutical care services. I fundamentally believe that we will reposition community pharmacy as an integral part of the modernising primary care team.

Because we do not have the detail of the regulations and directions, there are some concerns. Throughout our submission, we take the view that where something is agreed on a national basis according to national service frameworks and standards, that should not be diluted as it goes down through the boards. It is important that we have a national set of criteria and guidelines against which the pharmaceutical care services plan can be formulated. We stress that community pharmacy is involved in a participative and positive way, as one of the key stakeholders in the delivery of the plan.

Our other main concern centres on how a new contract will be granted in future, because it is highly likely that the current criterion, of assessing the need for a contract on the ground that such a contract is necessary or desirable, will go. Because we do not have the detail of the regulations, we are unsure what that will mean for community pharmacy. However, we fully support the need to address areas of underprovision throughout rural Scotland and in areas of extreme social deprivation.

We fully support the listing arrangements under which non-principals and principals will be fully accountable for their actions. In fact, such listing is best practice; it encourages best clinical governance.

Our colleague from the Scottish Consumer Council raised the subject of choice and also mentioned England. In rejecting the Office of Fair Trading recommendation, the Scottish ministers did not reject competition and choice. They made a pledge and commitment to the people of Scotland to improve patient care and access. The fact is that 85 to 95 per cent of community pharmacies’ work involves the NHS contract and not their retail business.

What does the word “choice” mean? In England, the word is used as a noun: choice probably means another 100 new pharmacies that could, I agree, sell paracetamol at a cheaper price. It will mean 302—or thereabouts—PCTs all having a different community pharmacy contract—

15:30

The Convener: Excuse me, but what is a PCT?

Alex MacKinnon: It is a primary care trust. There are more than 300 PCTs in England and part of the English contract will be left to the decision-making process in each primary care trust. Where does patient choice, post-code inequality and the need to get rid of such inequality fit in a system like that?

In Scotland, the word “choice” is used as an adjective. Choice means the delivery of quality and consistency. The new community pharmacy provision in Scotland will try to deliver core, essential services across every community pharmacy in Scotland. We want to make a fundamental difference to the health of the people of Scotland through their pharmaceutical care.

The Convener: We move on to the health boards. Given the specific issues that relate to the situation in remote and rural areas, I invite Highland NHS Board to go first.

Mary Morton (Highland NHS Board): NHS Highland broadly supports the policy of implementing pharmaceutical care plans and enabling boards to plan the delivery of pharmaceutical care services across their area. As Alex MacKinnon mentioned, it is extremely important that national guidelines are set so that all boards can consider the needs in their individual area in the same way. That is how we will develop a plan for the delivery of services in our area.

Obviously, given the issues of remoteness and rurality in the Highland area, we have a broader difficulty in providing services across our area. We welcome the opportunity to plan pharmaceutical services instead of being at the beck and call of
individuals who might or might not want to provide services in the area.

Dr Wallace: Pharmaceutical care services plans are a good thing. That said, it is inevitable that the plans will place an additional requirement on boards. Health boards should have the ability to provide or contract cost-effective services. That would give us choice about where we go for such services. It would also allow us to provide supplementary services in areas where there are gaps: methadone dispensing in Glasgow is one example of that. Greater Glasgow NHS Board believes that the plans are a good thing.

The Convener: Mr MacKinnon went on to talk about the pharmaceutical care services contracts in section 19 and the extension of the list in sections 20 to 21. Do you want to comment on those sections or to respond to what Mr MacKinnon had to say?

Dr Wallace: We support the amendment of the 1978 act that section 19 proposes, in particular proposed new section 17S(1). Some work is under way at the moment on a definition of “supervision” and we would like to see the conclusion of that work. We also welcome proposed new section 17T(3) of the 1978 act, under which we would see a move towards the incorporation of standards in contracts. As I mentioned, boards will require additional capacity to monitor aspects of the contract, but we support the proposed amendments to the 1978 act.

The Convener: Does Highland NHS Board want to say anything about the sections that deal with the pharmaceutical care services contracts and the pharmaceutical list? You might not have a comment—please do not feel obliged to make one.

Mary Morton: Broadly, NHS Highland supports all the comments that were made in the response from the Royal Pharmaceutical Society of Great Britain and the vast majority of those that came from the Scottish Pharmaceutical General Council. The bill will develop the ability of community pharmacy to provide the services that patients require by extending use of the workforce. I hope that that will give us the ability to provide the services that the public require.

The Convener: Mr Semple, you originally confined your comments to section 18. Given that we seem to have drifted on to the other sections, is there anything that you want to add in respect of the pharmaceutical care services contracts and the extension of the pharmaceutical list?

James Semple: I reiterate the point that Alex MacKinnon made. Although we completely support the thrust of the bill, the devil is in the detail. We need to wait until we see the regulations, as that is where the day-to-day problems might arise. We warn against the law of unintended consequences. Ideas that look good might in the long term affect the stability of what is currently a hugely effective network of pharmacies that dish out hundreds of thousands of prescriptions every day in a safe, effective manner. Representatives of the profession must be involved at all points in the process. Hopefully, at the end of the day we will get a new contract and make “The Right Medicine” work.

The Convener: Does Martyn Evans want to comment on the other sections of the bill?

Martyn Evans: We welcome and have no problems with the extension of the list. I would like at some point to comment on the planned provision of pharmacy services.

The Convener: Now would be a good time to do that.

Martyn Evans: I am concerned to make it as clear as possible that, although there is issues with the physical location of pharmacies in rural areas, there are competition issues in a range of other areas in Scotland, related to opening hours, quality of service and facilities. James Semple said that the devil is in the detail. The bill does not say how contracts will be arranged, and that affects a significant part of the service that pharmacies provide to the public. The Office of Fair Trading saw competition issues being raised, but planned service issues—who we plan for better service in local areas—are also raised. In its report, the OFT found that there were local pharmacy services monopolies whose delivery of services to the general public did not differ significantly. Where there were fewer pharmacies, especially in rural areas, the quality of service was lower. A smaller range of services was provided, because competition was not present.

The Office of Fair Trading saw competition as the solution to the problem. It argued that, if the control-of-entry requirements were removed, there would be greater competition. Despite what James Semple thinks, we did not fully support that approach. We said that there must be either more planned provision or more competition—the status quo would not work. We welcome what is planned, but we say that the devil is in the detail of how it will work.

We would like to see national standards. There are issues that cannot be decided in 15 different ways if there are not to be 15 different ways of providing the service. It is important that there should be national standards for supermarket services and for the provision of service at points of transition. Although we are generally in favour of competition, our research shows the value that is placed on pharmacy services. We support “The Right Medicine” as a way forward. There is much
support in community pharmacy for working within that agenda. However, we must bear in mind the fact that the current system of having a static market, which we are moving away from, has not helped to improve the quality of service that is delivered to the public.

The Convener: Janis Hughes has indicated that she would like to come in. One or two other members have also raised their hands. Before Janis asks her question, can Mr Naldrett say whether he has any indication of when the regulations will be available to us?

Chris Naldrett (Scottish Executive Health Department): We are working on the assumption that we will need something for stage 2. We are doing preparatory work on the regulations.

The Convener: So the regulations will be available at some time between now and our first stage 2 session.

Chris Naldrett: The regulations will be skeletal in parts and quite full in others. It will take a while to produce them, because we are still in the process of negotiation. The committee will appreciate that some contract conditions will still be the subject of negotiation in the summer.

Janis Hughes (Glasgow Rutherglen) (Lab): I have a question for the Scottish Pharmaceutical General Council, specifically on section 18 of the bill. In your submission, you say that you do not want and what makes a successful business. As competing organisations find out what the public want and what makes a successful business. As somebody said earlier, 80 per cent of pharmacies' income is from the NHS; therefore, the pharmacies are a service of the NHS.

The other way to find better services is to have a centralised planning system. However, centralised planning has not worked well in Scotland; we do not have a good history of it, so we must be careful about how we plan services and ensure that they are not dominated by the professional interest. I acknowledge that the professional interest is important, but it is only one interest among a wide variety of interests in the community. This goes back to access to primary care services. One of the key criticisms came from working people who cannot access pharmacy services when they want them because of the lack of competition within pharmacy.

I support the move towards more planned service; however, it should not just be about the physical location but about the quality of service. I agree with Mary Morton: the question is not just about opening hours, although opening hours and other services, such as home delivery, are important to patients. The evidence is that there has been less competition in those respects in the past, especially where small chains have a monopoly on local services. Increasingly, pharmacies are becoming expensive to buy. They cost about £500,000, and the only way someone can enter the profession is by buying a pharmacy. There is a capacity-todeliver issue at the moment in dental services. Pharmacy may have a capacity issue in the future because more and more young pharmacists are unable to buy pharmacies. The pharmacies will be taken over by bigger
businesses which, as in the Office of Fair Trading’s report, buy locally and then have local monopolies.

The Convener: Two members are waiting to ask questions. I will bring you back in after them.

Mr McNeil: I am keen on developing the role of community pharmacists and getting them back into the communities of which they used to be an integral part. I accept the benefits of competition and the convenience of going to a supermarket, but supermarkets are for people who have cars. Some people are automatically excluded from that choice because they live on estates. I would like to be encouraged to think that pharmacists—or local chemists, as they would be known in my area—will return to such areas. What would encourage them to do that?

A wee bit of explanation of the top of page 3 of the Scottish Pharmaceutical General Council’s submission is needed, because it seems to describe a barrier. I need an explanation of the different methods of provision. The submission refers to the principles of “The Right Medicine: A strategy for pharmaceutical care in Scotland” and talks about delivery

“by a mixture of supported, salaried and managed service provision”.

What are the differences between such forms of provision? What are the pluses and minuses? What will encourage more re-engagement with marginalised communities and allow them the benefits of a local pharmacy?

15:45

Alex MacKinnon: I will go back one stage and touch on out-of-hours access, which is a big issue that we intend to address in the new pharmacy contract and will be part of the planning process of a pharmaceutical care services plan. Some health boards are already piloting creative and innovative ways to improve access and out-of-hours access to pharmaceutical care, which will all be part of the process.

The key strengths of community pharmacy at present are its position in the community, its accessibility and the fact that people do not have to make an appointment with a pharmacist, who can probably be accessed for advice within five or 10 minutes maximum. I have been a pharmacist for 30 years. We truly believe that the only way to make a significant difference to the nation’s health from a pharmaceutical care point of view is to have some services agreed and delivered in every community pharmacy.

I suggest that if we are 100 per cent committed to resolving under-provision in an area, that should not involve a partial contract; the people in such an area deserve more than just part of a service. The point that I have tried to make is that there is concern that if we use different bits of the service to deliver different bits of an overall service package, the people in a deprived area might not receive the full spectrum of pharmaceutical care services. Services such as management, a chronic medication service, a public health service with advice and even diagnostic testing must be delivered where any pharmaceutical care services are provided. We must provide all the services if we want to get rid of postcode inequality in pharmaceutical care for the patients of Scotland.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The questions that arise in my head about competition and the health boards taking over supply of pharmaceutical services relate to the British Medical Association’s concerns about doctors dispensing. Dispensing by doctors is an advantage to patients in rural areas, but the situation is a worry for doctors, who receive an extra fee for dispensing, which is an enhancement that encourages doctors to work in areas to which it is difficult to attract them. I ask somebody to comment on how the proposal will affect dispensing practices.

I also wonder about security. When I started to work in general practice, chemists’ shops were open late, but as security became a problem, fewer chemists have opened late, so people have had to travel considerable distances to obtain prescriptions after a certain hour. That is difficult for people who have no car.

Another advantage to patients relates to prescribing. Some pharmacists are allowed to prescribe in line with protocols and agreements with doctors. I think that some dentists, orthoptists and what have you might also be able to prescribe, but I certainly know that some pharmacists, especially those in rural areas, can already do so. The proposed changes might be a good idea, but what will happen when the pharmacist goes on holiday? Will the service still be provided to the community if the doctor is not available? Will the locum pharmacist be able to prescribe? Has that been considered?

Dr Wallace: I defer to Mary Morton on rural issues.

On access, I hope that opening hours and locations of pharmacies will be considered in the pharmaceutical care services plans. We will need public involvement and engagement in developing those plans; community health partnerships’ patient participation forums could be one of the main ways of engaging with the public on that.

Clearly, more work needs to be done on the core elements of the pharmacy contract and I do not want to second-guess what those should be.
However, as I said, I think that health boards will want a narrow remit for provision of services such as methadone dispensing. We will not want to be constrained to provide the whole service, but we will want to be able to provide a niche service in areas where a contractor cannot meet demand.

Mary Morton: I agree with Iain Wallace’s point about services such as methadone dispensing. My understanding is that, if a dispensing practice can meet the pharmaceutical care needs that have been identified in a rural NHS board’s area, the NHS board would use that practice for provision of those services. I expect that practices that currently provide such services will continue to do so, but the process of deciding who should provide which service will need to be very open. There will need to be a level playing field for all, whether or not that causes discomfort to various individuals. It would certainly cause discomfort to community pharmacists if they felt that a new entrant could threaten their patch, so I can quite understand that there might be some discomfort for dispensing practices. However, we do not yet know the detail of how it all will work. I welcome the flexibility that the new system will provide.

James Semple: I want to reply to Martyn Evans, who made a good point about how local monopolies might previously have resulted in poor service by failing, for example, to provide home deliveries and all the other things that people tend to do when they are competing against each other. However, he has missed the point about the new contract’s fundamental change, which is that we will no longer be paid a piece rate for sticking labels on boxes. Once we start to be paid for delivering quality services, the driver will not be not so much to do things better than the guy down the road but to get paid, because we will no longer be paid simply for sticking labels on boxes. That is why I think that the issue he highlighted will not be a problem any longer.

Alex MacKinnon: On prescribing, I think that pharmaceutical prescribing will be key to the success of the new pharmacy contract. Under the new contract, it is intended that the minor ailments service that has been piloted by Ayrshire and Arran NHS Board and Tayside NHS Board will be rolled out across Scotland. By enabling pharmacists to write prescriptions for products from a national formulary for the treatment of minor ailments of exempt patients, access to medicines for such patients will be improved. We now have more than 200 qualified supplementary prescribers who can work with GPs on certain conditions by amending doses and so on. Supplementary prescribing will also be key to the planned chronic medication service, which will incorporate the model schemes of pharmaceutical care. Our vision for community pharmacy is that, further down the line, we will have independent prescribing pharmacists. That will only enhance pharmaceutical care for the people of Scotland.

Dr Turner: What will happen when pharmacists are on holiday? Has that been worked out—

The Convener: I remind Jean Turner that she is supposed to direct her questions through the chair. She must ask her question in a way that allows the rest of us to hear it.

Dr Turner: Sorry. My question is about what will happen with locums. The prescribing pharmacist might provide a good and effective service on which the community depends but, if the service is specific to a pharmacist, will there be difficulties when he goes on holiday if the locum is not a prescriber? Has thought been given to that issue?

James Semple: That is a good question, which goes back to what we said about national standards. We have to upskill everybody. At the moment, people might have done emergency hormonal contraception training, for example, in one health board, but not in another. Once we get national standards—I speak also as an owner of a locum agency—the locums will have to show what they have done and will be sent only to places where it is suitable for them to work. That can be handled easily.

Martyn Evans: I want to make a point about pharmacies in areas of multiple deprivation and low-income areas. The most important aspect of pharmacies is their convenience. At the moment, pharmacies tend to cluster around general practices, because that is where people get their prescriptions and they want to have them dispensed fairly quickly. We do not believe that having more choice of pharmacies in supermarkets and travel stations will reduce the convenience of pharmacies near general practices; they will still be attractive. The issue is that sometimes a local pharmacy will move out of an area because the GP moves out of the area. Co-location and planning of services are important to us.

Secondly, there are provisions in the bill to relax the requirement for a pharmacist to be present on a variety of occasions, which we think is a more modern approach to pharmacy provision. We accept that there was sense in the pharmacist’s being present in the place where pills were dispensed when, as in the old days, the pharmacist physically made up pills. Now sometimes, if a pharmacist goes away and conducts a short consultation in a private room, dispensing cannot take place, so we think that the bill makes more modern provisions in that respect. Although patient safety will be maintained, the bill will allow greater flexibility in delivery of a modern pharmacy service.
Alex MacKinnon: The new pharmacy contract in Scotland is different from that in the rest of the UK, because it could involve patient registration. The issue of clustering around health centres will not be so important in the future in that the patient will register with the pharmacy of their choice to receive a package of pharmaceutical care.

The Convener: We have heard frequently this afternoon that the devil is in the detail. I do not know whether the devil’s representative wants to make a final comment.

Dr Wilson: You have heard from Chris Naldrett about the regulations and we accept that more detailed work needs to be done. On planning, which was mentioned a number of times, the intention is to produce national guidance on the local planning process. Boards also have a responsibility to plan for primary medical services, so there is therefore the opportunity to ensure complementarity, which is relevant to the point about dispensing doctors, who are not covered formally by the bill but by the Primary Medical Services (Scotland) Act 2004. That has not changed and it is not intended that provision of those services will be affected directly. Indeed, there is an opportunity for the two professions to work together more closely than they have done in some areas in the past.

On supervision, the Medicines Act 1968 determines the nature of, and requirements for, supervision by pharmacists; we are partly dependent on that. On prescribing, the number of healthcare professionals who can prescribe either independently or in a supplementary sense is increasing, which will add to the complexity of the relationships within primary care between community pharmacists and those who are prescribing. The detail must take account of that.

The Convener: I thank all the witnesses for coming and everybody else for participating. That ends our public businesses.

15:59

Meeting continued in private until 16:27.
1st March 2005 (6th Meeting, Session 2 (2005)), Written Evidence

SUBMISSION BY FORTH VALLEY LOCAL HEALTH COUNCIL – MRS MARGO BIGGS

Part of Bill: Part 4

Main Objective: Strengthening disciplinary powers over health professionals

Do you agree with the main objective of this part of the bill? YES

If yes, why?
This strengthening of disciplinary powers is necessary in view of recent events in the NHS (not only Shipman). There is a need to get away from the “old boy network” – patient safety should be the main concern. If something which raises suspicion is noticed by anyone from domestic staff to consultant that person should feel able to report it, therefore a culture of “whistle blowing” should be encouraged.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY THE BRITISH DENTAL ASSOCIATION

Part of Bill: Part 4

Main Objective: Strengthening disciplinary powers over health professionals

Do you agree with the main objective of this part of the bill? Yes

If yes, why?
The BDA supports the roles proposed for the NHS Tribunal and NHS Boards in the Bill, subject to the comments below.

If not, why not?

Not applicable

Are there any other comments you would like to make?

The BDA has no objection to standardising NHS disciplinary procedures, but the legislation does not address how they will relate to the role of the General Dental Council and its Professional Conduct Committee, nor of other professional regulatory bodies. We would be keen to avoid the situation where FHS practitioners might be undergoing at the same time more than one set of disciplinary procedures for the same case. The BDA believes any decisions by NHS Boards or the NHS Tribunal should not prejudice or contradict the role of the Professional Conduct Committee of the General Dental Council.

NHS Boards’ general dental services lists also include Salaried General Dental Practitioners (SGDPs) as well as independent contractor general dental practitioners. SGDPs, whilst covered by the General Dental Service Regulations, are also covered by local disciplinary procedures through their employers. It is imperative this arrangement, and how the two disciplinary procedures will interface, are acknowledged to ensure salaried dentists do not have to undergo more than one procedure.

The BDA hopes the legislative changes would eliminate all the serious shortcomings of the present system and facilitate efficient and expeditious resolution of all disciplinary cases, in the best interests of patients and of practitioners.
Whilst recognising the need to protect patients it is also important that the legislation recognises the rights of practitioners and their rights to appeal.

We feel it is important to emphasise the importance of the responsibility for maintaining the accuracy and confidentiality of any information submitted to NHS Boards and for ensuring the grounds for disclosure of such information are clearly defined.

We feel it is necessary for a legal definition for the new ground for suspension “of protection of the public interest”

SUBMISSION BY BMA SCOTLAND

Smoking, Health & Social Care Bill: Part 4: Discipline

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

Introduction
The BMA welcomes the general principles of Part 4 of the Smoking, Health and Social Care (Scotland) Bill which aims to harmonise aspects of the disciplinary procedures of family health service practitioners and introduce greater measures to protect patients.

Professional regulation
The BMA is concerned that there is no recognition within the Bill, explanatory notes or policy memorandum of the role of professional regulatory bodies such as the General Medical Council (GMC). The BMA continues to work closely with the GMC to create efficient, safe and fair disciplinary procedures for the profession and we would urge the Health Committee to seek assurances that any changes to NHS Tribunals as a result of this Bill will be consistent and compatible with existing regulatory procedures for all of the professions falling under the remit of the NHS Tribunal.

Changes to the NHS Tribunal
The BMA has no objection to extending the remit of the NHS Tribunal to cover all independent contractor health care professions and to introduce procedures that ensure the public interest is protected.

The BMA also accepts the need for the additional ground of disqualification – unsuitability by reason of professional or personal conduct. However, there is a lack of detail on the definition of these new grounds and we would wish to see this clarified within the legislation. The GMC (and other professional regulatory bodies) has clear definitions for such conduct and these could be adapted for use by the NHS Tribunal.

Removing the sanction of local disqualification by the NHS Tribunal would seem sensible in protecting the public interest, and national disqualification would ensure that a family health service practitioner who is unsuitable to practice in one area is unable to practice elsewhere in Scotland.

Summary
This Bill creates an additional ground for disqualification by NHS Tribunals and removes their ability to suspend practitioners locally.

While we support the general principles underlining Section 4 of the Smoking, Health and Social Care (Scotland) Bill, the BMA would like to see greater clarity on the definition of what constitutes “personal conduct” (e.g. conduct which might reasonably demonstrate material harm or threat to patients).
SUBMISSION BY ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN SCOTTISH EXECUTIVE

Part of Bill: Part 4

Main Objective: Strengthening disciplinary powers over health professionals

Do you agree with the main objective of this part of the bill?

The Society is totally supportive of the intention to protect patients from health care professionals who are unfit to practice.

If yes, why?

The Society is the regulatory body for all pharmacists throughout Great Britain and has extensive experience of investigating complaints about individuals and pharmacy companies, and taking appropriate action to protect the public. It fully endorses the functions and responsibilities of a Modern Regulator as set out in the Kennedy Report and is in the process of modernising its disciplinary processes through a Section 60 Order under the Health Act 1999. The extension to the NHS disciplinary processes outlined in the Bill will be complementary to those exercised by the Society, but we have some concerns about their effectiveness, which are outlined below.

If not, why not?

The Bill considerably extends the disciplinary roles and responsibilities of Health Boards and the NHS Tribunal. It is essential that these duties are discharged equitably, efficiently and effectively, and that there are clear links with the disciplinary processes of the professional regulatory bodies including the Royal Pharmaceutical Society of Great Britain. We appreciate that much of the detail will be contained in regulations and guidance, but wish to be assured that the following issues will be addressed.

• Investigation of complaints. The Fifth Report of the Shipman Inquiry was critical of the lack of investigation of complaints against doctors. The Society has a team of 18 Inspectors who regularly inspect community pharmacies and investigate complaints relating to pharmacists and pharmacy services, taking evidence to legal standards. This is an essential component of an effective disciplinary process, but there is no reference to it in the Bill or accompanying documents.

• Timescales for the process. It is important that the stages of the disciplinary process are undertaken within reasonable periods of time, both to ensure prompt action to protect the public and to respect the rights of the health care professional subject to the process. The latter aspect is important given the new power of Health Boards to suspend practitioners pending application to the NHS Tribunal. (Incidentally, paragraph 107 of the Policy Memorandum states, ‘Any practitioner subject to suspension proceedings will have the right to a hearing and, if suspended, will continue to be paid.’ As the majority of pharmacists subject to this process are employees of pharmacy companies or self-employed locums it is not clear who will be responsible for paying them when they are unable to provide NHS services.)

• Consistency of approach. Health Boards will be able to suspend practitioners from their own lists on the existing ground of patient protection and on a new ground of protection of the public interest. The NHS Tribunal will be able to inquire into cases referred under a new ground of unsuitability by reason of professional or personal conduct. These new grounds are very broad and open to wide interpretation. It is essential that clear and specific guidance on these terms is provided to avoid inconsistent application of the process, resulting in inequitable treatment of practitioners and inevitable legal challenge.

• Available sanctions. It is proposed that the NHS Tribunal will have two sanctions available to it: substantive or conditional national disqualification. We suggest that these two alternatives may not be adequate to deal appropriately with the considerably extended range of cases that the Tribunal will have to consider. Cases where a practitioner’s ability is impaired by health problems need particular consideration.
• Linkage with regulatory bodies. Neither the Bill nor the accompanying documents make any reference to the role of the professional regulatory bodies or their disciplinary processes. The existence of two parallel but unconnected systems creates possibilities for confusion and delay and consequent risk to the public. As the regulatory body for pharmacists who will be subject to the revised NHS disciplinary processes in Scotland the Royal Pharmaceutical Society of Great Britain is keen to ensure that this does not occur and that the two systems are complementary. This can be secured through development and implementation of formal Concordats or a Memorandum of Understanding between the Society and NHSScotland. This would set out arrangements for cooperation on disciplinary matters concerning pharmacists, including mutual exchange of information and evidence, and we request that this becomes a statutory obligation through the regulations.

• Cross-border information exchange. We have previously referred to the need for a consistent approach across Scotland and this applies equally to national boundaries. It is particularly important for patient protection that there is an effective mechanism for sharing essential information about the conduct of a health care professional between UK NHS services to prevent individuals disqualified in one country from providing services in another.

Are there any other comments you would like to make?
No

SUBMISSION BY SCOTTISH HAEMOPHILIA FORUM

The Skipton Fund arose only as the result of the campaigning in Scotland by the Scottish Haemophilia Forum, the Motion supported by 80 MSPs from all parties, the unanimous support of the 1999-2003 Health Committee of the Scottish Parliament and the decision of the then Health Minister Malcolm Chisholm who announced to Parliament in January 2003 that he was thinking making payments of £20,000 to those infected with Hepatitis C as the result of Blood Products or Transfusions.

Sadly since then, the work of the Scottish Parliament appears to have been hi-jacked by Westminster. On the 29th August 2003 Malcolm Chisholm announce that he would be making ex-gratia payment of £20,000 and a short time after this John Reid Health Minister announced that the Westminster Parliament would follow Scotland’s example. Regrettably this announcement stated that the dependants of those who had died prior to 29th August 2003 would be excluded.

Following the announcement three meeting were held in London the first on the 14th October 2003 at the Department of Health Offices in Skipton House (thus the Fund has been named after a building rather than acknowledge the role of Scotland). These meeting consisted of a senior civil servant from each of the four countries of United Kingdom, the Chief Executive of the Haemophilia Society and myself as Chairman of the Scottish Forum, the Chief Executive of the MacFarlane Trust and representatives from two other organisations.

At this first meeting despite requests that a minute of the meeting be taken this was resisted by the civil servant from the Department of Health who undemocratically took the role of chairman.

From the onset it was apparent that there had been a dialogue prior to the meeting between the civil servants from the Department of Health and the Chairman and Chief Executive of the MacFarlane Trust thus the meeting was faced with a fait accompli that the MacFarlane Trust take on the responsibility of administering the now to be known as the Skipton Fund. At this meeting about two hours were spent on draft application forms that had been prepared by the MacFarlane Trust!

Prior to the next meeting which was held on the 26th March 2004 the Skipton Fund had been registered as a private company and without consultation had appointed four directors all who were trustees of the MacFarlane Trust. At this meeting there again was a request that minutes be taken given that there was a need of a record and an understanding how decisions would affect applicants.
The final meeting to my knowledge was held on the 17th May 2004. At this meeting notes relating to the meeting of the 26th March 2004 were circulated but the chairman was not open to questions regarding inaccuracies. It is our opinion that these notes were only made available as the result of a question raised by a MSP in the Scottish Parliament. Unfortunately no notes have been circulated in respect of this meeting.

It is our understanding that other meetings took place during the same period these consisted of Hepatologists (liver specialists) the Haemophilia Society at short notice was asked to nominate a Haematologist (blood specialist) it is uncertain whether this consultant attended more than the first meeting. We are uncertain whether there has been any meaningful consultation with the United Kingdom Haemophilia Centre Directors Organisation (UKHCDO) and the Government Departments drawing up the proposals for Skipton.

**Issues of Concern**

We have grave concerns regard the proposals regarding the “Appeal Panels”.

It is uncertain whether the proposal in the next paragraph, regards Appeal Panels, announced had been made by Government or the Skipton Fund!

“The Appeals Panel would be constituted and convened consistently on each occasion that it met or deliberated on cases. The Panel would be Chaired by a legal professional such as a QC, and consist of lay representatives, a lawyer, a GP and a hepatologist. We expect the Appeals Panel to meet on a quarterly basis (at least for the first year or two) before a review of how the process has been working is carried out.”

1) Why is there a need to set up a private Company limited by guarantee given that its function will only be to administer the Fund by sending out application forms, making payments based on a set criteria and rejecting others?

2) Given that Skipton will be funded by public finance, why is it not part of a Government Department thus ensuring that a Minister be politically responsible and answerable to elected members?

3) As a Private Company funded by public finance, how and who will monitor the Fund?

4) Why has the money provided as an ex gratia payment, to people infected with Hepatitis C through NHS Blood, being used to pay the staff of Skipton?

5) In the event of an Appeal Panel being set up how will the panel members be funded?

6) In other situations where a person has been refused a payment by for instance Disability Living Allowance by the Department of Works and Pensions, the Appeals Panel are appointed independently by the Department for Constitutional Affairs and funded by the Appeals Service.

7) Membership of the Panel, why a GP rather than a haematologist, given that most of the appellants will have been recipients of blood transfusions or products.

8) Generally the majority of patients, seen by hepatologists involved in the field of Hepatitis C are due to a choice of life style. (Scottish Executive statistic state that there are 568 people in Scotland infected with Hepatitis C as the result of Blood) Therefore some concern has been voiced.

9) Will all members of the Appeals Panel be recruited in the same way?

10) Will the legal members be recruited acknowledging different legal systems in the UK?

11) Will there be recognition that lay member should have an understanding of the issues and experience of Hepatitis c. Rather than paid professional staff?

12) Where will Hearings take place?

13) Will the appellant be able to attend?

14) If the Hearings are being held for instance in London will appellants have their expenses met?

15) Will the appellant be able to have legal representation and who will meet the cost?

16) What expenses will be paid to Panel members and who will meet the cost?

17) How will appellants obtain expert opinion to challenge the decision of the medical panel?

18) Will all the documents used by the Skipton Fund in reaching a decision be made available to the appellant?

We note that within Part 5 of the “Bill” Section 24 sub section 5 “The Scottish Ministers may revoke or amend a scheme under this section” We would urge the Committee to recommend to the
Minister that the proposed figure of £50,000 recommended by the Scottish Executive’s Expert Group chaired by Lord Ross should substitute the proposal of £20,000 by Skipton.

We would urge the Committee to amend the “Bill” and remove the discrimination refusing payments to the dependants of those who have died prior to the 29th August 2003.

There are several concerns regards how different Consultants may deal with application to Skipton resulting in long delays for those who have applied.

We also are aware that some of the tests proposed to determine whether an individual meets the criteria for the second stage are flawed.

As previously mentioned we believe that the medical membership of the Appeals Panel should be a haematologist rather than a GP.

Philip Dolan
Chairman – Scottish Haemophilia Forum

SUBMISSION BY SKIPTON FUND

Skipton Fund is the company that has been established to administer the hepatitis C ex gratia payments scheme (“the scheme”) on behalf of the four health administrations.

The company was set up under the auspices of The Macfarlane Trust ("MFT"), which is a charity that was founded in 1987, funded by the Department of Health, to provide support to people with haemophilia who were infected with HIV through their treatment by the National Health Service. Some time after the announcement on 29 August 2003 of the scheme, MFT were asked by the Department of Health ("DoH") whether they would be prepared to administer the scheme. In December 2003 the Trustees of MFT agreed to do so, subject to certain conditions, and proceeded during the early months of 2004 to work closely with officials from the DoH and the devolved administrations to design both the operating procedures of the scheme and the administrative vehicle.

Because the scheme was not a charitable activity, MFT could not directly undertake the task. A company limited by guarantee, Skipton Fund Limited ("Skipton"), was, therefore, set up as the most appropriate entity. In the interests of speed of implementation and, subsequently, of operation, and in order to make best use of the expertise of MFT in handling such a task, four directors were appointed who were Trustees of MFT, two of whom were appointed as such by DoH and two by the Haemophilia Society.

Following protracted development with the four health administrations of operating procedures, in particular the criteria for determining eligibility for receiving payment and an application form to ascertain for each applicant whether these criteria had been met, Skipton started operations on 5 July 2004. The choice of this date shortly before the summer holiday season led to some early operational difficulties, which were overcome in the autumn. Activity in Skipton is now running at a low rate.

Skipton is now staffed by an Administrator, Keith Foster, and one other staff member. All Skipton’s payments are made through the finance department of MFT, using proven systems. Frequent progress reports, of which the attached is the latest, are supplied to the officials of the four health administrations.

The scheme provides for payments of £20,000 (Stage 1) to those who meet the medical criteria that show infection through NHS treatment, and for subsequent payments of £25,000 (Stage 2) to those who infection has led to serious liver disease. The statistics show that there have been a small number of Stage 1 applications declined, some (137) because they do not fall within the scope of the scheme (and are not, therefore, eligible for appeal) and some (45) because of doubts that the medical eligibility criteria have been met (as when, for example, an applicant has a history of intra-venous drug abuse that might have been a source of hepatitis C infection). Payment on
very small number of Stage 2 applications has been deferred because the existence of serious liver
disease cannot yet be proven; such applications can be re-submitted when further evidence of
such disease is found.

An Agency Agreement is close to completion which will formalise the contractual arrangement
between Skipton and the DoH (on behalf of the devolved administrations). An appeals process is
also being developed.

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<tr>
<th>Skipton Fund Position 14/2/05 (4/2/05)</th>
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<tbody>
<tr>
<td><strong>Stage 1</strong></td>
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<td>Application forms dispatched</td>
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<td>Paid</td>
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<td><strong>Stage 2</strong></td>
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<td>Application forms dispatched</td>
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<td>Paid</td>
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<td><strong>Wales</strong></td>
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<td>Application forms dispatched</td>
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<td>Paid</td>
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<td><strong>Scotland</strong></td>
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<td>Application forms dispatched</td>
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<td>Paid</td>
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<td><strong>N Ireland</strong></td>
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<td>Application forms dispatched</td>
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<td>Paid</td>
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<td><strong>and including MFT</strong></td>
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<tr>
<td>Application forms dispatched</td>
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<td>Paid</td>
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<tr>
<td><strong>Declined (Stage 2 deferred)</strong></td>
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<td>Application forms dispatched</td>
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<tr>
<td>Paid</td>
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<td><strong>natural clearers</strong></td>
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<td>on medical criteria or infection date</td>
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<tr>
<td>Application forms dispatched</td>
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<tr>
<td>Paid</td>
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<tr>
<td><strong>Applications with queries</strong></td>
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<tr>
<td>Application forms dispatched</td>
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<td>Paid</td>
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<td><strong>Total completed applications received</strong></td>
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<td>Application forms dispatched</td>
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<td>Paid</td>
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<td>(Applications received as % of forms posted)</td>
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<td>Application forms dispatched</td>
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<td>(Paid as % of forms received)</td>
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<td>(Declined/deferred as % of forms received)</td>
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<td>Application forms dispatched</td>
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<td>Paid</td>
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<td>Stage 2 application forms despatched as % of Stage 1 forms received</td>
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We continue to issue about 7 registration forms and about 20 Stage 2 application forms per week.

KJF 14/2/05
Smoking, Health and Social Care (Scotland) Bill: Stage 1

14:04

The Convener: Item 3 on the agenda is continuation of our evidence taking on the Smoking, Health and Social Care (Scotland) Bill. Today we will hear oral evidence on two aspects of the bill. We will consider part 4, which deals with discipline, using the same round-table format as we used last week. When we take evidence on part 5, which deals with infection with hepatitis C as a result of national health service treatment, we will use the standard format of witness panels to which we are more accustomed.

The witnesses for part 4 are already at the table with us. At the outset, I inform them that witnesses who are called to give evidence by a committee are entitled to claim travel expenses. Does the committee agree to delegate to me authority for deciding whether any claims that arise from stage 1 consideration of the bill should be paid?

Members indicated agreement.

The Convener: As I said, the first session today will be in round-table format. I thank all the witnesses in advance for participating. I draw everyone’s attention to the paper that introduces the round-table approach and sets out how it will work. Members saw it at work in practice last week. The committee papers include background papers from the Scottish Parliament information centre on part 4 and all the written submissions, both from people who are present and people who are not here.

I invite the Executive officials to outline briefly the main provisions in part 4. Dr Hamish Wilson is head of the primary care division and John Davidson is from the workforce and policy division’s general medical services team.

Dr Hamish Wilson (Scottish Executive Health Department): At the moment, the National Health Service tribunal is the ultimate disciplinary body within the national health service for general practitioners, dentists, pharmacists and opticians. The tribunal’s main sanction is to disqualify a practitioner from membership of the list that the health board holds for his or her profession. It also has a power of suspension, pending the outcome of any case.

I will outline the main changes. The bill introduces a third ground for disqualification, in addition to those relating to efficiency and fraud—namely, unsuitability by reason of professional or personal conduct. Section 22 brings within the tribunal’s jurisdiction additional categories of persons, in particular those who assist with the provision of general dental services and general ophthalmic services, dental corporations, persons who perform personal dental services and registered pharmacists. That change follows on from the changes to listing, which were discussed a week ago.

Section 22 also removes the sanction of local disqualification and leaves only national disqualification at the hand of the tribunal. At present, the tribunal can only disqualify someone locally. The view was taken that that was inappropriate and that, if a disqualification were necessary locally, it would also be necessary on a Scotland-wide basis.

Section 22(7) introduces a new ground for suspension, when it is “otherwise in the public interest”.

Section 23 updates the provisions by allowing decisions that are taken elsewhere in the UK to be applied to Scotland.

The Convener: I ask the two patient representatives to comment specifically on part 4. Stewart Scott is the chair of Borders local health council and Margo Biggs is a member of Forth valley local health council.

Margo Biggs (Forth Valley Local Health Council): We welcome the new ground for disqualification. Our primary concern has always been about the linkage of information, so that incidents can be reported timeously and dealt with accordingly. That is my main comment.

Stewart Scott (Borders Local Health Council): We have heard what Dr Wilson said. We are talking about practising 21st century health care. There is no doubt that we need to match that with 21st century legislation that enables clear and unambiguous approaches to dealing with issues of suspension and discipline of all professional groups that are involved in health care. The public expect no less.

The proposals in part 4 provide a good basis for proceeding to amend and strengthen the disciplinary powers of boards and tribunals. Gone are the days when the majority of patients were passive recipients of health care, and there is a need for more active involvement of the public in decisions about disciplinary matters. I do not come from a medical background, but I wonder whether appraisals of general practitioners and others might be a good way of highlighting any shortcomings in their clinical skills or methods of practising. I do not see any mention of appraisals in the papers, but GPs are taking on board that new approach and they might well be a useful way of picking up on problems much earlier and allowing earlier progress to be made, rather than picking up on them later, when the damage has
been done. We all know the benefits of that.

The Convener: We move on to the witnesses from the various professional bodies. Dr Love might be the appropriate person to respond to Mr Scott’s comment on appraisals. With us are Alex Mathewson, who is north branch representative from the British Dental Association Scottish council; Dr David Love, who is deputy chair of the British Medical Association Scottish council; Hal Rollason, who is chairman of Optometry Scotland; and Angela Timoney, who is chairman of the Scottish executive of the Royal Pharmaceutical Society of Great Britain.

I ask the four professional representatives to make specific comment on the bill, and I ask Dr Love to address Mr Scott’s specific concern.

Dr David Love (British Medical Association Scotland): Generally, the BMA has no objections to the Smoking, Health and Social Care (Scotland) Bill. We acknowledge the need for the new category of professional or personal conduct to be introduced. There have been instances in which persons who were clearly unfit to practise were not covered by the existing categories, so we accept the need for the new category. We also accept that it is common sense to drop the option of local disqualification and to ensure that disqualification applies nationally.

We have only one major concern, and that is the lack of a definition of professional or personal conduct. The policy memorandum states that the ground will apply if

“a practitioner has been convicted of an offence, the nature of which suggests he or she no longer deserves the trust which is necessary”.

That is quite right, but the way in which the bill is written makes the ground a wide-ranging catch-all that could be abused and misinterpreted. It is terribly important for subsequent regulations and guidance to make it clear to both the profession and the tribunal what sort of professional or personal conduct could lead to disqualification of a GP’s right to earn a living, which is a severe sanction.

We also note that there is no reference to the professional regulatory body of GPs, which is the General Medical Council. It would be sensible for subsequent regulations and guidance to be compatible with current GMC guidance on what constitutes unsatisfactory professional or personal conduct, which I realise might change in the light of the review that is taking place following Dame Janet Smith’s inquiry into Shipman.

In response to Mr Scott’s particular question, GP appraisal as it is currently modelled and practised in Scotland is a formative educational exercise between the appraiser and the appraisee in which a doctor identifies priorities for learning in the following year and the appraiser assesses progress and compliance with that learning plan in succeeding years. It is not primarily a method of detecting poor performance or underperformance. If poor performance is thought to be an issue during appraisal, the appraisal process stops and the GP concerned is referred to the performance procedures that are in place at health board level, which might lead to referral to the tribunal. Therefore, appraisal is not the vehicle for instigating disciplinary procedures.

I say that with the large proviso that the whole business of appraisal and revalidation is being re-examined on a United Kingdom basis. The chief medical officer is examining the matter in England, as a result of the Shipman inquiry, so the GMC might change its position on the requirements for appraisal and revalidation in future.

14:15

The Convener: Mr Scott will have an opportunity to respond, but first we will hear from the other three professional representatives.

Hal Rollason (Optometry Scotland): I apologise for not submitting comments on tribunals earlier. I submitted a response from Optometry Scotland yesterday, but I understand that the committee will not have had a chance to consider it yet.

Optometry Scotland and the General Optical Council replied to the Scottish Executive consultation last June and broadly supported the Executive’s proposals. In the response that we submitted yesterday, we state:

“Optometry Scotland welcomes the harmonisation of disciplinary procedures of family health service practitioners, and as you would expect, we are firmly committed to the concepts of improving patient protection and optimizing NHS resources.

In general OS supports the future role envisaged for the NHS Tribunal but thinks that the policing of these proposals may be difficult. Consideration must also be given to the place of trainees and students since these people also have close patient contact.

OS does agree that all the primary care professions should be included in whatever scheme for fitness is produced, but there should be a realistic assessment of a practitioner’s risk profile. The various family health service practitioners will have very different degrees of patient contact and opportunity to cause harm to those patients. The Tribunal when assessing any one practitioner’s risk to the patient or the NHS must take this into consideration.”

The Health Committee might want a copy of the submission that the GOC made to the Scottish Executive consultation. Yesterday I was in contact with the registrar, who has sent a note to the Scottish Executive that it will pass on to the committee shortly.

In our response to the committee, we also say:
"It might be extremely difficult to decide whether a person is a fit person following a conviction that does not result in a successful prosecution. It may be more appropriate for the National Regulatory bodies to be the arbiter and take responsibility for the character of their registrants. It may be more appropriate for Health Boards to refer suspected people to the regulatory body rather than to a whole new system of investigation. This would give a consistency of approach throughout the UK."

We have some specific reservations. One relates to paragraph 107 of the policy memorandum, which suggests that, while a practitioner is suspended, they will continue to be paid. However, if an optometrist is unable to work, he cannot generate any income and so cannot be paid. That is a slight difficulty.

Another reservation concerns paragraph 114 of the explanatory notes, which states that a body corporate may be suspended or disqualified on the grounds of fraud or unsuitability. I understand that that is already the case, but we think that it is slightly unfair. In our response to the committee, we disagree with the proposal and argue:

"Each situation would need careful investigation before making a decision, as it would be unfair to punish an entire organisation for the act of a single individual"

in that organisation. The submission continues:

"A corporate body may have a large number of practices" and a few directors,

"but could be disqualified in total, based on the actions of one or two people. The actions of one individual may be unknown to anyone else" in the company

"or may be malicious in their intent."

In conclusion, we state:

"OS would not support an extra layer of administration if it duplicates tasks already performed by the National Regulatory Bodies, or which such bodies could easily assimilate."

However, we understand that the tribunal is concerned specifically with NHS issues and that the regulatory bodies deal with all issues.

As Margo Biggs said, there need to be clear lines of communication between the national regulatory bodies and the NHS tribunal. We think that it is important and advisable that the family health service practitioner groups are closely involved in any policy development or review that follows on from this.

**Angela Timoney (Royal Pharmaceutical Society of Great Britain):** This is a good time for pharmacy. A lot of changes are happening in the profession. "The Right Medicine: A strategy for pharmaceutical care in Scotland" has been in place since 2002 and the profession supports that strategic direction and the new services that are now being delivered.

It is the view of the Royal Pharmaceutical Society of Great Britain that parts 3 and 4 of the Smoking, Health and Social Care (Scotland) Bill are inextricably linked.

The society is the professional and regulatory body for pharmacists. That dual role is unique in the health care profession. It means that we have responsibility for pharmacists’ undergraduate training, their entry onto the register, standards of practice and assessment of competence. If things go wrong, we are able to identify that at an early stage and provide support, which picks up on the point that the Borders local health council representative made. Where that is not successful, disciplinary proceedings and the ultimate sanction of removal from the register might result. The society has more than 150 years’ experience of providing both regulatory and professional input.

As I have said, our view is that parts 3 and 4 of the bill are linked. Last week, when the committee discussed part 3, which deals with pharmaceutical care services, many people around the table stated that there is a need for nationally agreed standards to ensure that there is not inequity in the provision of services across Scotland. The society has extensive experience of setting standards and of developing practice guidance, and we would like to be involved in that and in developing and commenting on the regulations. It is our view that the next stage is then assessing competence against those standards. Part 4 would apply where there are problems with monitoring those standards, as it relates to the disciplinary proceedings that might be involved.

The society is totally supportive of the intention to protect patients from health care professionals who are unfit to practise. We endorse the functions and responsibilities of a modern regulator that are set out in the Kennedy report and are modernising our disciplinary processes through a section 60 order under the Health Act 1999. The Kennedy report talks about the functions of a modern regulator as being not simply to deal with discipline and sanctions but to deal with proceedings from undergraduate training right through, to ensure that, at every stage, people are fit to practise and that, when things go amiss, corrective action is taken at an early stage.

We feel that the NHS disciplinary procedures that are outlined in part 4 will be complementary to those exercised by the society and that there should be clear links between the NHS tribunals and the regulatory bodies so that those duties can be discharged effectively and efficiently. We have an inspectorate within the society that inspects community pharmacies and checks to ensure that they meet professional standards and have safe systems of work. It also responds to complaints, so we are both proactive and reactive in our responses to problems in the profession.
In undertaking that work, inspectors know at an early stage when something is amiss and can intervene on behalf of patients and pharmacists. It is our view that the regulations that follow the bill will need to ensure that there are two-way links between the NHS and the society, so that we can deal appropriately with professionals.

The timescales involved in such processes are another reason why that is important. It is necessary to have streamlined and efficient processes to ensure patient safety and to protect professionals. The committee might be aware that, last week, the English Minister of State for Health announced plans to tackle the cost of long, drawn-out disciplinary procedures for doctors and dentists in England, following a Public Accounts Committee report that suggested that the cost was around £40 million, because of the costs of legal fees and of paying people when they are suspended. It is important that the detailed and complex disciplinary systems and procedures are effective and efficient.

We have a busy agenda so I will conclude. We express our support for taking forward NHS tribunals, but the society wants to work with the committee on parts 3 and 4 of the bill to ensure that the regulations work effectively for patient safety.

Alex Matthewson (British Dental Association Scottish Council): I promise members that there has been no collusion with the other people at the table, but the committee will see from the British Dental Association’s submission that we also agree with the general principles of the bill and the part about discipline. There is no harm in going over the issues again. The reason why we like the bill is that it will strengthen the disciplinary powers, because we have no truck with underperforming dentists or people who are a disgrace to our profession. We realise that there are some anomalies just now that the bill will iron out.

We are unhappy about one or two things. The professional conduct committee of the General Dental Council is already looking into areas where discipline is necessary. There should be some mechanism whereby the tribunal and our professional bodies can work together in harmony.

We are pleased about the removal of local disqualification. We feel that disqualification should be national.

The power of suspension is an interesting one. The policy memorandum refers to “protection of the public interest”.

There is a need for a definition to go along with that. We know that the General Dental Council has a strong definition on that area of indisceipline and malpractice. Some extra words are necessary in the bill.

One or two witnesses have referred to the fact that, according to the policy memorandum, “Any practitioner subject to suspension proceedings will have the right to a hearing”— which is fair— “and, if suspended, will continue to be paid.”

General dental practitioners are paid on an item-of-service basis. If they do not work, they do not earn, so that has to be clarified.

We understand the measures on removal from dental board lists. However, we are concerned that the confidentiality and accuracy of reports should be maintained and ensured in case of innocence. We are almost talking about people already being guilty. We want to ensure that when a spurious allegation is made against a doctor or a dentist and the matter is all cleared up, no aura of suspicion hangs over them.

The Convener: Before we move on to the open session, I ask Mr Davidson whether he has anything to say about the payment of opticians and dentists while suspended because, clearly, both professions have an interest.

John Davidson (Scottish Executive Health Department): Suspension was introduced for doctors, dentists and so on in about 1996. At that time, we introduced the principle that, if a practitioner was suspended, he would continue to receive his net income from the health board. The provisions for that applied only to the classic example of a principal GP but, clearly, we can build on that principle and try to ensure that anyone who is suspended receives their net income. We will consider that.

The Convener: The issue comes down to who pays the net income.

Hal Rollason: There is no net income if we do not work. There are no capitation fees or anything like that for optometrists.

John Davidson: We stated that a GP’s income would be preserved as far as possible. We would take into account the fact that he did not have any practice expenses during the time he was suspended. That is why we used the expression “net income”. We consider that the health board will ultimately pick up the cost, because it is the health board that decides to suspend.

The Convener: Does that clarify things for the dentists and opticians?

Alex Matthewson: Not really, because “net income” does not carry much meaning for me. As a general dental practitioner, I have vast expenses that I have to continue to pay, even though I am not working.
Hal Rollason: The same applies to me. I work with a pre-registration trainee optician—if I do not work, they do not work and nor do any of the other practice staff.

14:30

Dr Wilson: There is no disagreement about the principle that while somebody is suspended, they should continue to receive an income. The practical problem that we face with some contractors is determining what exactly the income should be, because normally they earn their income in a particular way. One can consider a practitioner’s historical earnings to determine their average earnings. As with some other issues, practical work needs to be done to follow up the matter. We need to work out with the individual professions a fair way of remunerating suspended practitioners.

Angela Timoney: I am pleased to hear what Dr Wilson says because pharmacy has a particular problem. As the committee discussed at its previous meeting, we have pharmacists who are contractors, but who employ pharmacists within a pharmacy. For instance, Boots has employee pharmacists. If an employee is suspended by the NHS, it would not seem reasonable in many situations for Boots to pay. We need discussions about appropriate remuneration for such people.

The Convener: Clearly, the issue needs to be resolved.

Members have more general questions. Shona Robison wanted to ask about professional conduct.

Shona Robison (Dundee East) (SNP): I am particularly interested in the comments from Margo Biggs of the Forth valley local health council, who is sitting beside me. Her written evidence mentions the

“need to get away from the ‘old boy network’”

and states that

“patient safety should be the main concern.”

I am sure that we all agree with that.

Margo Biggs continues:

“If something which raises suspicion is noticed by anyone from domestic staff to consultant that person should feel able to report it, therefore a culture of ‘whistle blowing’ should be encouraged.’

Obviously, the bill has limits and it may not achieve that culture, but will it go some way towards allaying those fears? More generally, what needs to happen beyond the bill to achieve that aim?

Margo Biggs: The bill will improve matters by helping to create a culture in which causes for concern are shared and in which it is not felt that, by bringing concerns to public attention, a person is in some way being disloyal to their profession. Dr Love mentioned Dame Janet Smith’s Shipman inquiry. One of her suggestions was that patients should be asked to comment on their level of satisfaction at various stages of their treatment. That would improve matters further. It is all very well with hindsight after Shipman to raise issues such as the concerns that relatives may have felt at the time, but patients and carers must be more involved throughout treatment.

We also need more robust record keeping, to which I alluded previously. Another suggestion in Dame Janet Smith’s findings was that health boards should have robust databases through which people, including patients, would be able to access practitioners’ track records. That sets alarm bells ringing because it is similar to league tables in education and because people may make judgments on false bases, but we must have more transparency and more of a culture in which concerns are not seen as a betrayal of colleagues.

Shona Robison: What do the representatives of the Executive say on the general point about how patients and the public fit into disciplinary matters? I know that it is a difficult area, and that there is a balance to be struck, but the same point was made earlier by the representative from Borders local health council, who was talking about the involvement of the public in disciplinary procedures. Is that something that the Executive has considered? If so, what form could that take?

Dr Wilson: I would separate complaints from discipline as the two procedures are separate in Scotland. You will be aware that a revision of the complaints procedure in Scotland is already under way, which would strengthen the role of organisations such as the successors to health councils in the investigation and pursuit of complaints. That may itself be subject to review, depending on the outcome of Shipman 5. Work is already under way on modernising and making more effective the complaints procedure.

If a case comes to discipline at health board level, the discipline committee that hears the case—which will be heard at a health board that is not the health board where the offence may have taken place—will consist of lay people as well as professional people. There is already involvement there. On an NHS tribunal, one of the three members is a lay person: its chairman is a legally qualified individual, there is a member of the profession and there is a lay member. Lay members are actively involved in the formal procedures. As Margo Biggs and Stewart Scott said, significant effort is made at local level to catch problems early, so that we avoid going down the discipline route wherever possible.
As Dr Love will know, work was carried out two or three years ago on poorly performing doctors, which resulted in a procedure that allowed for earlier identification of problems, much of which comes from information provided by patients. That procedure is implemented in such a way as to avoid going down the discipline route and to provide help and support to the individual practitioner, so that problems do not escalate and become disciplinary matters.

Shona Robison: Does that happen routinely, or were you referring to a specific case?

Dr Wilson: A procedure is now in place.

Shona Robison: Will that be applied consistently in every case?

Dr Wilson: Yes—where poor performance is identified. Dr Love referred to that in his remarks on the appraisal system, which is separate but parallel.

Hal Rollason: Optometrists probably work at the most retail-oriented end of the health service. Many optometry companies send out questionnaires in which one is asked to gauge on a 1-to-10 basis how good the test was, what explanations were given, what happened and what the handover to the dispensing optician was like. We might not want to go down a wholly formal, league-table version of that with information being collated by the health board, but I see no reason why doctors, dentists or other health professionals could not do the same.

The Convener: Surprise, surprise—Dr Love wishes to come in at this point.

Dr Love: One of the major requirements under the new GP contract is to carry out a patient survey, part of which involves feedback on the doctor’s performance. The surveys solicit feedback from, on average, 50 randomly selected patients who are seen in normal surgeries. A validated questionnaire is used—it is independently analysed—which is retained by the GP and put in the revalidation folder, after which it will be examined as part of the appraisal and revalidation procedures. It is all beginning to happen.

A point was made about information on individual doctors being more readily accessible. That recommendation was about the General Medical Council’s database, not health board databases. It was felt that the GMC should make it much clearer what doctors’ past records were and what information the GMC holds on them.

Alex Matthewson: To put Mr Scott’s mind at least partially at rest, there are already two routes to looking after the concerns of the patient as far as the dental profession is concerned. One is through health boards, which have dental practice advisers who do practice inspections, which could involve an assessment of cross-infection control, of the premises or of record keeping. In other words, anything that "would seriously compromise or disrupt the efficient delivery of local health care"

could be looked into at local level.

Secondly, the dental part of the practitioner services division has district reference officers who assess five cases on the basis of the quality of the work that was delivered. Put very simply, patients are asked how the dentist did. If the dentist’s work does not pass muster or if there is one bad reference, that triggers a series of five or so inspections. I should point out that the references are graded 1 to 4, where 4 is the worst. If there is a 4, the matter could be referred to the General Dental Council and disciplinary action could result.

Mrs Nanette Milne (North East Scotland) (Con): If I have understood things properly, the witnesses believe that the NHS tribunal and the professional regulatory bodies need to work together in a complementary way instead of duplicating one another’s work. In its submission, the Royal Pharmaceutical Society of Great Britain says that such an approach

"can be secured through development and implementation of formal Concordats or a Memorandum of Understanding between the Society and NHS Scotland."

I wonder whether Ms Timoney would care to elaborate on that statement, and whether other witnesses think that that would be the way forward.

Angela Timoney: In my introduction, I mentioned that our inspectors visit every community pharmacy and check the premises and professional standards. That enables us to identify at an early stage whether there are problems.

A memorandum of understanding between the society and the NHS would allow us to have an agreement about what information could be exchanged when moving from a support function to concerns and disciplinary issues. Such an approach would protect patients and allow us to have more efficient processes. Because NHS tribunals rely on patient complaints, other concerns might not come to the surface or result in a complaint. For example, when we investigate certain matters, on the one hand we need to find an appropriate way of feeding into systems and, on the other, the NHS must give us certain information. After all, as other witnesses have pointed out, we are dealing with people outside the NHS as well as people within it.

Mrs Milne: How does that fit with the thinking of the other professional bodies?
Dr Love: I am not certain that most cases will reach tribunals via complaints. Although that might happen, many cases could arise as a result of court convictions. However, the anxiety is that no one knows what is meant by the phrase “by virtue of professional or personal conduct” in the bill. The tribunal and practitioners have to know what it means, and we are simply flagging up that most of the professional regulatory bodies already have fairly copious guidance on what constitutes satisfactory and unsatisfactory professional and, indeed, personal conduct. In fact, the GMC produces a constant stream of booklets that we are all meant to read. They are usually very helpful and set out a clear framework of what is or is not acceptable. We need to link that guidance with the regulations that will guide tribunals.

The Convener: Perhaps the Executive officials can tell us about the definitions of misconduct.

Dr Wilson: I confirm Dr Love’s point that we see the need to be more specific in guidance about some of the words that are used in the bill. That said, I must point out that some of those words are consistent with the text of legislation south of the border. No definitions have been needed in that regard; moreover, professional regulatory bodies also provide a good deal of background information. We intend to produce guidance that will follow through the bill’s enactment and provide clear examples of professional and personal misconduct, public interest and so on.

14:45

Mrs Milne: I would have thought that the last thing that we need is duplication of all the books that the British Medical Association brings out. It will be good if the regulations make the system simpler so that there is clear understanding and no duplication. Have the other witnesses anything to say?

Hal Rollason: I agree. We want to avoid duplication of tasks, and it is important to share information. Optometrists think that they are onerously dealt with by their regulatory body, compared to some of the other professions. That is just a personal opinion, which the body knows about. The most important things are sharing of information and protection of the public.

Alex Matthewson: There is a burgeoning industry in all things concerned with standards: NHS Quality Improvement Scotland has just brought out a draft standard of dental practice. The re-accreditation and revalidation that is required every year to be a practising dentist is getting more and more onerous. Various amounts of postgraduate work—for more than used to be the case—must be done every year and we still have practice inspections that examine everything from our hepatitis B status to the nature of our toilets. We are being examined all the time and, a bit like the optometrists, we feel that we are being spied on on every corner and that it is not possible to get away with anything nowadays, although that is as it should be.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): There is a crossover in what you were talking about. I was going to go into the details of the provisions on unsuitability by virtue of professional or personal conduct, but we have discussed that. The Scottish Pharmaceutical General Council suggests in its submission that “unsuitable to be on the list” would be a better phrase. In some ways, that seems to me to be vague as well, although the SPGC’s criticism of the other wording was that it was too broad and open to interpretation.

How much are the witnesses worried about the workforce? Perhaps enough optometrists are working to cover all the hoops that they have to go through nowadays. How concerned are you about having sufficient people to cover all the extra postgraduate work that has to be, and is, done and about the fact that young doctors and pharmacists who are in training will be open to disciplinary proceedings and might be making mistakes? Will you elaborate on that? It has a bearing on future recruitment, because people might be scared to work in a profession that is unclear about how it labels people as being unsuitable. How would that work out?

Hal Rollason: There is no workforce problem with optometry, which is attracting a good number of entrants to all the universities that provide the course. Optometry Scotland has felt for some time that students and pre-registration trainees should be covered for their own and patients’ protection as much as anything else, so we have no issue with that. We are pretty well regulated. Optometric advisers—who do regulatory work on the submissions that we make for payment—work locally for health boards and NHS National Services Scotland, which used to be called the Common Services Agency. Workforce and regulation are not problems.

Angela Timoney: I will speak on behalf of pharmacists. We do not have a problem with people being interested in becoming pharmacists or with recruiting to the profession, and the calibre of people that we want to recruit should want to be regulated and to practise to the highest possible standards. I have no concern about that, but the RPSGB has codes of ethics and practice, and I would be concerned about duplication. I would like it to be the case that what the RPSGB considers
to be appropriate personal and professional conduct meets the standards that the NHS tribunal sets so that pharmacists do not have to go down parallel tracks and so that there is no dubiety between the two sets of standards. Therefore, we need to work together on developing the regulations to make them efficient.

**Dr Love:** Can I comment on doctors and training? There is an issue about the regulatory process in respect of weeding out unsuitable people before they do damage. There is also a debate about whether the GMC should extend its remit to undergraduates; however, clearly that is nothing to do with the bill. There is a workforce issue about increasing appraisal procedures, which involves a large number of doctors taking time away from patient contact and carrying out appraisals on another large number of doctors who also have to take time out from patient contact. Appraisals are worthwhile exercises, but there is a service delivery problem that has not been played into the workforce calculations—certainly not for GPs.

**The Convener:** There has been quite a lot of discussion about the existing regulatory bodies and the new system. I wonder whether Dr Wilson or Mr Davidson can tell us what are the links between the new system and the regulatory bodies.

**Dr Wilson:** It is an opportune time to consider the matter. All the national regulatory bodies have been reviewing their own procedures and how they operate—not just because of Shipman, but because of a series of other factors. We want to ensure that the system is fair to patients and to practitioners, so the proposals that have come from all the professional bodies for harmonising procedures and making them complementary to one another are important. We will want to pursue those proposals, following the passing of the bill.

**Mr Duncan McNeil** (Greenock and Inverclyde) (Lab): We have concentrated on discipline and referral not being specific, and we have heard it conceded that referral will be more specific when the time comes. What concerns me is the alternative that has been proposed. On the use of the power to refer someone to the NHS tribunal, the SPGC’s written submission states:

“SPGC suggests that only those carrying a six-month prison sentence i.e. those offences of a serious nature should be reported.”

Does that mean that it is okay for a drunk driver, someone who beats his wife or someone who abuses a child to be a family health service practitioner? What does that mean? Would that power be triggered only by a six-month jail sentence?

**Angela Timoney:** Those comments were made by the Scottish Pharmaceutical General Council, which is a separate body from the Royal Pharmaceutical Society of Great Britain.

**Mr McNeil:** Oh. I am sorry. It was not you.

**Angela Timoney:** As a regulatory body, we may take a different view from that.

**Mr McNeil:** Nobody supports that view.

**The Convener:** Ms Timoney is saying that the regulatory body takes a different view.

**Mr McNeil:** It is here, in the evidence that is in front of us.

**The Convener:** I appreciate that. Unfortunately, we do not have somebody from that organisation present.

**Mr McNeil:** What a pity.

**The Convener:** Perhaps that is something that we could explore in writing. Do members have any more questions for the witnesses, or do the witnesses feel that anything has been missed out?

**Margo Biggs:** This is possibly not totally relevant to today’s meeting. In general discussion, possibly because of the last week’s media coverage, particularly the campaign in *The Herald*, the regulation of NHS 24 sprang to mind. I wonder how it feeds into the system whereby people are acting in some ways independently. I do not know whether that is relevant.

**The Convener:** It is quite a good question.

**Dr Wilson:** NHS 24 is not covered by the provisions that we are talking about. I am unable to comment further on the issues surrounding NHS 24; all I can say is that the provisions we are talking about refer to those who are on the list to provide medical, dental, pharmaceutical and optical services.

**Margo Biggs:** I realise that. However, the thought processes that were engendered by discussion made me wonder about the vulnerability of patients in relation to some of the concerns that have been raised over NHS 24. Perhaps that could be considered in another forum.

**Mike Rumbles** (West Aberdeenshire and Kincardine) (LD): That is a legitimate question and I am glad that it has been raised. NHS 24 does provide a medical service in the form of advice, which may be wrong or damaging, so perhaps it should be included. Would the Scottish Executive consider bringing it in at a future stage?

**The Convener:** Why was it not considered appropriate to bring NHS 24 into the ambit of the bill?

**Dr Wilson:** If we may, we shall take that question away and write to the committee about it.
The Convener: That was a nice late lob from Forth Valley local health council, but that is the beauty of sessions such as this.

Alex Matthewson: As a matter of interest, I have been in the dental profession for 40-odd years, and I can remember only two tribunals during that time. Could the Executive give us an estimate for how often a tribunal would sit? Two in 40 years does not seem to be an awful lot from a dental point of view. Does it happen more often with the other professions?

John Davidson: Until 1996, there was a long period without any tribunal cases and then there was a case concerning a dentist. I think that the last case before then was in 1984. Since 1996, we have had about one case each year. Recently, we have had two cases running at the same time, so there is an indication that the workload has increased.

Alex Matthewson: Is that to do with dentistry or with other areas of medicine?

John Davidson: It is spread across the professions.

Mr McNeil: We need to understand what is going through the system and how that case load compares with official complaints to give us some balance in understanding which complaints arrive at a tribunal and which are settled through the process.

The Convener: Perhaps we could get some information from the Executive about tribunal history, so that we know what that position is. We shall also endeavour to get information about the complaints.

Alex Matthewson: It seems that complaints progress far down the line before tribunals kick in. I just wanted to know what the importance of the tribunal was, because many matters are sorted out before a complaint reaches that stage, although perhaps not to the satisfaction of patient representatives. It would be good to find out.

Hal Rollason: I have some paper copies of our submission if you would like me to leave them for members.

The Convener: That would be helpful. Thank you.

Mrs Milne: As the question has been asked about how many tribunal cases take place, I just wondered how many cases, by comparison, had been dealt with by the professional disciplinary bodies in the same 20-year span.

The Convener: No doubt the clerk can contact the appropriate regulatory bodies and get some background information on that.

14:58
Meeting suspended.

15:01
On resuming—

The Convener: Part 5 of the bill deals with infection with hepatitis C as a result of NHS treatment. In taking evidence this afternoon, our focus is on the bill, which proposes a legal basis for the existing system of ex gratia payments. The committee will hold a further separate evidence session to examine the case for a public inquiry; that session, of course, will involve representatives of the Scottish haemophilia forum and the Minister for Health and Community Care. I remind witnesses and members not to stray into that area today, because we are dealing specifically with what is in the bill.

I welcome Philip Dolan, chairman, and Dave Bissett, vice-chairman, of the Scottish haemophilia forum and Frank Maguire, who is the legal adviser to the forum. I invite Philip Dolan to make a brief introductory statement, which I ask him to confine to five minutes.

Philip Dolan (Scottish Haemophilia Forum): Thank you for the opportunity to speak to the committee. This is the first forum at which we have been able to discuss our concerns about the Skipton Fund. The committee has received our submission, which I do not intend to go over, other than to highlight a few points. We have concerns about the Skipton Fund.

Frank Maguire will speak on the legal aspects of our concerns about the bill, of which you have given us a copy. He is much better equipped to deal with the legal aspects than we are.

It seems that the minister will have the opportunity to lodge amendments. Perhaps I am misreading the information that I have—no doubt you will put me right about that. We have always expressed our concern that the Skipton Fund seems to discriminate against the dependants of the people who died prior to 29 August 2003. We think that that is unfair and we do not know why the decision on it was reached. I am the only person here who attended all three of the meetings about Skipton that were held in London and there are no minutes of the meetings. We are concerned about how a record is held of how Skipton has come to decisions.

We have concerns about the fact that the appeals panel will lack any involvement from haematologists, who are the people who have been most involved with all those who have developed hepatitis C as a result of receiving blood products or blood transfusions. That is a concern, especially given the fact that the Skipton
Fund deals only with those who acquired hepatitis C through NHS blood products or transfusions.

That is all that I will say at this stage, but I am happy to answer questions. Mr Maguire will be able to deal with the legal aspects.

The Convener: I do not want extensive or lengthy opening statements. If Mr Maguire can restrict his statement to no more than a minute or two, we can bring out the other issues in questioning.

Frank Maguire (Scottish Haemophilia Forum): As a general point, let me state that we welcome section 24 of the bill, which will give Scottish ministers the scope and power to provide for a scheme that is more amenable to people in Scotland. I have a lot of experience of how the Skipton Fund has operated for people in Scotland since it started in July last year. First, the scheme is based very much on written applications. Many people, including many of my clients, find the forms intimidating and difficult to complete, which is a big disincentive. However, I think that section 24 will give Scottish ministers the scope to provide for claims to be presented orally. It should also mean that the scheme can have a presence in Scotland so that people can have a face-to-face discussion if they want to inquire what they should do with their form and what information they need to provide on it, or if they do not understand the scheme’s requirements. At the moment, the fact that the Skipton Fund is based in London makes things extremely difficult.

Secondly, no appeals procedure has yet been put in place for the scheme. Applications have been refused, but there is no mechanism whereby my clients and others can appeal those decisions. Another problem with the appeals system concerns the question whether lawyers and others will need to travel to London to make their case or whether the appeals panel will sit in Scotland. Either way, there is a difficulty. Obviously, it would be difficult and impractical—and, indeed, costly—for many of my clients to travel down to London for an appeal, but requiring all those lawyers to come up here will also have a cost implication. However, there is something to be said for having an appeals procedure in Scotland. Section 24 will give Scottish ministers scope to do that.

As well as those general points about section 24, I hope to be able to highlight, in response to questioning, some specific points about the terms in the bill, some of which are contradictory, inconsistent and inaccurate. I will go through those issues as and when we are asked questions.

Janis Hughes (Glasgow Rutherglen) (Lab): The appeals panel is dealt with in some detail in the Scottish haemophilia forum’s submission, which highlights a concern about the absence of a requirement for a haematologist on the appeals panel. I think that the stipulation is that the panel must have a GP and a haematologist. Given the issue with blood transfusions, I can understand why people might see a need for a haematologist to play an important role on the appeals panel, but could not a GP play that role, given that GPs look after patients throughout their illness?

Philip Dolan: Very few GPs have had direct involvement with hepatitis C. Some GPs will have been involved, but that is not true of the majority. For most people with haemophilia, their first application form to the Skipton Fund will have been filled in by the United Kingdom Haemophilia Centre Directors Organisation. Often, a haematologist will have been involved in that process, because virtually everyone who has developed hepatitis C got it through a blood transfusion. Therefore, the process generally involves some contact with a haematologist.

There is a question over whether a GP could deal with stage 2 applications to the Skipton Fund, because even haematologists find it difficult to work out the equation that determines whether someone reaches that stage. Therefore, there is a role for haematologists. One GP to whom I spoke recently was completely at a loss when they were asked by a patient to fill out the form.

The United Kingdom Haemophilia Centre Directors Organisation says that it has been involved in little or no discussion during the process even though it is the main organisation and most people who have developed hepatitis C are people with haemophilia. We have no idea why a GP was put on the appeals panel; I have also raised questions about how the other members of the board are recruited.

Dave Bissett (Scottish Haemophilia Forum): As haemophiliacs, we do not have a lot of contact with our GPs. We go straight to a centre for treatment. When I go to see my GP about anything we usually have a discussion about how things are, but GPs are not really up to speed on what is going on.

Shona Robison: The first of my two questions is on the point that is made in your evidence, and the evidence from the Royal College of Nursing, that the committee should examine section 24(1)(c) of the bill, which refers to those who “did not die before 29th August 2003.”

You suggest that that cut-off date disadvantages families and partners, who have no access to compensatory payments from any fund or legal process. Will you confirm that the Scottish haemophilia forum is calling for that provision to be amended or deleted from the bill to avoid the arbitrary cut-off date for those relatives who will miss out because the person who died of hepatitis C happened to die before 29 August 2003?
Has the Scottish haemophilia forum done any work on the number of families who are concerned about or caught up by that arbitrary date and who have therefore missed out on payments? Have any costings been done on what it would cost to include those people? That is my first question.

**The Convener:** We will deal with that question first.

**Philip Dolan:** We do not know the figures because of the need for confidentiality and so on, but hepatitis C has been an issue since the birth of the Scottish Parliament in 1999. Why choose 2003 and not 1999? Why discriminate, given that there are only a limited number of cases? It is complete discrimination against us.

Perhaps I am just a maverick, but I have not registered with the Skipton Fund. I hope that a public inquiry will address the issues at a later date. If I walked out of the Parliament today and got knocked down, my dependants would get nothing because I am not registered with the Skipton Fund. The fact that one has to be registered is another example of discrimination.

Initially the forum was concerned only with haemophilia, but in the course of our work we have taken on board other people who contracted hepatitis C through blood transfusions, who do not have an umbrella organisation to represent them. Frank Maguire has had more dealings with that group.

**Frank Maguire:** I will give an example. I have two death certificates here. On the first, the cause of death is hepatic failure and septic shock and the date of death is 7 May 2003. On the other, the cause of death is hepatitis C-related liver disease and the date of death is 4 September 2003. I see no difference between those cases. The date of death is pure chance and nobody has any control over it, but in one case the payment was made and in the other it was not. That puts the matter in stark contrast.

I have handled nine fatal cases; four of the people in those cases died in the period before 29 August 2003. It is quite hard for some of my clients to accept that they have gone through all the suffering because they were infected by the hepatitis C virus through a blood product or a blood transfusion and that because Parliament has only just got round to dealing with the issue, they are disadvantaged even though their pain and suffering are exactly the same as someone else’s. That is the injustice. If we are dealing with numbers, and I have nine fatal cases out of 130 cases, and four of those people died before the date, we are not talking about an awful lot of money.

15:15

**Shona Robison:** The evidence from the Skipton Fund says:

“Activity in Skipton is now running at a low rate.”

Mr Maguire said in his opening remarks that there was a disincentive because the scheme was based on written applications and the form was long. Do you think that the low rate of activity—I assume that that means a low rate of applications—relates directly to the amount of paperwork that a person has to fill out? Are your clients telling you that the process is preventing them from applying? Is the situation as stark as that?

**Frank Maguire:** I cannot deal with statistics, but I can tell you my experience. My impression is that although a lawyer is helping people, they are still having difficulty with the process. We are helping them with that. A vast number of people out there do not have a lawyer. The Skipton Fund does not like lawyers; it will not correspond with me. It will write to my client and my client has to come to me. I do not understand the reason for that, but that is what the Skipton Fund does. That is a disincentive, even for my clients who are using a lawyer. There is almost a disincentive to use a lawyer, because the Skipton Fund will not correspond with me.

There are several people out there who are struggling and trying as hard as they can to deal with the form. Not only do they have to fill in the form, they have to go and see someone and ask them to do something with the form. A lot of activity is required of the client.

There is a lack of information on the Skipton Fund. Where do people find out about it? How do they know what to do with the long form that they have to fill in? People sometimes find that their GP or medical adviser does not know about the fund either. I have a case in which it has taken from August last year until now to get the form filled in because the GP did not understand it and the consultant refused to deal with it because he was not getting paid; the form then went backwards and forwards to the Skipton Fund. We went to the fund and said that the consultant would not sign the form because he was not getting paid, and the fund said, “That’s not our problem. You will have to pay for it.” The client had no money to pay for it, so I wrote to the minister and he got involved. There are many bureaucratic systems in place that are potential disincentives.

**Philip Dolan:** This point might come up later, but I will mention it just now. Paragraph 3 of the Skipton Fund’s submission is very misleading. First reading of that paragraph might give the impression that, of the four directors who were appointed to Skipton, two were from the
Department of Health and two were the result of nominations from the Haemophilia Society. I have received an e-mail from the chief executive of the Haemophilia Society who assures members that the UK society was never asked to nominate persons to be appointed as directors.

We have grave reservations about the closeness of the Skipton Fund, the Macfarlane Trust and the Department of Health. The chairman of the Skipton Fund, Peter Stevens, is one of the nominees of the Haemophilia Society to the Macfarlane Trust, but we certainly did not nominate him or any other person to the Skipton Fund. That raises questions about relationships. Mr Steven’s term of office as a representative of the Haemophilia Society on Skipton finishes in July this year. A lot of things are going on. I want to be clear on the point that we were neither asked nor invited to make nominations to Skipton.

**Dr Turner:** I have two questions on the matter of filling in the form: one is on the form itself and the other is on the private nature of the company. I know of at least one person who is having great difficulty with filling in the form. How many consultant haematologists have said that they did not have time to fill in the forms? I understand that, in this case, they pleaded that the problem was one of workforce issues.

We heard earlier about someone who filled in the form as a private service and, because he was paid £200 to do it, the form was filled in a little bit more quickly. Consultants in the NHS do not seem to have the time to do that. From what you said, it seems that the length and complexity of the forms mean that it is not appropriate for GPs to complete them.

**Frank Maguire:** The consultants have to set aside time to fill in the forms. First, they have to see the person who has brought in the form to have it completed. They then have to set aside time to get out and look at the patient’s notes, some of which are quite large. The consultant might then have to go back and talk to the person about their case. Consultants have to go through that procedure before they get down to filling in the form. If they are diligent, they want to get it right; they know how important that is to the patient. All of that has to be fitted into the work of a busy practice.

No one is saying to the consultant, “We will set aside time for you”, or “We will pay for you to do this.” Some consultants find the lack of payment quite galling. They are doing the work of filling in the forms, yet who gains a saving as a result? It is probably the private company. Skipton wants to keep down costs by making the process simple and by putting the burden of completing the report on to the consultant, who has to do it gratis. That saves the private company money and, in turn, makes it more profitable. That is the dynamic of what is going on.

I agree that the form is difficult to complete. There is also an issue for consultants in terms of the time that they have to take to complete the forms and the fact that they have to make themselves available to do so. I emphasise again the fact that medical records are very large.

**Philip Dolan:** The haemophilia directors have been fairly helpful in relation to helping people to fill in the forms at stage 1. That said, it depends on the part of Scotland in which people reside. Some directors are pedantic about how they fill in the forms. We know of cases, certainly in this part of the world, in which people’s forms went backwards and forwards between the consultant and Skipton and, at the end of it, people got no money. However, because the haemophilia director in another part of Scotland knows the patients, they can say that someone needs a payment and the payment is made.

Greater complications are involved in stage 2 payment applications. As I said earlier, I know from conversations that I have had with the haemophilia directors in Scotland that some of them have a great deal of difficulty in completing the second part of the application process, partly as a result of their trying to get meetings with hepatologists. I know of one case in which both the professionals work in the same hospital and yet an e-mail that was sent in November says that one can meet the other to discuss the filling in of the forms in February. I am talking about people who walk by each other in the link corridor of the hospital in question.

**Dr Turner:** I am concerned about the fact that a private company should have been formed in order to distribute the fund. I think that it was the Scottish haemophilia forum that went into detail about the private nature of the company. I do not understand why that had to happen. My understanding is that, under the Freedom of Information (Scotland) Act 2002, it is very difficult for a private company to give out information.

**The Convener:** Perhaps Mr Maguire can respond in respect of the difficulties that arise simply because Skipton Fund Ltd is a private company.

**Frank Maguire:** Questions arise because of the fact that it is a private company. What is in it for the private company? We do not know how much the directors are paid, how profit oriented they are or what their profit motive is, and whether they are being efficient because the company provides a public service or because they want to save money.

If I were to be cynical, I would say that—given the requirement for written applications, the
practice of batting everything back to the patient, the avoidance of lawyers and the avoidance of other costs—Skipton is keeping the costs down so that its profit is higher. If the company gets involved in such things, its expenditure goes up, so its profit is obviously less. Whether I can get into that, or whether the company can reveal that, is a different matter altogether. The company keeps talking about judicial review, but such a review is normally conducted on an administrative body such as a local authority or a public body. There is a question mark over whether I could judicially review the actions of a private company, if only the private company and not the minister were involved. There is an obstacle involved when the Skipton Fund talks about judicial review.

Dr Turner: That is what I thought.

The Convener: Witnesses from the Skipton Fund are coming later this afternoon. We hope that they will be here by 4.15, although there have been difficulties with their flight. I understand that they have now arrived, so we will be able to put some of those questions directly to the Skipton Fund representatives.

Mr McNeil: I am shocked to hear that consultants are being obstructive and that they are not being helpful. We know that, in other areas, consultants are an essential part of the network to get people who are suffering from certain conditions through the system and referred to self-help groups. I am really shocked and disappointed that that delay has arisen. I do not know whether the committee can do something about that with the minister to clear away some of those problems. It may be useful for us to get some more information about the form. How long does it take for the consultant and the person together to fill out the relevant part of the form?

Dave Bissett: Often they do not have to be together. The consultant has the information.

When I filled out the stage 1 application form, there was one page that the applicant had to fill in and the consultant filled in the rest. For the record, I would like to say that we have had no problems at Ninewells hospital in Dundee. The consultants there have been first class at getting the forms filled in.

Mr McNeil: Can you be more specific about where the problems lie? Which health boards are affected?

Dave Bissett: I believe that there is a problem in Edinburgh.

Mr McNeil: Where else?

Frank Maguire: There is a case in Glasgow.

Mr McNeil: There is one case in Glasgow. How many are there in Edinburgh?

Dave Bissett: I do not have a figure, but I know that there is a problem.

Mr McNeil: It would be useful if we could get some of those figures.

The Convener: Could you do some digging around and get some further information to the committee on that aspect of the issue?

Philip Dolan: Yes. There have certainly been individuals in Edinburgh who have had difficulty with the forms being batted backwards and forwards. We know that, in some instances, consultants took one and a half minutes to complete the stage 1 application form. In other cases, the process has taken months, because the consultants have wanted to go into greater detail. I can talk about individuals but, as you will appreciate, most people who have been involved have wanted to keep away because of the stigma that is attached to their condition.

The Convener: I appreciate that there is a difficulty, but it helps the committee if we can get as much information as possible about what is happening.

I would say the same to Mr Maguire. If you know of specific areas of Scotland or situations in which that specific problem has arisen, could you ferry that information to us? It would be gratefully received.

Frank Maguire: To be clear, I raised the matter with the minister and he took action on a specific case. However, it is a bit silly to have to go to the minister to get a form filled in.

Mr McNeil: The situation that you have described is shocking and not acceptable. We want to have an understanding of the extent of that situation so that we can put it right. Thankfully, we do not need to write to Dundee, because the consultants there may represent best practice, but we need to identify why that is not happening in other areas.

I presume that you have a copy of the submission from the Skipton Fund. Your own submission has been helpful to us in considering the evidence. You say that the two representatives from the Haemophilia Society who are directors were not nominated by the Haemophilia Society to the Skipton Fund. Do you have good links with them? Have they been able to raise and address some of the issues? Or is it the case that they have been of no effect and that you have had no contact with them?

Philip Dolan: I am a trustee of the Haemophilia Society and the matter has been discussed with the trustees.

The concerns about the appointment of the directors, which was done without consultation,
have been discussed with the trustees of the Haemophilia Society. For the benefit of the representatives of the Skipton Fund, who have probably now arrived, I repeat what I said earlier: we have an e-mail from the chief executive of the Haemophilia Society—I will make the e-mail available—in which he confirms that the society was not consulted and did not make any appointment. We believe that the Haemophilia Society is having on-going conversation on the issue, but, unfortunately, the chief executive of the society could not be with us today to answer questions. We do not know why the Skipton Fund was set up—whether it was for reasons of speed or for some other reason—but we should have been consulted and had a say.

Mr McNeil: Is there any reason why you would not have nominated the two people concerned? Do you have objections to them? Do they have any association with the Haemophilia Society?

15:30

Philip Dolan: The Haemophilia Society nominated both of them for the Macfarlane Trust, on which people serve for a period of time. However, the Haemophilia Society might not wish to reappoint those people to the Macfarlane Trust in the future and may have preferred to appoint other persons to the Skipton Fund. The chief executive and chairman of the Macfarlane Trust were initially appointed to set up the Skipton Fund. The chairman of the Macfarlane Trust, who is with us today, is also the chairman of the Skipton Fund. Given the procedures in Scotland to ensure that everything is visible and up front, that relationship is rather close.

Mr McNeil: Given that we will question representatives of the Skipton Fund later on, and that you may not do so at this stage, do any other points jump out of the Skipton Fund submission, including the figures that have been provided, with which you disagree or to which you object?

Frank Maguire: My problem with the Skipton Fund is how it conducts itself. We have discussed the difficulty with forms and how the burden is put on to the patient. It would be of great assistance if the Scottish Legal Aid Board changed its policy of refusing automatically applications from people who want advice regarding the Skipton Fund. Given the procedures in Scotland to ensure that everything is visible and up front, that relationship is rather close.

Mr McNeil: Is there any reason why you would not have nominated the two people concerned? Do you have objections to them? Do they have any association with the Haemophilia Society?

The Convener: Does that happen even at the level of advice and assistance?

Frank Maguire: A person would get something—the initial £80-worth or whatever—but if more work needs to be done, the Scottish Legal Aid Board just says that the Skipton Fund deals with the matter and that is the end of the story. There is a constant struggle with the Scottish Legal Aid Board to get it to authorise increased expenditure to cover more work on accessing medical records and assisting clients. That goes right through the system.

Philip Dolan: To answer Mr McNeil, the concern is why we need the Skipton Fund. Why could the function not have been carried out at arm’s length from, or within, the Department for Work and Pensions? Only a limited time is available. Once all the applicants for the first and second phases have been dealt with, there will be only a trickle of people applying, as their condition worsens from chronic hepatitis into cirrhosis and cancer. The Skipton Fund seems to be an organisation that deals with paper—sending out forms, receiving them, sending out money and coming to decisions based on criteria that are not known to me or other people.

In two years’ time, instead of having a large office in Westminster—the most expensive part of London—a confessional box in a church will be sufficient, because the body will need only a part-time worker. As Mr Maguire pointed out, we do not know how much of the money that the Skipton Fund was set up to pay to patients is being spent on administrative costs and rent. I do not know whether you are planning to consider the appeals system, which is one of our major concerns.

The Convener: You have made that point already. Mr Maguire mentioned specific issues that he wanted to raise. I invite him to take the opportunity to do so now.

Frank Maguire: With regard to compensation, we must consider what is best for people in Scotland. The system is not ideal, but we must be practical about it. It should be possible to access the system both in writing and face to face. There should be face-to-face access to advice. People should be able to go to an office in Scotland to ask someone questions, or another person should be able to do that for them. The face-to-face dimension is completely missing because the fund is based in England. It does not matter whether the system is run by the Skipton Fund or another body.

When people’s claims are rejected, they must be given clear reasons, with appropriate reference to the evidence, for why that has happened. We do not get reasons—we are just given a little one-liner that says “refused”. Why?

The Convener: That is similar to the way in which the Crown Office indicates that it is refusing to proceed.

Frank Maguire: Yes. I am concerned that, if we have an appeals procedure that is London focused, it will be based more on written communication and there will be an attempt to avoid oral representation. Oral representation is essential in any appeals procedure. A face-to-face
question and answer session reveals much more than is contained in written documents and allows people to get right to the rub of the problem, without being misdirected in various ways. With face-to-face meetings, people understand why their important application has been turned down.

The system that we seek would ensure accessibility to both advice and decisions. Reasons for decisions and access to information would be provided. It would be helpful if that information were held here. There would also be an appeals procedure that was Scotland focused and accessible in Scotland. If the Skipton Fund can provide what we are seeking, that is fine. If it cannot, we must have our own system. If the number of applicants is declining, as has been indicated, such a system would not be very expensive. However, the benefits to people in Scotland would be great.

Dave Bissett: The Skipton Fund submission refers to payments of £20,000 and a further £25,000. No one has ever told us how those figures were calculated. Where did they come from? What do they mean? The Skipton Fund’s advisers came up with an equation, based on liver tests, to work out whether someone should receive a second-phase payment. Any liver specialist will tell you that those tests do not necessarily mean that someone does not have cirrhosis or cancer—they are only a guide. Even if a good part of the liver is taken in a biopsy, it cannot provide 100 per cent certainty.

I qualify for the first section of payments, but not for the second. Although some of my readings are high, they do not fit into that category. I have probably had hep C for about 30 years. From the symptoms that I experience, I know that I have some sort of liver damage, but the tests do not show it. The equation that has been developed does not mean much to me. Over the years, even before hep C came into being, we were told that the tests were guides and that there were no guarantees. The fund intended to come up with a non-invasive test, but it was not able to do so. However, if it worked out an equation to determine who should get the second payment, could it not have worked out an equation to calculate what people were losing through ill health and stress?

I have a brother who is seriously ill and cannot work. He had his own business and is probably losing about £50,000 a year in earnings. He qualifies for the second payment, so he gets £45,000. The chap who runs the Skipton Fund probably gets more in his salary than my brother gets in compensation. Where do the figures come from? Did someone just decide that the figures sounded good and that by giving people £20,000 they could get rid of them? That is not satisfactory.

The Convener: We have a few minutes left in this session. I do not want to move off this topic if people want to raise issues. I remind witnesses that we have the written submissions, so it is not necessary to repeat everything that is in them. Committee members have no more questions. Do you have any final comments on the bill?

Frank Maguire: I wish to address an important point on section 24, concerning eligibility. Section 24(2)(b) states that a person will not qualify if their sole or main residence was not Scotland when they applied for a payment or if, in the case of someone who died, their sole or main residence was not Scotland when they died. I cannot see the logic of that. The issue should be that the conduct complained of happened in Scotland. No matter where you live after that, you should be paid if the NHS in Scotland infected you with hepatitis C.

Let us consider the practicalities if we keep that provision. I have cases the length and breadth of Scotland. Take the example of a baby in Shetland who was infected with hepatitis C virus. If as a teenager that person goes to England to get a job, their sole or main residence will be in England. In that instance, they will be disqualified. Why should that be? At the other end of the age spectrum, an elderly person might go to live with or near their children in England, France or elsewhere. By that fact, they will be disqualified. It is illogical that when making an application a person’s sole or main residence must be in Scotland. That has no connection to what we are talking about. All that they should be required to prove is that, wherever they live, they were given a product or transfusion in Scotland and that it was administered by the NHS. Section 24(2)(b) should be removed from the bill.

In addition, there is a contradiction between what the Skipton Fund says and what section 24 says about people who receive money by way of another scheme or litigation—cases are proceeding on negligence grounds. Guidance from the Skipton Fund asks:

“Will any payments I have received from other schemes, or as a result of litigation, be deducted from the payments made to me by the Skipton Fund?”

to which the answer is, “No.” However, section 24(3)(b) states that a scheme may

“provide that the making of a claim, or the receipt of a payment, under the scheme is not to prejudice the right of any person to institute or carry on proceedings … (but may also provide for the taking account of payments under the scheme in such proceedings)”.

That seems to say something different from the Skipton Fund. Perhaps section 24(3)(b) should be examined closely and amended.

Why was the cut-off date of 1 September 1991 picked? I cannot explain that. If it was chosen because it is believed that no infected blood was in the system, I would like to see the evidence. We
have never had an inquiry—we will not talk about that today—but because the issue has never been fully explored, how can we be satisfied that 1 September 1991 is the correct date? Where is the incontrovertible evidence? I have indications from clients that they were infected after that date. In any event, why not leave the question of whether you received hepatitis C from infected blood as the matter of proof? Whether you were infected in December 1991 or in 1993, you would still have to prove it. Leave it open and do not prejudge the issue.

I can submit those points in written form.

**The Convener:** You do not need to now, because you have put them on the record, unless you want to follow up with more detail. We have two minutes left. Do committee members want to ask questions on the last points that were raised?

**Shona Robison:** That is important evidence. I was aware of the issue around the date of 29 August 2003, but the important points that you make require further explanation, which I hope we will receive.

**Helen Eadie (Dunfermline East) (Lab):** Is the £15 million that the Executive has set aside adequate?

**Frank Maguire:** That is very hard to forecast. There are people in the system who do not know that they have hepatitis C. That is another problem, and it is why there is a problem with application. People cannot make an application if they do not know that they have the condition, but they still get disqualified for not making one. Those people in the system who do not know that they have hepatitis C are being discovered as and when they return for treatment, or if they die. The number of people concerned is unknown. We also do not know how many people will die of hepatitis C. Judging from the cases that I have dealt with, deaths have occurred in 2003 and 2004, and there will be some in 2005 and into the future, no doubt. That is difficult to assess.

£15 million may be set aside, but I hope that the Scottish ministers will recognise that there would need to be more if that fund were exhausted. I would not like ministers to keep within that £15 million by trying to keep expenditure down and doing various sorts of cost-cutting exercises. That would only go against the people who are trying to make a claim.

15:45

**The Convener:** I will allow Mr Dolan to come in very briefly, as we need to move on.

**Philip Dolan:** Dave Bissett raised the question of the £20,000 payments. The Scottish Parliament set up an expert group under Lord Ross, which recommended a minimum sum of £50,000. We do not understand why that has not been implemented. Perhaps the committee is in a position to review that during its consideration of the bill. The concerns that we have expressed about the appeals system are important, and I know that you will be taking those concerns and our submission into account.

**The Convener:** I thank the three witnesses for coming along. Witnesses from the Skipton Fund will give evidence later. We now have to move into private session, as previously agreed. We have had to rejig our agenda because of late planes and so on. I will first suspend the meeting for a couple of minutes to allow the room to be cleared.

15:46

Meeting suspended until 15:49 and continued in private thereafter.

16:27

Meeting continued in public.

**The Convener:** I reconvene the meeting in public and welcome Peter Stevens, the chairman of the Skipton Fund, and Keith Foster, scheme administrator of the Skipton Fund. We have heard evidence from representatives of the Scottish haemophilia forum. Mr Foster did not hear all of that evidence, but he heard a significant portion of it. I suspect that committee members will have questions arising out of that evidence. I ask one or other of the witnesses to make a brief statement about the Skipton Fund in connection with the legislative proposals that we are considering.

**Peter Stevens (Skipton Fund Ltd):** I apologise for delaying your proceedings, convener. The matter was out of my control.

**The Convener:** We understand.

**Peter Stevens:** The Skipton Fund began operations on 5 July last year, having been set up earlier in the year following discussions that have been going on since the announcement of the hepatitis C ex gratia payment scheme at the end of August 2003. Everything that has been done in setting up the scheme and in staffing it has been done in the interests of getting the payments made as quickly and efficiently as possible.

There are four directors of the fund who were all trustees of the Macfarlane Trust, which was invited by the Department of Health, on behalf of the health departments in the four Administrations, to put its resources, expertise and experience at the disposal of the departments to run the scheme. The directors have a job to do in signing off payments and I believe that we have already made well in excess of 80 per cent of the
payments that the scheme will ever be required to make. That is all I wish to say at the moment.

16:30

The Convener: I thank you for being commendably brief.

Does Mr Foster want to add anything, or shall we go straight to questions?

Keith Foster (Skipton Fund Ltd): It is probably best to go straight to questions, but I will first explain my role. I came in as administrator at the start of the scheme, so questions on procedures are probably best directed to me, whereas questions on policy can be directed to Peter Stevens.

Shona Robison: My first questions relate to the status of the Skipton Fund. Will you confirm whether it is a private company? Concerns were raised earlier—you might have heard them—about whether, as a private company, you make a profit through the operation of the fund. Will you clarify that and whether the directors are paid or unpaid? Further to that, I ask you to tell me the breakdown of finances for the Skipton Fund—for example, administrative costs, office costs, the payments and the costs of appeal. I do not necessarily expect you to be able to answer that today, but you might be able to provide the information in writing, as it would be useful to have a breakdown of the fund’s finances for those elements.

Secondly, I have questions about your written evidence. You say: “Activity in Skipton is now running at a low rate.”

We heard earlier that there are concerns about the length and complexity of the fund’s application forms, which might put potential applicants off applying in the first place and might be one of the reasons for that low rate of activity. What is your view on that? Has that concern been raised with you?

Mr Stevens, you just said that 80 per cent of the payments that the scheme will be required to make have been made. Do you mean by that that you think that 80 per cent of the payments that you will ever make have been made or are you referring to 80 per cent of the payments that have been applied for to date? Will you clarify that point?

The Convener: The witnesses can decide between themselves who should answer which questions.

Peter Stevens: The Skipton Fund is a company limited by guarantee. It is our intention to minimise the profits and to make them as close to zero as possible so that we do not have to concern ourselves with profit distribution or tax. If there is a profit, it will be carried forward from one year to the next to pay for the following year’s expenses and, in the long run, I anticipate that the company will be totally non-profit making.

At the moment, there is a slight uncertainty in everything to do with operating costs, because some VAT might be involved in services that the Macfarlane Trust supplies to the Skipton Fund, but HM Customs and Excise is taking a considerable amount of time to analyse the nature of the two operations and whether VAT payments will be required.

The directors give their services for free; there are no directors’ fees. We have considered that directors might deserve a fee for the amount of time that they spend not performing directors’ functions but coming into the office to process and sign off application forms, but no one has booked one yet.

Shona Robison asked me to amplify my statement that we have made more than 80 per cent of the payments that we will ever make—I emphasise “ever”. Roughly 4,400 application forms have been sent out to people who have completed their registration. We are registering people at a rate of about seven a week—one a day—so it will be a long time before the initial estimates of between 6,000 and 8,000 applications are received. Indeed, I do not think that those figures will ever be reached.

When people register, they have no idea whether the application form will be complex. The registration form is very simple and the application form is even simpler for applicants. The bulk of the application form must be filled in by the claimant’s clinician, because it is concerned with medical evidence; there is no other complexity in the form. The application process is simple and the form was designed so that it would not put anyone off applying.

That is all the information that I can give in answering the member’s questions. Mr Foster will add something.

Keith Foster: I will leave a couple of spare forms with the clerk so that members can see them. The witnesses from the Scottish haemophilia forum made the point that the forms are complex and Shona Robison asked about that. However, the forms are not complicated for claimants, who need only fill in their name, address and national insurance number, sign the form and send it to us in a pre-paid envelope. All the work that needs to be done is then undertaken by the claimant’s clinician.

The witnesses also expressed concern that there were difficulties in getting the forms completed. However, such cases tend to be isolated. I administer the scheme for the whole of
the UK, so I can say clearly that the number of problems is small in relation to the number of claims that are being processed. Although such cases obviously present a big problem for individual claimants, the problem is not regarded as large globally. The chief medical officer has written to all consultants in a bulletin, to advise them of the existence of the Skipton Fund and to ask them to consider forms in that light.

Members might have encountered constituents who are having difficulties because GPs are being asked to fill in forms. We suggest that a consultant fill in the form whenever that is practical, but that does not always happen. Because of GPs’ terms and conditions and their contracts with health authorities, fees might be charged. Also, GPs are not necessarily au fait with the details of the disease.

Shona Robison: Are you saying that you do not expect the £15 million that the Scottish Executive set aside to be claimed? You seem to be indicating that fewer applications than you expected have been made to date. How much of the £15 million has been claimed so far? What figure is represented by the 80 per cent of payments that you say that you have made?

Peter Stevens: Currently, Scottish stage 1 and 2 payments total roughly £8 million. If we were going to reach the figure of £15 million, which would be consistent with the entire scheme having around 8,000 applications, I would have expected that by now we would have heard from more than 6,000 people. However, we have heard from 4,500 people. I do not see where the other 3,500 applicants are. The scheme has been running for several months and has received quite a lot of publicity through the chief medical officer’s circulars. We receive requests for new registrations at a rate of seven per week, as I said, and the figure has been falling gradually for about three or four months. I do not know where the other 3,500 applications would come from.

Shona Robison: Unless eligibility for payments is widened.

Kate Maclean (Dundee West) (Lab): I was not clear about Peter Stevens’s response to Shona Robison’s question about the fund’s running costs. You said that the VAT issue is being sorted out, but notwithstanding that, what percentage of your budget goes on ex gratia payments and what percentage do you budget for running costs? You must have an idea of the approximate percentages. It would be interesting to know what they are, because there seems to be concern about the matter.

Peter Stevens: So far, we have paid out about £65 million in ex gratia payments. The fund’s running costs to date are less than a quarter of 1 per cent of the total figure.

Helen Eadie: Convener, should I ask all my questions now?

The Convener: Yes.

Helen Eadie: Why was not the Haemophilia Society invited to nominate individuals to the Skipton Fund’s board? Why was there no correspondence with lawyers? I am raising issues that Frank Maguire mentioned.

Peter Stevens: I am sorry, but I did not catch your second question.

Helen Eadie: Why did the Skipton Fund decline to enter into correspondence with lawyers such as Frank Maguire who took on cases?

Is the Skipton Fund regarded as a public body under freedom of information legislation? Would it respond to requests for information in the same way as a public body would do?

Finally, in answer to Shona Robison’s questions you said that information had been provided to consultants in a bulletin. We all receive bulletins and newsletters and it is not possible to read everything. Would it be better to provide such guidance to doctors in a direct letter? I do not think that a bulletin is an appropriate form of communication.

Peter Stevens: As I said, the composition of the board was designed simply to get things started and to get the job done quickly. As directors, we regard our appointments as being interim, and at some stage I am sure that we will be asked to stand down and perhaps a more representative board will be set up. We have no problem with that. It might be worth pointing out that the principal function of directors is to approve the making of payments. There are four directors, three of whom are Macfarlane Trust trustees who are resident in London, so we can get to the office quickly without having to spend time and money before we can perform our function. In other words, the directorship is a working job rather than a question of status.

In general we have not replied to lawyers’ letters because we passed them back to the officials in the health departments of the four Administrations, who asked that they, rather than the fund, should enter into correspondence on legal matters. I stress that we act only as agents; we are not an independent body that has discretion over matters.

I understand that we are subject to the freedom of information legislation and would have to respond appropriately to requests, although I am sure that we would take guidance from officials in doing so.

I take Helen Eadie’s point about the communication of information. Again, information about the scheme and the Skipton Fund is in the
hands of officials from the four Administrations, rather than in our hands. We do not have access to the process of sending circulars to doctors or consultants; that is a matter for the health departments of the four Administrations.

Mr McNeil: Is the 80 per cent achievement rate a UK figure? What is the figure in Scotland?

Keith Foster: That is an overall figure. I would have to calculate the Scottish figure. I will give some statistics that I prepared before I came here. Your paperwork talks about 581—

Mr McNeil: I have seen that somewhere.

Keith Foster: I am talking about the Smoking, Health and Social Care (Scotland) Bill and the related documentation, which says that Scotland has 581 hepatitis C sufferers. I do not know where you took that figure from, but at our last count, we had received 461 applications.

16:45

The Convener: That is not our figure; it is the Scottish Executive’s. Any discrepancy is between the Executive and you.

Keith Foster: I was just making a comparison. The documentation talks about 580 people and 460 payments have been made.

Mr McNeil: There have been 460 claims.

Keith Foster: Yes. We have gone through those who knew about the scheme fairly quickly. The fund’s concern, which Mr Stevens just touched on and Frank Maguire talked about, is about reaching people who were affected many years ago and do not necessarily know about the scheme, although it is hep C awareness year. The Skipton Fund has asked the Department of Health how it will promote the scheme to the wider public. We would like the devolved Assemblies to think about that, too.

It is vital not to miss people. The Haemophilia Society and the haemophilia world are close and have good contacts, but one of my big worries as an administrator is that people who were affected many years ago and are probably becoming elderly may not know about the scheme, so we need people to be advised of it by their GPs and others.

Mr McNeil: That information about the figures was useful. Will you provide us with figures for Scotland and the achievement rate here?

Keith Foster: As I said, we have processed claims from people who are aware of the scheme. We must try to quantify who else out there should benefit from the scheme. We are beginning to see many claimants who are different from those who claimed at the start. Many now are elderly and have heard of the scheme only through word of mouth. Their infection dates are much earlier than the peak times of the 1970s and 80s. That is why those people’s claims are appearing more slowly.

Mr McNeil: Have you no feel for the additional number?

Keith Foster: Mr Stevens said that when the fund started, the top figure that was talked about was 8,000 for the UK. That is probably too high. If we can have not so much a relaunch but the right emphasis in the medical world, the global figure might reach about 6,000 to 6,500.

Mr McNeil: That leads me to another line of questioning that I might as well run with. Have you allocated some of your budget to targeting those people and raising awareness? How will you fund that process?

Keith Foster: Unfortunately, our hands are tied. We have no budget for marketing, if that is the right word. We must approach the Department of Health for what we need. We are involved in the hepatitis C awareness programme, which is widely available through the internet. Only a week or so ago, we talked to the department about raising our profile again in the press, so that people more widely are aware of what we are doing.

Mr McNeil: I have a question about clinicians and medical evidence that I was going to skip but will not. How long does an average Scottish claim take?

Keith Foster: The question, “How long is a piece of string?” comes to mind. The whole process can take seven to 14 days, or it can take many months if the clinician spins it out. With regard to what was said earlier, it is true that applications come back much more quickly from certain pockets. Much depends on an individual’s viewpoint on filling in the forms. As was highlighted earlier, there have been cases in which the Parliament had to step in to say to consultants, “This is part of your doctor-patient relationship. The forms need to be completed.”

Mr McNeil: The earlier evidence about certain areas can be substantiated. Can you provide us with some of your information?

Keith Foster: No, I would not wish to do that.

Mr McNeil: Why not?

Keith Foster: That would isolate people who do not need to be isolated, because the problem has been solved.
Mr McNeil: So there are no current problems. The issue has been resolved.

Keith Foster: As far as I am aware, we have no outstanding applications from Scotland that are causing us problems.

Peter Stevens: We use the same form for people with haemophilia and people without haemophilia. Consultants who have to complete the application form on behalf of somebody with haemophilia—who will be somebody about whom they are well informed; they will know him or her quite well—say that it takes two or three minutes. However, it will take some time to complete the form for somebody without haemophilia who is rarely seen, whose hepatitis C is not active and who was infected through some form of hospital process perhaps 30 years ago. The issue is not the form itself, but digging out the paperwork and finding the records that will demonstrate the source, date and route of infection. The form itself is simple.

Mr McNeil: But there is a problem with people in some areas not prioritising the completion of the form. Is the fee a problem? It was suggested that because consultants are not given an appropriate fee, or if there is a dispute, the form is at the bottom of their list. A clinician can obstruct the whole process, which can prevent people who need the money from quickly receiving payouts. Where are those people?

Keith Foster: We know of a few, but they are not all in Scotland. There have been some in Scotland—

Mr McNeil: But not now.

Keith Foster: Not that I am aware of. There have been problems, but as far as I am aware they have been resolved. I do not know whether you have information that I do not have.

Mr McNeil: We may be able to give it to you.

Keith Foster: We always have a number of forms that are out being filled in and of course I do not know where all those forms are, but our overall impression is that there is no huge problem. There have been isolated pockets, not only in Scotland, where consultants have said, “I’ve got too many to do,” which is a problem. There may be a problem with GPs completing forms if they are not happy to do so. That may be another area about which we are not entirely aware.

The Convener: You heard the end of Mr Maguire’s evidence. Can I confirm from what you are saying that the decision on the 1991 cut-off was not taken by you?

Keith Foster: Correct.

The Convener: Mr Maguire also raised questions in respect of the appeal procedure. Was it set up by—

Keith Foster: The appeals process is still being set up by the Department of Health.

The Convener: Right. So it is outwith your bailiwick.

Keith Foster: We will administer it once it is in place.

The Convener: But you do not make decisions about it.

Keith Foster: No.

The Convener: I am trying to address the points that were raised. I am beginning to get a clear understanding of your role. Effectively, all policy decisions are made elsewhere. You simply administer them.

Keith Foster: We do what we are told.

Mike Rumbles: When do you envisage the appeals process being in operation?

Keith Foster: We would like it to be in operation as soon as possible but, unfortunately, we are in the hands of other people.

Mike Rumbles: Have you been given any indication?

Keith Foster: No.

Peter Stevens: I understand that there was a meeting yesterday between officials from the Scottish Executive Health Department and the Department of Health at which reference was made to the appeals process. I am told that the meeting was useful, but I have not yet received a report on it—I will get that tomorrow.

The Convener: Helen Eadie has a question. Is it one that these witnesses can answer?

Helen Eadie: My question is on a point that was raised by Frank Maguire. I do not know whether these witnesses can answer it. Can the Skipton Trust be judicially reviewed?

Peter Stevens: Presumably.

The Convener: Helen Eadie has a question. Is it one that these witnesses can answer?

Helen Eadie: My question is on a point that was raised by Frank Maguire. I do not know whether these witnesses can answer it. Can the Skipton Trust be judicially reviewed?

Peter Stevens: Presumably.

The Convener: But that has not happened.

Shona Robison: I have a point of information. In a letter to me dated 21 December, Andy Kerr, the Minister for Health and Community Care, stated that the employment of the appeals panel would be done through the public appointments process and would take a few months to complete. We may want to tie him down on that.
I have a more direct question on an issue that I pursued earlier, although I do not know whether the witnesses will be able to answer it. As a manager and an administrator of the system, they are indicating that there may be money left in the system after everybody is paid. I am interested in that on behalf of those who are excluded from the scheme because their relatives did not die before 29 August 2003. As things stand, will there be enough money left in the system to widen the eligibility criteria to include those people?

**Peter Stevens:** If my view is right that we are heading towards—as Keith Foster said—6,000 to 6,500 eligible claimants rather than 8,000, the fact that the departments have put aside money based on 8,000 claimants would suggest that there will be unspent funds at some time. However, I do not know when it might be decided that progression from stage 1 to stage 2 has gone as expected and will not require a greater proportion of the budget than was originally estimated. That will be up to the health departments.

**The Convener:** There are no further questions. The session has been helpful, although there have been many questions that you cannot answer. The fact that you are not in a position to answer them is in itself helpful to us. I am sorry that you had such a hard time getting here today.

**Peter Stevens:** It has been a pleasure.

**The Convener:** It must seem like an awful long journey for such a short time. Nevertheless, your attendance has been valuable and I thank you very much.

I ask for the room to be cleared as we move back into private session.

16:58

*Meeting continued in private until 17:10.*
SUPPLEMENTARY EVIDENCE BY THE SKIPTON FUND

Further to the recent committee meeting and request for further information please find enclosed within this note the figures requested.

The fund has dispatched in excess of 4500 claim forms throughout the UK. For operational reasons the “regionalisation” of forms only occurs on receipt back of a completed application to the fund office.

In this respect for Scottish Registrants we have paid:

<table>
<thead>
<tr>
<th>Type of Application</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>428 Stage 1 application</td>
<td>£8.56m</td>
</tr>
<tr>
<td>50 Stage 2 applications</td>
<td>£1.25m</td>
</tr>
</tbody>
</table>

Total £9.81m

In respect to the percentage of paid applications that have been processed by the fund in relation to received completed application forms, this currently stands at 89.5%. (This percentage does not include any form that is still to be received by the fund which is still being completed by doctors and specialists.)

Please do not hesitate to contact me further clarification is required.

Keith Foster
Scheme Administrator

SUPPLEMENTARY SUBMISSION BY SCOTTISH HAEMOPHILIA FORUM

I thank your good self and Members of the Committee for the opportunity to provide evidence and views on Section 24 of the Bill concerned with infection with Hepatitis C as a result of NHS treatment.

In the interest of time there were two other matters which I did not raise and which hopefully I can now by way of written submissions.

The first of these is related to Section 24 (1)(c) and Section 24 (2) (b) which concern eligibility. I attach a document entitled “The Skipton Fund – What it is and how it works” and would refer you to section 3(g) of the document. It states that no payments will be made in respect of those who have died before 29th August 2003. It then states that in the case of eligible persons who died between 29th August 2003 and 5th July 2004 payments will be made to their estate. However it then goes on to say where eligible persons die after 5th July 2004, payments will only be made to their estate if the eligible person has applied to the Skipton Fund whilst they were still alive.

The Scottish Haemophilia Groups Forum object to this further condition of the eligible person having to apply whilst they were alive in order for their relatives being able to claim.

Firstly we cannot see any reason why as between deaths 29th August 2003 and 5th July 2004 payments cannot simply be made to the estates of a person who has died from Hepatitis C infection arising out of NHS treatment.

There is no explanation as to why this additional rule is inserted. There is nothing wrong surely in a relative applying after someone has died where the person who has died has not applied.

Secondly there might be good reason why someone has not applied while they were alive. It may not be discovered that they were suffering from Hepatitis C until after their death e.g. when a post...
mortem is done. They may not have been in a fit state, coping with their injury, to making the application. Indeed the requirement to make an application may have occurred at one of the hardest points in their condition. There are also a number of social reasons why someone would not apply given the prejudices which attend Hepatitis C and they may have still been in the process of deciding whether or not to make an application.

The second submission relates to paragraph 24 (2) (a) where it says that the question as to whether a person became infected with Hepatitis C as a result of treatment needs to be determined on the balance of probabilities. This is a somewhat technical term and I have reservations as to whether those who administer the Skipton Fund understand the concept. It is a question of weighing up all the factors and evidence and coming to a decision whether it is more likely than not that the treatment was so caused. I would be concerned if there is an automatic reaction from the Skipton Fund to dismiss an application where there were suggestions of alcohol, tattoo, drugs as well as transfusion or administrative blood products. That would not be a proper application of the test. A fund which is administered with a view to not only efficiency but keeping expenditure down may tend towards automatic dismissal rather than the fuller proper consideration on the balance of probabilities.

Given that the proposed Bill has a considerable impact on death cases by way of eligibility or application, and these can also be the most serious and distressing cases the Fund has to deal with, I respectfully suggest that the Committee hears the evidence from a family or families whose loved one has died from the Hepatitis C virus and questions of exclusion or access seen from their perspective.

Yours faithfully

THOMPSONS

SS

Note referred to:-

1. The Skipton Fund – What it is and how it works
THE SKIPTON FUND - What it is and how it works

1. WHAT IS THE SKIPTON FUND?
(a) It is a scheme for making lump sum payments to certain people who became chronically infected with Hepatitis C as a result of receiving NHS treatment with blood or blood products.
(b) It operates throughout the UK - making payments to people who were infected in England, Northern Ireland, Scotland and Wales.
(c) The money paid out by the Fund is provided by the 4 UK Government administrations on a compassionate basis – the payments are not an admission of legal liability.

2. WHO CAN APPLY?
(a) People who have contracted Hepatitis C as a result of receiving blood or blood products from the NHS prior to September 1991.
(b) Those representing the estates of people who would have qualified for payments from the scheme had they not died between 29 August 2003 and 5 July 2004.
(c) Those infected with Hepatitis C as a result of the virus being transmitted from someone else who was themselves infected as a result of receiving blood or blood products from the NHS prior to September 1991 (eg someone who was infected at birth by a mother who had been previously infected through NHS treatment).

3. HOW DOES THE SCHEME WORK?
(a) The scheme will make a lump sum payment of £20,000 to any person who now has Hepatitis C as a result of receiving blood, blood products or tissue from the NHS prior to September 1991.
(b) People who had Hepatitis C in the past as a result of receiving blood or blood products from the NHS prior to September 1991, but who have cleared the virus as a result of treatment, will also receive £20,000 lump sum payment.
(c) People who have cleared the virus as a result of treatment or who have cleared it spontaneously after a period of chronic infection will also be eligible for payments from the scheme.
(d) People entitled to the basic £20,000 payment as described above will receive an additional £25,000 payment if they develop or have developed a cirrhosis or liver cancer, or have had a liver transplant or are on a transplant waiting list.
(e) People who have been infected with HIV through blood or blood products in the past, and have in addition contracted Hepatitis C in the same way, will be eligible for payments from the scheme in the same way as those who have only been infected with Hepatitis C.
(f) It will be assumed that people who have developed Hepatitis C after being treated with Factor VIII or Factor IX blood clotting factor concentrates were infected as a result of that treatment. Virtually all haemophiliacs will fall into this category.
(g) No payments will be made in respect of those who have died before 29 August 2003 or to people who have cleared the virus spontaneously in the acute phase of the disease. In the case of eligible people who die between 29 August 2003 and 5 July 2004, the payments will be made to their estate. Where eligible persons die after 5 July 2004, payments will only be made to their estate if the eligible person had applied to the Skipton Fund whilst they were still alive.
(h) The scheme will not pay any legal costs that people incur in preparing a claim for payment from the Skipton Fund.

If you have further queries after having read this guidance - contact the Skipton Fund Helpline 020 7808 7160. If you phone the Skipton Fund Helpline it may be busy and your call will be recorded so please be ready to leave a telephone number to which it will be possible to return your call. Or if you can e-mail the Skipton Fund at apply@skiptonfund.org.
THE SKIPTON FUND – APPLYING FOR A PAYMENT

1. HOW DO I APPLY?

(a) If you want to apply for a payment you can do so by completing the online registration form (available at www.skiptonfund.org), or by applying direct to the Skipton Fund. They can be contacted by telephone or email, details of which appear above. If you would prefer to write to the Fund, their address is PO Box 50107, London, SW1H 0YE. Once your registration form has been received, the Skipton Fund will enter your personal details on a database and allocate you a unique reference number.

(b) The Skipton Fund will then send you an application form, bearing your reference number, together with comprehensive guidance on how to use the form. After answering a few questions concerning your application and signing the form, you should then pass it to your doctor – who will answer the questions that relate to your illness and how you might have been infected.

(c) We suggest that if you are being treated for a bleeding disorder you ask your consultant haematologist to complete these sections of the form. We suggest other applicants ask the consultant who is dealing with their Hepatitis C to do this. If these doctors do not have access to all the necessary information, they may advise you to take the form to your GP or to another specialist doctor.

(d) The application form you will receive initially only covers applications for the basic payment of £20,000. Once the Skipton Fund has checked that you are entitled to the basic payment then it will be open to you to apply for the additional £25,000 payment. You are entitled to this additional payment if your condition has progressed to the stage where cirrhosis is present, or you have been diagnosed with liver cancer, or have undergone a liver transplant. You will need a separate form to apply for the additional payment which you will be able to obtain from the Skipton Fund on request. There is no time limit to eligibility for this additional payment so if you are not entitled to it now you can apply for it again in the future if your condition deteriorates.

2. WHAT HAPPENS ONCE THE FORM HAS BEEN COMPLETED?

(a) When the form is completed, your doctor will send it to the Skipton Fund. The Skipton Fund will then write to you to let you know this has happened.

(b) The Skipton Fund will then check the information on your form. The Skipton Fund will then write to you to tell you whether your application has been successful.

(c) If your claim is successful and you are to receive the £20,000 basic payment, the Skipton Fund will transfer the money to you according to the instructions you gave in the registration form. The same will apply should you subsequently apply successfully for the £25,000 payment, unless you tell the Skipton Fund otherwise.

3. WHAT HAPPENS IF MY DOCTOR IS UNABLE TO PROVIDE THE INFORMATION REQUIRED?

(a) If your doctor is unable to provide the necessary information, eg because some or all of your medical records are missing, they will send the form to the Skipton Fund anyway with an explanatory note. The Skipton Fund may then decide to provide your doctor with a different form that allows a fuller explanation of your circumstances.

4. WHAT DO I DO IF I DISAGREE WITH A SKIPTON FUND DECISION?

(a) If you disagree with a decision of the Skipton Fund you can appeal. You should contact the Skipton Fund for details on how to do this.

(b) If the Skipton Fund makes the basic payment of £20,000 but does not agree that you are entitled to the additional £25,000 payment, this does not prevent you from applying again in the future if your condition deteriorates.
THE SKIPTON FUND – ADDITIONAL INFORMATION

Were all the blood products provided by the NHS prior to September 1991 capable of transmitting Hepatitis C?

It varies from product to product. Factor VIII and IX blood clotting factor concentrates manufactured by the National Blood Service in England and Wales were treated to inactivate the Hepatitis C virus from 1985.

Factor VIII blood clotting factor concentrates manufactured by the Scottish National Blood Transfusion Service were treated to inactivate the Hepatitis C virus from April 1987.

Factor IX blood clotting factor concentrates manufactured by the Scottish National Blood Transfusion Service were treated to inactivate the Hepatitis C virus from October 1985.

Products manufactured in Scotland were commonly used in Northern Ireland.

Will I lose other benefits if I am entitled to under other Government schemes if I receive payments from the Skipton Fund?

No. Payments made from the Skipton Fund will be disregarded when assessing means tested Social Security benefits and tax credits. They will also be disregarded when you are means tested for housing improvement and repair grants or for residential care charging. However, if you are asked to provide details about your income on a form, you should declare your Skipton Fund payment(s).

Will any payments I have received from other schemes, or as a result of litigation, be deducted from the payments made to me by the Skipton Fund?

No.

Will I have to prove that it was NHS treatment that caused me to have Hepatitis C?

It depends. If you have received certain blood products (including Factor VIII or Factor IX blood clotting concentrates) then the Skipton Fund will assume that it was this treatment that caused your infection. Other forms of treatment will be considered on a case-by-case basis.

Can I see what my doctor has written about me on the application form?

You are entitled to see the answers your doctor has made to the questions in the applications form. If you want this information you should ask your doctor.

What happens if I receive the basic £20,000 and I either develop cirrhosis, liver cancer or have a liver transplant in the future, or am already in this position?

You will not be able to apply for the additional £25,000 payment at the same time as you apply for the basic payment – you can apply for the additional payment at any time but will need a separate application form which you will be able to obtain from the Skipton Fund. If you apply for the additional payment and are unsuccessful, you can apply again if your condition deteriorates, but not usually within a year of a previously unsuccessful application. You will only receive the second payment if Skipton Fund has first checked that you are entitled to the basic payment.

If you think that you may already be entitled to the second payment you should contact the Skipton Fund for further guidance and an application form.
• What happens if my appeal against the Skipton Fund decision is not supported?

If your appeal is not supported by the Appeals Panel then you can ask the Courts to review your case. This is called a judicial review.

• Do I need the help of a lawyer when applying for a payment from the Skipton Fund?

The Skipton Fund application process is designed to allow people to take forward their application themselves. The forms only require you to provide very basic information and your doctor will supply the necessary medical input. There is therefore no need for you to consult a lawyer. However, you are free to seek legal advice if you wish, for example, if you are considering appealing against a Skipton Fund decision. The decision is yours, but please note that the Skipton Fund will not pay any legal costs that you may incur.

• I wish to apply on behalf of the estate of someone who died between the 29 August 2003 and 5 July 2004 – what do I do?

If you are the former parent, partner or other next of kin of such a person, or are the executor of that person’s estate, you should contact the Skipton Fund for an application form. The guidance that comes with the form will explain what you need to do. The Skipton Fund will only accept a single application in respect of a deceased person.

• I wish to apply on behalf of someone who is unable to apply by themselves (for example because they are disabled or too young) – what do I do?

The form should be completed with the applicant’s personal details. If necessary, please provide a “care of” address. You should record your name and relationship to the applicant where indicated.

• I have been infected with Hepatitis C through contact with someone who is eligible – what do I do?

If you have not been directly infected with Hepatitis C as a result of NHS treatment with blood or blood products, but instead have been infected by someone who has, you are eligible to make a claim to the Skipton Fund. If you know the identity of the person who is the source of your infection, please wait until they have made a successful application before applying yourself. Once their application has been approved, complete and return an application form, noting your circumstances where indicated. If you do not know their identity, or if they died before 29 August 2003, then you should complete an application form as far as possible, return it to the Skipton Fund and wait for them to contact you.

• Will the Skipton Fund make payments to people who have been infected with other diseases as a result of receiving blood or blood products from the NHS?

No. The Skipton Fund only makes payments related to infection with Hepatitis C.
Convener and Members of the Health Committee,

Smoking, Health and Social Care (Scotland) Bill – Stage 1 Consultation
Part 4: Discipline

Optometry Scotland welcomes the harmonisation of disciplinary procedures of family health service practitioners, and as you would expect, we are firmly committed to the concepts of improving patient protection and optimizing NHS resources.

In general OS supports the future role envisaged for the NHS Tribunal but thinks that the policing of these proposals may be difficult. Consideration must also be given to the place of trainees and students since these people also have close patient contact.

OS does agree that all the primary care professions should be included in whatever scheme for fitness is produced, but there should be a realistic assessment of a practitioner’s risk profile. The various family health service practitioners will have very different degrees of patient contact and opportunity to cause harm to those patients. The Tribunal when assessing any one practitioner’s risk to the patient or the NHS must take this into consideration.

The General Optical Council responded to the Scottish Executive consultation document in June 2004 and the Health Committee may wish to ask for a copy of that submission, as it is relevant to this part of the Bill. It is unfortunate that the National regulatory bodies are not mentioned in the Act or its appendices, as it would appear essential that there is clearly defined co-operation and demarcation of responsibility between the General Optical Council and the NHS Tribunal.

It might be extremely difficult to decide whether a person is a fit person following a conviction that does not result in a successful prosecution. It may be more appropriate for the National Regulatory bodies to be the arbiter and take responsibility for the character of their registrants. It may be more appropriate for Health Boards to refer suspected people to the regulatory body rather than to a whole new system of investigation. This would give a consistency of approach throughout the UK.

OS does have some specific reservations and these are outlined below with reference to the relevant part of the Bill, Policy and Memorandum or Explanatory Notes section.

Policy Memorandum Section

Number # 103
This states that the “NHS Tribunal is the principal disciplinary body for family health service practitioners”. Should this be reworded to the same as Section # 107 of the Explanatory notes which restates this as the “Tribunal is the principal NHS disciplinary body for FHS practitioners”?

Number # 104
OS would ask that definitions or examples of “unsuitability by reason of professional or personal conduct” be produced.

Number # 107
This proposal suggests that a practitioner while suspended will continue to be paid, but if an Optometrist is unable to work, he/she cannot generate income, and therefore cannot be paid. This requires clarification, as the financial penalty of suspension will be considerably different depending on whether the practitioner is a Health Service salaried employee or an independent contractor.

Explanatory Notes Section

Number # 114
This states that a body corporate may be suspended or disqualified on the grounds of fraud or unsuitability. OS disagrees with this proposal. Each situation would need careful investigation before making a decision, as it would be unfair to punish an entire organisation for the act of a
single individual. A corporate body may have a large number of practices, but could be disqualified in total, based on the actions of one or two people. The actions of one individual may be unknown to anyone else within the body corporate, or may be malicious in their intent to that body corporate.

OS suggests that cases of fraud or unsuitability should be directed to the individual or practice concerned and not to the body corporate as a whole. Similar arrangements should apply to franchises and partnerships.

In conclusion

OS would not support an extra layer of administration if it duplicates tasks already performed by the National Regulatory Bodies, or which such bodies could easily assimilate.

OS thinks it is important that, and would be advisable for, the FHS practitioner groups to be closely involved in any policy development or review that follows on from the Bill.

Yours sincerely,

Hal Rollason
Chairman
8 March 2005 (7th Meeting, Session 2, (2005)), Written Evidence

SUBMISSION BY ALZHEIMER SCOTLAND

Smoking Health and Social Care (Scotland) Bill Part V Section 30

Alzheimer Scotland has welcomed the overall success of the Adults with Incapacity (Scotland) Act 2000, though aware of a number of important issues which have arising since its implementation, including the relatively poor uptake of the provisions of Section III for intromission with funds, and the vexed question of when to apply for Guardianship measures under Part VI.

Alzheimer Scotland recognises the particular professional concerns which have led to patchy use of Part V of the Act, and is content to support the proposed amendments to the Act.

We do so because they should:

i) help improve compliance with Part V of the Act,

ii) increase recognition that the Principles in Part I of the Act should be applied whenever any form of medical treatment is required for an adult with incapacity.

However, we have a number of concerns:

i) Part V of the Act was introduced without doctors being provided with the necessary guidance and training on the assessment of mental capacity. This has not yet been remedied. That guidance and training will now need to be extended to other professions. Alzheimer Scotland believes that no professional should be permitted to issue certificates of incapacity unless they have had that basic guidance and training.

ii) The proposed widening of the professional groups issuing certificates of incapacity should not be seen to diminish the need for comprehensive inter-disciplinary consultation in assessing the needs of adults with any incapacity, always involving the adults concerned and their informal carers.

iii) The proposed extension to the duration of certificates of incapacity should not be seen to diminish the importance of regular and comprehensive re-assessment of any ongoing treatment.

iv) Alzheimer Scotland has been particularly concerned by continuing reports of inappropriate prescribing of psychotropic medication to people with dementia in care homes, sometimes over long periods; and of covert administration of medication.

Part V of the Act was introduced without any specific registration or monitoring arrangements. There is an onus on the Scottish Executive, the professional bodies and monitoring organisations to help ensure that its provisions are universally applied and properly recorded, in order to secure the protection of some of the most vulnerable people in our communities.

SUBMISSION BY ENABLE

Proposed amendments to part 5 of the Adults with Incapacity (Scotland) Act 2000

Introduction

ENABLE is the largest voluntary organisation in Scotland of and for people with learning disabilities. We have a voluntary network of members throughout Scotland and over 500 national members of whom two thirds have a learning disability. We also have over 4000 members in 65 local branches. We provide both a legal and information service as well as campaigning on behalf of people with learning disabilities and their carers. ENABLE also has a limited company, ENABLE Scotland, which provides a range of services for children and adults with learning disabilities.
including supported employment, small care homes, community day services, short breaks and out-of-school care for children.

The introduction of the Adults with Incapacity (Scotland) Act 2000 (“the Act”) followed many years of campaigning by various organisations, including ENABLE, for the law to be revised. We broadly welcomed the new legislation and have responded to various consultations. We have consulted our members in connection with this paper. Our primary concern is to make sure any changes to the legislation provide a definite benefit to adults with incapacity rather than health or other professionals. However, we recognise that practical issues have arisen with the implementation of the Act that were

Extension to the range of health professionals who can sign certificates

The legislation currently allows only doctors to sign Certificates of Incapacity. Where a person appears to lack capacity any other health professionals involved must ask a doctor to authorise the treatment. This can cause delay in receiving appropriate treatment as well as unnecessary stress. In our experience this is particularly an issue in relation to dental treatment although the situation will be the same for the other health professionals currently excluded.

In principle we have no objection to the proposed amendments to the Act. We acknowledge this may lead to a quicker and better service for people with learning disabilities. However, carrying out treatment under Part 5 is a two-step procedure. Firstly, a decision must be taken on whether or not the treatment is necessary. Secondly, a judgment about a person’s ability to consent needs to be made. Careful consideration needs to be given to the guidelines issued to health professionals on assessment of capacity. Furthermore given that there still appears to be a lack of clarity among doctors about when the Act should be used we would like to see a commitment to further training. This is covered below.

Extending the duration of certificates of incapacity

The legislation currently provides that the maximum length of a Certificate of Incapacity is one year. Our view is that, given one doctor can grant a Certificate and the procedure is not subject to the same checks as guardianship, one year should continue to be the norm.

In principle we do not object to an amendment to the Act allowing Certificates to last for three years in certain cases. However, the guidelines on using longer certificates should be very clear and their use should be restricted to circumstances where there is little or no prospect of capacity being regained. We would suggest that where a longer Certificate is granted it would be good practice to carry out an annual review. The majority of people for whom it would be appropriate to grant a longer Certificate are likely to be receiving regular medical care. Accordingly a review is not unreasonable or unduly burdensome.

We would also emphasise that great care should be taken in assessing any person’s capacity. Even where a condition is unlikely to improve a person’s capacity may not always be constant. For example, the capacity of a person with a learning disability may improve over time where better or more appropriate support services are provided.

Codes of Practice and Training

If the proposed changes to the Act are made then the Code of Practice will also need to be amended. We suggest that the contents of the Code should be considered carefully and a further consultation exercise should be undertaken before the changes are finalised.

In our experience there continues to be some confusion amongst doctors about Part 5 of the Act. In particular, there seems to be a lack of clarity about when it is appropriate to issue a Certificate of Incapacity. There also appears to be little information about the potential use of Treatment Plans.
We have experience of cases where parents or professional carers are still being asked to sign consent forms for adults over the age of 16.

We believe there continues to be a strong need for additional training and awareness raising among doctors. If these changes are implemented the number of people who can potentially sign a Certificate of Incapacity will be substantially increased. Consideration must be given to properly resourced training about the Act. Such training should include not only the application of the underlying principles and how to assess capacity but also communication skills. In our experience user led training is the best way to make an impact. Ideally, we would also like to see the provisions of the Act and communication skills become an integral part of the initial training of health professionals.

SUBMISSION FROM SCOTTISH ASSOCIATION FOR MENTAL HEALTH

Part 5 – Miscellaneous - Amendments to the Adults with Incapacity (Scotland) Act 2000

SAMH was a member of the Alliance for the Promotion of the Incapable Adults Bill. We welcomed the passing of the Act, as we believe that it provided a much needed updating of the law in accordance with human rights, protection for adults with incapacity, and protection for health professionals by providing a clear legal framework within which treatment can be given.

We firmly believe that any changes to the Act, regulations or Codes of Practice must not be taken lightly. There must be cogent justifications for any changes; they must not be seen to be watering down provisions designed to safeguard the rights of adults with incapacity for the convenience of professionals.

Extension to the range of health professionals who can sign Certificates of Incapacity

SAMH is aware of concerns that the current provisions, which mean that only a registered medical practitioner can sign the certificate of incapacity, are leading to delays in adults receiving treatment for acute symptoms, such as dental treatment for the relief of pain. We are not opposed to other health professionals, such as dentists or opticians, being able to sign a certificate of incapacity relating to treatment within their area of expertise provided that they are suitably trained in relation to the Act’s provisions and the assessment of capacity. Whilst we can also see an argument for nurses being able to sign incapacity certificates, we believe that this should be restricted to nurses in more senior grades (say grades F and above).

Research published last year by the Scottish Executive stated that:
"Medical practitioners, and GPs in particular, have expressed a lack of confidence in their skills and abilities to assess capacity" and;

“The need for further guidance on the assessment of incapacity and communicating with the adult emerged from at least three different source: the review of information and training; the review of the codes of practice; and feedback from stakeholder groups, especially the medical profession”.

Assessing capacity requires particular skills, including communication skills, and a thorough knowledge and understanding of the relevant provisions of the Act and its underpinning principles. It should be a requirement that health professionals, to whom powers are to be extended, undertake accredited training in assessing capacity before they are empowered to sign incapacity certificates. NHS Education Scotland could develop an appropriate training programme.

Extending The Duration Of Certificates Of Incapacity

SAMH is not opposed to the upper limit of the duration of certificates being extended to 3 years with the strict proviso that this should only be possible in relation to adults with little or no prospect of capacity being regained. Whilst we can see that this may apply to adults who have advanced dementia or profound learning disabilities, we cannot see that it should apply to people with mental health problems as these result in fluctuating levels of capacity.

We note that the provisions in the Bill envisage that the circumstances in which the certificate might be extended beyond one year will be prescribed in regulations. We believe that it is essential that
there is wide consultation with all relevant stakeholders in relation to the content of these regulations.

SUBMISSION BY ROYAL COLLEGE GENERAL PRACTITIONERS (SCOTLAND)

Thank you for seeking our comments on this bill.

The RCGP supports the level of protection of vulnerable people given to them through the Adults with Incapacity (Scotland) Act 2000 and, as such, supports the principles underpinning this legislation.

The RCGP feels that this is a sensible piece of legislation, in that there is clearly a need for protection for adults without capacity. But overall there are concerns relating to the additional administrative burden and workload on GPs as a result of the legislation, and the perception that the certificates are another piece of possibly unnecessary paperwork.

However in light of this, and with specific reference to the two proposed changes to the Adults with Incapacity (Scotland) Act 2000, which are contained within the Smoking, Health & Social Care Bill, section 30, the RCGP welcomes the changes as a positive move to reduce the administrative burden on GPs.

On the proposed changes, the RCGP would make the following comments:

Amendment One: The extension of authority to grant a certificate

Concerns over the reliance on medical practitioners alone to sign the certificate were raised by the RCGP through the Adults with Incapacity (Scotland) Act 2000 Review. It was felt that other professionals such as nurses, dentists, community psychiatric nurses, might in fact be much more familiar with the patients.

As such, the RCGP welcomes proposals contained within section 30 of the Smoking, Health & Social Care Bill, to extend the authority to grant a certificate under section 47 (1) to health professionals who have the relevant competencies to assess the capacity of a patient.

Currently the Adults with Incapacity Act limits responsibility for assessment of incapacity to medical practitioners only. The RCGP believes this is inappropriate as it includes all registered medical practitioners regardless of the nature of their professional experience and training, while excluding others such as appropriately trained specialists, clinicians and clinical psychologists.

In addition, we support the view of the BMA, which is concerned about issues raised by the Health Committee during its early discussions on this Bill (11 January 2005). Extending the ability for other health professionals to issue certificates will not remove overall responsibility for the care of patients from the general practitioner or other doctor, rather it is intended that this amendment would prevent unnecessary delay and discomfort for patients requiring treatment. GPs would continue to issue certificates of incapacity for general authority to treat, but it would no longer be necessary for doctors to issue certificates for treatments provided by independent health professionals.

Many healthcare professionals, other than medical practitioners, have specific training and expertise in dealing with incapable adults and are in a position to judge an adult’s capacity for making decisions regarding treatment. In addition, doctors may not understand specific (e.g. dental) treatments in any detail and would therefore not be best placed to judge the capacity needed in those circumstances.

The broad definition of ‘medical treatment’ in the Adults with Incapacity Act potentially limits the access of incapacitated adults to routine treatment without formal assessment. Subsection (2)(b) lists those persons who will be able to issue a certificate, but only in respect of their own area of clinical practice. Care must be taken to ensure that terms such as dental treatment or nursing treatment are not interpreted narrowly. The essential requirement is that the practitioner doing the
assessment is capable of assessing capacity and forming a view on the likely benefit to the adult of the treatment proposed.

The RCGP and the BMA acknowledges that the list of those persons who will be able to issue a certificate can be amended by regulations subject to consultation. The RCGP supports the view of the BMA that clinical psychologists be added to this list.

Amendment Two: Duration of certificates

The RCGP have previously raised concerns over the one-year validity of certificates and as such welcomes the proposed changes, as supported through previous consultation.

This position is based on cases where patients, for example, with severe learning disabilities or progressive dementia, are unlikely to recover. Seeing them annually, simply to fill in a further certificate is seen as a waste of valuable time and simply an exercise in bureaucracy. Therefore, the proposal to extend the maximum duration of the certificate of incapacity to three years, with the length of the certificate being dependent on the nature of incapacity of the individual, is strongly advocated by the RCGP as a sensible measure.

In summary, and in its whole, the RCGP welcomes the changes proposed in the Smoking, Health and Social Care (Scotland) Bill, that would amend the Adults with Incapacity (Scotland) Act 2000.

These changes will improve the health care accessible by those vulnerable people using the health care system, while paving a way forward to eradicate some of the bureaucracy that arose from the original Adults with Incapacity (Scotland) Act 2000.

Yours sincerely

Dr Mairi Scott FRCGP
Chair
Royal College of General Practitioners (Scotland)

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 30

Main Objective: Easing authorisation of medical treatment for adults with mental incapacities.

Do you agree with the main objective of this part of the bill? yes

If yes, why?
RCN Scotland supports the extension of the legislation to include nurses as health professionals able to assess capacity and issue a certificate of incapacity thereby enabling the nurse to treat a patient incapable of consenting.

Are there any other comments you would like to make?
Section 30 (2) (b) is welcome as it extends powers to registered nurses in a specialist area to issue a certificate to allow a general authority to treat an adult with incapacity. It would mean that those nurses make the assessment of capacity. This may be particularly useful for nurses working with people suffering from dementia who may be better placed to see the incremental changes in capacity.

RCN Scotland understands that the effect of section 30 (2) (c) (ii) is that the new power for nurses in a specialist area to make this assessment would be limited to the nursing care needed. However, this goes against the overall purpose of the certificate which is to allow "general authority to treat". It may be that the Committee will need to check this against an example. Would an MS specialist nurse have the legal power to certify nursing treatment only for a patient with MS who lacked capacity, or does this power give her legal authority to authorise medical treatment (say the start of artificial hydration and nutrition)? The policy memorandum does not make this distinction
clear in relation to nursing and medical treatment. The example that is given relates to dentistry but this does not take into account the multi-disciplinary working between a specialist nurse and a doctor in relation to setting the boundary for the powers to be included in the certificate to be issued by the nurse.

The policy intention is to make two amendments to section 47 of the 2000 Act. The first will extend the authority to grant a certificate under section 47 (1) to health professionals who have relevant qualifications and training to assess the capacity of patients. This group is in addition to “registered medical practitioners” who are capable of making an assessment of the patient’s capacity as required in terms of section 47. Importantly, the certificate will only be valid within their specialism, for example a dentist could only authorise dental treatment. The authority to issue a certificate will be expanded in terms of the Bill to include dentists, ophthalmic opticians and registered nurses, but there is provision also to extend to other professional groups by regulation. Consequential changes will be made to other sections in Part 5 of the Act.

Issues to consider here are whether there are categories of nurse who cover a range of different conditions that may lead to a lack of capacity, say older people’s nurses, and assess whether this power is too wide for them because of the range of conditions or illnesses that may lead to a lack of capacity. Such nurses in a wider role may need different types of training in the assessment of capacity. However the RCN believes that it inappropriate to set out specific categories of nurses in legislation.

RCN Scotland would like to suggest that any further guidance could be set out in the Code of Practice which supports the implementation of the Act. For example training will be needed to ensure nurses are competent to assess mental capacity. They will also have to understand for which treatments they can consent i.e. are within their nursing specialism. It is likely that dentists and other health professionals will also need training and we note there are no costs identified in the financial memorandum. This is clearly going to be the case and the very real costs will be:

A) to design and deliver the training;
B) to identify, release and backfill nurses for the training;
C) to assess competence in practice; and
D) to identify that potentially nurses undertaking this role will merit job evaluation under Agenda for Change and this may attract a higher salary.

These costs are not only to the NHS but also the independent sector which has large numbers of care homes caring for the elderly and some specialising in dementia care employing some 5000 nurses.

RCN Scotland does not propose that a register be kept centrally of competent nurses. However, it should be included in the Code of Practice as good practice to keep records of nurses and others who are trained to assess capacity. This is a matter of public accountability as well as professional recognition.

RCN Scotland is currently unaware of the existence of a ‘nursing tool’ to assess competency but we are continuing with our search. We would also draw to the attention of the Committee the role that Nurse Consultants should be playing in Scotland to put strategic developments into practice. RCN Scotland’s manifesto for the 2003 election called for a targeted approach to the establishment of Nurse Consultant posts in all mainland NHS Boards in key areas including mental health, cancer, coronary heart disease, older people’s care, children and public health. Unfortunately, despite Ministerial commitment for a tripling of current numbers to a target of 54 by 2005, only half of that number are currently in place.

RCN Scotland believes the Minister and Chief Nursing Officer should put funds in place to require NHS Boards to create Nurse Consultant posts in these areas as well as Child Protection and Learning Disability nursing. Nurse Consultants and specialist/advanced nurses in mental health, older people’s nursing and learning disability would be ideally placed to lead modern nursing care with excellence in practice, evidence based care and service developments as core elements.
The Committee should also note that the NMC is currently consulting on a framework for the standard for post registration nursing i.e. advanced practice. The outcomes of this work could inform future nursing developments.

SUBMISSION BY BRITISH DENTAL ASSOCIATION

Part of Bill: Part 5, section 30

Main Objective: Easing authorisation of medical treatment for adults with mental incapacities.

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

The legislation to allow a dental practitioner to sign and issue a certificate under Section 47 of the Adults with Incapacity (Scotland) Act 2000 within his or her own professional area will facilitate the care of adults with incapacity, particularly when emergency relief of dental and oral pain and discomfort is required. Under the existing act, delays often occur in the treatment of patients suffering from dental pain whilst a Certificate of Incapacity is being sought.

In addition, the dental practitioner skilled and experienced in the care of patients with special needs may well have more understanding of the procedures and the ability to assess a patient’s capacity for consenting to specifically dental treatment than a medical practitioner.

If not, why not?

Not applicable

Are there any other comments you would like to make?

No

SUBMISSION BY EC HARRIS

Introduction

Thank you for attending and participating in the high level seminar which took place on 20 May 2004 in Edinburgh, and which was the final element in the Scottish Executive’s public consultation on ‘the use of Joint Ventures to deliver primary care/joint premises’. The seminar concluded that Local Improvement Finance Trusts (LIFT) will most likely work in Scotland as a potential means to help deliver primary care facilities for the 21st century.

The NHS LIFT ‘model’, which is already being used in England, is an initiative designed to encourage greater integration of service delivery within the primary and community care sector.

Trevor Jones, Chief Executive and Head of Health at the Scottish Executive, gave the key note address at today’s seminar which was facilitated by leading international consultancy EC Harris, and co-sponsored by legal practice DLA and major accountancy firm Grant Thornton. More than 70 delegates, representing a wide range of organisations with an interest in the health sector in Scotland, attended the event. These included: local authorities, health boards, housing associations, enterprise agencies, property developers, funders, consultants, contractors, ‘Communities for Scotland’ and the ‘Scottish Health Partnership Forum’.

Delegate groups debated the Scottish Executive’s key consultation points on ‘the use of Joint Ventures to deliver primary care/joint premises’. This paper outlines the conclusions that were made following the seminar’s seven different workshops to debate key consultation points. These points were:
The scope and definition of the proposed powers to enable Scottish ministers and Health Boards to form and hold shares in joint venture companies. 

The coverage and size of joint ventures, any possible alternative models and their structure and governance arrangements. 

The formulation and operation of joint ventures and how they should be regulated. 

The consideration of the structure of joint ventures as companies limited by share capital. 

The application of Community Planning Partnerships and their planning processes as vehicles to establish joint premises developments. 

The governance arrangements for public sector individuals acting as directors of joint venture companies. 

The suitability of the LIFT model for Scotland and any unique conditions in Scotland that would merit variations to the model adopted in England. 

Private Sector views on the English LIFT model and the likely interest in a Scottish LIFT.

The conclusions to each of these consultation points is summarised in the next section.

a) The scope and definition of the proposed powers to enable Scottish Ministers and Health Boards to form and hold shares in joint venture companies.

It is suggested that the proposed powers be drawn as flexibly as possible in both scope and definition.

Although the most likely joint venture vehicle is a company limited by share capital (the objects of which are the provision of facilities to persons exercising functions under the National Health Service (Scotland) Act 1978), the opportunities for synergies with urban regeneration projects would indicate it is also worth extending the scope of the powers to include the formation and participation in “public-public” joint ventures including by means of a company limited by guarantee or the use of a limited liability partnership (for reasons of tax efficiency and transparency) the objects of which are to undertake regeneration of urban communities. Such vehicles may not themselves undertake the provision of facilities but may delegate that obligation to subsidiary (possibly joint venture) vehicles with the private sector.

Furthermore, if Scotland is to develop a joint venture arrangement similar to LIFT, the powers of the Scottish Ministers and Health Boards to form and participate in joint venture companies should reflect that LIFT Companies (i.e. the vehicles in which the public sector investment would be held) are likely to be holding companies for the subsidiary vehicles (fundco and holdco) which will likely be established to undertake the individual waves of each LIFT scheme rather than the vehicles which actually undertake the provision of facilities.

The proposed powers should also include the ability to delegate the appropriate functions of the Health Board to the relevant joint venture vehicle and allow for potential cross subsidisation between government departments. For example, the returns derived from one subsidiary (e.g. providing healthcare facilities) may be used to invest in another project undertaken by LIFT Co (e.g for community services accommodation, education or regeneration).

It is assumed that the intention is to limit application of such powers to the provision of facilities (which itself should be interpreted in the widest sense to include services, equipment and any funding agreements etc ancillary thereto). However, although ultimately a matter of policy, given that in England, the provision by LIFT Companies of limited clinical services is under consideration. It may therefore be worth drafting the powers sufficiently widely (e.g. “for an approved purpose”) to avoid the need for further legislative amendment in the event that such a policy should be required.

The powers need to limit the exposure of the partners and minimise the risk of losses. To cover Directors taking personal liability for risks above those incurred within their normal duties, insurance protection will be required.

Clearly, the capability and training of officers to become Board Directors in LIFT Co needs to be considered at the earliest opportunity, together with the cultural impact of becoming a shareholder.
a) The scope and definition of the proposed powers to enable Scottish Ministers and Health Boards to form and hold shares in joint venture companies. There should be a definition of the required competencies and personal qualities for the role of Board Directors. This should be used to select the most capable individuals for these roles and should also drive the training programme to ensure that there is support and succession planning to protect the interests of the partnership.

In summary, it is important the powers provide the opportunity for:

• Flexibility
• Demonstration of Value for Money
• Checks and balances (i.e. Corporate Governance)
• Aligning the investment needs of Public and Private sector partners.
• The Secondary Fund Market
• Exit from the partnership

b) The coverage and size of joint ventures, any possible alternative models and their structure and governance arrangements. If a LIFT type structure is to be replicated utilising project financing then it is suggested that individual schemes will need to have sufficient "critical mass" to attract funders. This is particularly important, as bid costs may be higher during the implementation period until the process becomes familiar and standardised project documentation has evolved and become accepted.

However, this concept has to be balanced against the interests of local communities and wherever possible maintaining "ownership" of individual schemes at a local level.

Health Boards and Local Authorities should continue to be able to form joint ventures with each other and the private sector (e.g. as on West Lothian) without use of the ultimately selected template being mandatory.

Alternative models include traditional joint ventures (i.e. a virtual vehicle), and the use of companies limited by guarantee or limited liability partnerships. The regeneration sector has also spawned a number of alternative delivery models, which may be worth considering.

As mentioned above, public-public joint ventures for purposes, including inter alia provision of healthcare facilities may be worth considering in certain circumstances, particularly where the overall objective is urban regeneration.

The structure and governance arrangements of whatever vehicle is ultimately selected can be tailored to meet individual requirements as necessary, and thus the structuring of such arrangements is not seen as an obstacle or impediment to achieving stated objectives.

c) The formulation and operation of joint ventures and how they should be regulated. The role that Partnerships for Health has played in facilitating the implementation of the LIFT model in England would appear to have been important to its success. A similar structure (i.e. a body such as Partnerships UK in conjunction with NHS Scotland) should be tasked with interfacing between the Scottish Executive and individual projects during the establishment stage.

It is essential that such a body is aware that a "one size fits all" structure is unlikely to work in Scotland. Alternatively, whatever joint venture model is selected, the risk transfer model embodied in the LIFT Lease Plus Agreement appears to present a useful template that could be replicated (e.g. even on a conventional lease structure). Consideration is needed as to the overall role of the joint venture. There were two case specific examples discussed; the overall strategic partnership that is created to form a long-term vehicle for delivering a diverse range of outputs that may not be fully defined at the outset. With this in mind, the partnering aspects of the appointment and agreements are paramount as this will be a relationship based on mutual values and objectives. Alternatively, it may be desirable to set up more tactical arrangements that are designed to deliver specific programmes or projects.
The structure of the joint venture should clearly identify the roles and responsibilities of the partners involved and needs to achieve a meeting of cultural and practical requirements.

From the public sector perspective, there should be a recognition that the traditional purchaser/provider relationship must evolve. There needs to be greater awareness of the balance between commercial focus and service delivery. Whilst there will be areas for mutual compromise, some requirements in the public sector (i.e. corporate governance, Standing Orders, Financial Instructions, etc.) are not negotiable.

There was a concern that in the English LIFT model, the appointment process was skewed by the over emphasis on the quality of design. There was a danger that consortia were appointed on the strength of the Architectural input rather than their partnering qualities.

There will be a necessity to demonstrate value for money at all stages. It may be possible to obtain benchmarking information from other PPP projects within Scotland, plus data from LIFT in England.

It is essential that standardised controls for monetary commitments are in place from the outset. These should be written in to the agreements and should contain no ambiguity on the roles and responsibilities of the partnering organisations and the individuals involved.

d) The consideration of the structure of joint ventures as companies limited by share capital. There are a number of structures that can be adopted and tailored to meet the circumstances of an individual scheme. The exact structure should be flexible enough to support the objectives of each area. Alongside this, however, the shareholders agreement needs to be clear in terms of rights and obligations.

Robust public sector strategic planning is needed to reduce the "comings and goings" within the joint venture. However, this must be balanced against the need for flexibility of structure to allow other partners (public & private) to join or leave during the tenure of the company.

Experience in England has shown that changes to the structure of the partnership have inevitably incurred the burden of additional time and costs to all parties.

A balance is needed between flexibility and deliverability.

A company limited by share capital is seen as the best option because of affordability (it will allow greater borrowing) and the fact that it is a tried and tested model.

e) The application of Community Planning Partnerships and their planning processes as vehicles to establish joint premises developments. In the existing Scottish legislative framework, there is a statutory responsibility to involve stakeholders in consultation processes. There is a wish to avoid duplication of existing mechanisms.

Community Planning Partnerships are considered a good forum and appear to be central to developing the process of planning premises, given their role in facilitating joint working and long term planning. However, community-planning consultation is a specialist, skilled activity and the availability of resources could be an issue.

There is a concern that Community Planning Partnerships could create tensions as they have limited involvement and experience of the planning process for creating physical assets.

There are numerous initiatives from the Departments of the Scottish Executive many of which involve Community Planning Partnerships and these need to be tied together by the Executive to avoid confusion and conflict between the different parties. Inter-Departmental communication and cooperation within the Scottish Executive is seen as essential to achieving this aim.

There is a need to develop the link between local and strategic planning, which was perceived to be missing from the current LIFT process.
Methods to ensure that all appropriate stakeholders are fully engaged in the planning process. The scope of the planning process needs to be clearly defined. For the purposes of the consultation workgroup it was taken to apply in its broadest sense to the overall planning and delivery of projects.

Existing frameworks can be applied - Community Planning Partnerships within the Scottish context and the SSDP used in English LIFT projects. To optimise engagement, a Scottish process probably needs to draw on both.

The Strategic Service Delivery Plan (SSDP) should be initiated and driven by the Health Boards and draw in key public sector stakeholders such as senior GPs but not involve the private sector - this is for later.

NHS Scotland seen as playing a greater role than its English equivalent because of the size and structure of the Scottish health sector. Question whether an independent "Partnerships for Health" is needed or the existing unit can be strengthened to take on this kind of role.

Early stage planning needs to be focused very much on healthcare driven objectives - regeneration is a by-product, not a driver.

Local conditions will affect the balance of input from different stakeholders - local authorities may take a greater or lesser role according to the circumstances, for example, so the process needs to be flexible enough to accommodate these variations.

The process of stakeholder engagement should be carefully planned throughout, with clear ground rules and system of champions / spokespeople as appropriate, who are able to represent the interests of their stakeholder groups effectively.

What clearly doesn't work is where the key spokespeople for the project are not stakeholders (e.g. consultants!).

Each SSDP is local to a particular area, but it may not be communicated to all of the stakeholders in the locality. Some partners become involved late in the process and others fall away as Financial Close is approached. It was felt that within the English LIFT process, the consultation process was piecemeal and caused delays to the programme. It was suggested that it could be improved by having agreed milestones and objectives with a fixed close that is linked to specific outcomes.

The group would like to see the focus of LIFT broadened to include other community based services beyond health, though it was recognised that this could create issues around service planning. It was suggested that a regeneration “badge” would allow a wider range of services to be included in the LIFT, though there was a clear need for a single Agency to take the lead. It was recognised that this approach could carry a risk of the priority objective of improving health outcomes in the community being diluted.

It may be helpful to embed the supply chain in the joint venture vehicle at an early stage to ensure that their views contribute to the planning stages. Examples of potential benefits include identification of sites and broader development opportunities that cannot be realised by the public sector in isolation.

g) The governance arrangements for public sector individuals acting as directors of joint venture companies.
Such arrangements should not be problematic. Public sector individuals undertaking such a role is a fairly well worn path and problems of "conflicts" are likely more apparent than real. In any event, the constitutional documents of the joint venture companies including Shareholder Agreements between shareholders commonly regulate issues as between investors including the conduct required should a conflict of interest arise.
On the other hand, training of public sector individuals undertaking such a role in such practices may be beneficial. It may also be worth appointing a body to undertake monitoring roles to compare practice across projects and potentially provide support should difficulties arise.

From the public sector perspective, the parameters for reinvestment of the proceeds derived from joint ventures should be clearly laid out.

There will always be an imperative to demonstrate transparency and auditability in all transactions. All decisions, fiscal or otherwise need to be taken in the light of the evidence available at the time. This will drive the requirement for independent monitoring reporting.

Additionally, the interpretation and development of policy must flow through the process to avoid inconsistent decision-making.

One important topic covered by this area of policy will be Conflicts of interests. There should be clear guidance for public sector individuals on how to identify and resolve any areas of uncertainty and how to react, should a conflict arise.

Consideration to how conflicts are to be dealt with (e.g. “Chinese Walls”, etc.) could be developed prior to the formation of joint venture companies. There are many existing examples of these protocols already in existence and a suitable model from elsewhere could be easily adapted.

h) The governance arrangements for public sector individuals acting as directors of joint venture companies.

There would not appear to be anything unique to Scotland, which would suggest LIFT is not a suitable model. However, there are some peculiarities that would have to be addressed. Examples of these are provided below.

The Employment Protocol
This will probably affect the pricing model. However, in this respect it is no different to other PFI/PPP Schemes undertaken in Scotland;

Legal system e.g. land issues
Title to land is held by the Scottish Ministers rather than Health Boards and this would probably require some amendment to the standard LIFT documentation. More generally, well-drawn documentation, which represents a workable framework, is more likely to be successful. The LIFT model in England appears to have reached a sensible balance between public and private sector interests and if LIFT is to be replicated for Scotland, time spent adapting the documentation is likely to reap rewards down the line.

Demographics
It may be difficult to balance critical mass with local community ownership if schemes in the highlands are bundled together. Community involvement and participation is likely to be key to the success of such initiatives;

Political Climate
The Scots are generally more hostile to PFI/PPP than their southern counterparts. However, the fact that the public sector stands to benefit from potential profits through participation in the joint venture vehicle may prove a selling point.

Scottish PFI Market
The market is fairly sensitive. Care must be taken with the timing of projects coming to the market. However, this may prove to be less sensitive as different contractors may be attracted (i.e. smaller players) given the size of the individual schemes. However, the quality of standard documentation will play a critical part, as there is unlikely to be an appetite to reinvent the wheel and incur significant bid costs.
Structural and organisational characteristics

No PCTs, so who drives the local agenda? Because the same Boards run primary and secondary care in Scotland there will be different challenges than in England (where PCTs and acute trusts are separate).

Scotland has no PCTs, there are 15 Health Boards. The individual Boards have flexibility to structure health organisations in their geographical area. It was uncertain how LIFT would be implemented – ie driven centrally by the Scottish Executive or devolved to the Health Boards for local interpretation. Whatever option was chosen, it was seen as essential that the policy should be as fully developed as possible before the roll out.

The SSDP must reflect and integrate the estates strategies of all of the stakeholder organisations.

PfH are not present in Scotland, will there be an equivalent created?

However, it was believed that involving LAs will be easy because of the level of joint planning that already goes on. It was believed that as a result LIFT in Scotland will be even more flexible with more exciting outputs.

Staff side issues characteristics

It was felt that the staff side was stronger in Scotland i.e. where JVs would displace existing public sector staff this would be resisted very strongly. Employment protocol ie TUPE. FM – UNISON was believed to be against LIFT in Scotland.

Geographical characteristics

Geographical issues - the conurbations of Glasgow and Edinburgh are similar to England, however, there are some very remote communities with small populations in Scotland. The challenge will be how these communities can be joined into viable JVs. It will be even more critical to encourage Local Authorities to be involved because of the need to gain critical mass in remote areas. One size fits all won’t work – geography/remote areas. The geographic factors of Scotland are different to England, ie central belt of population and remote and sparsely populated rural areas.

Socio Economic characteristics

Overall it was believed that there was not as much deprivation in Scotland and so they are starting from a better position.

Summary

Self evident that some form of LIFT model could work but not exactly the English model. Key issues include: population density, condition of estate, perceived investment requirement. What is the size of the market? Concern from the private sector about broadening the scope beyond the relatively "low tech" approach seen in England so far.

There may be opportunities to learn from and improve upon the English approach. Examples include

Is the 40%:60% shareholding split in LIFTCo appropriate for Scotland?
What central support will be available (e.g. equivalent of Partnerships for Health)?

It was stated that strong project management of the process was considered essential to the success of LIFT.

i) Private Sector views on the English LIFT model and the likely interest in a Scottish LIFT.

The robustness of future programmes of work is factor that will influence the private sector interest in joint ventures, i.e. lack of certainty/guarantees on pipeline workload. Each phase should ideally be profitable as a stand-alone venture.

Agreements need to be long term and exclusive to be most attractive to the Public Sector. Exclusivity, however, was seen as complex as e.g. Local Authorities may also have other exclusivity agreements.
Bid costs are considered high, therefore cashflow and funding to financial close and the speed of close are issues. Within the English LIFT model contracts now defined to enable recovery of bid costs.

Due to high bid costs, bidders in Scotland may not wish to bid for projects that are too big.

Deliverability. Land ownership issues have been a problem in England. The Public Sector needs to raise its game to ensure robust strategic planning so that commitments can be made.

Scope of services within the deal. Most members in the group agreed that soft FM should be included – although one contractor felt that it should definitely not be. Clinical services should not be included. Will the private sector be interested in LIFT if FM is not included, or only partially included? Very interested - this is a hybrid PFI / land play.

Funding Issues:
• It was seen as desirable/essential that funding goes into the main LIFT CO.

• LIFT in England was seen as good and the timing was right (political pressure to deliver). That same time pressure may not be there in Scotland. However, primary care is leading the drive to deliver improved healthcare services.

• If there is more time available, there may be benefit from waiting and learning lessons from the English experience.

• Banks may not wish to fund projects that are too small to be financially attractive.

• How can Scotland reduce the costs of LIFT compared to PPPs? (NB this may be a misconception – are the LIFT costs higher on fair comparison of all services?).

• This approach may suit the size of contractor base in Scotland.

• It would be helpful if a portfolio approach could be adopted to help spread risks.

• It may be appropriate to implement 1 or 2 pilots in geographically distinct areas (e.g. Central Belt, Highlands)?

• Perceived lack of public sector skills. Some kind of PfH-type facilitator required.

3. Conclusion
Delegate groups debated the Scottish Executive’s key consultation points on ‘the use of Joint Ventures to deliver primary care/joint premises’ before coming to the conclusion that LIFT was a model that could be adopted in Scotland. The adoption of LIFT is subject to legislative changes being enacted which would allow private sectors organisations to enter into joint ventures with Scottish health boards. The delegates concluded that a number of related issues would need to be addressed to enable LIFT to work effectively in Scotland. These include:
• There needs to be recognition of the differences in demographics and geography in Scotland versus the experience so far of LIFT in England. This could require batching of geographic areas to achieve the critical mass required to make the LIFT model viable and hence attractive to private sector investors.

• Long term strategic planning is required from the Scottish Executive and the local health boards to avoid a piecemeal approach and to provide long-term certainty for private sector investors.

• A flexible approach is required rather than a ‘one size fits all’ model. This would allow for differences in the ownership structure of LIFT Companies, provide flexibility for changes over time, and flexibility on the range of services to be included in each respective LIFT.
WHilst LIFT can be a catalyst for broader regeneration initiatives, focus should not be lost on the overarching objective of LIFT which is to deliver primary health facilities for the 21st century and hence improve overall patient health outcomes.

An executive spokesman from the Scottish Executive said: “Today’s seminar has played a valuable part in the Scottish Executive’s consultation process. We are committed to engage with all potential stakeholders and we very much welcome the opportunity to receive the views of those who have attended and contributed to today’s successful event.”

Ken Talbot, Head of EC Harris’ Scottish Operations, said: “This seminar has been a unique opportunity for those involved in, and those interested in, primary care in Scotland to contribute to the public consultation process that will help to establish the framework for the delivery of 21st century primary care facilities in Scotland. We hope that the conclusions drawn today will contribute positively to the public consultation process that will help shape government policy for Scotland, including potential legislative changes required to allow public private partnerships in this area.”

SUBMISSION BY COSLA

COSLA is pleased to have the opportunity to give oral evidence to the Health Committee on the Joint Ventures elements of the Smoking, Health and Social Care (Scotland) Bill. As the Committee will know, COSLA has already submitted evidence on the Bill generally and, specifically, on financial aspects. As requested, the following comments are restricted to the Joint Ventures provisions. Our comments will focus on the following areas:

- Consultation on Joint Ventures
- Concerns and Opportunities on Joint Ventures
- Views on what should happen now

Consultation on Joint Ventures

The Committee will be aware of the perceived lack of involvement of Scottish Local Authorities in the joint ventures elements of the Bill. These sections of the Bill do have relevance to local government, if not immediately, then potentially in the longer term. From the practical perspective, local authorities have a range of experience, good, bad and mixed in involvement in private partnerships. The overall principle of partnership with non-local government bodies has not, and will not, be rejected on ideological grounds.

There is a view that the development of the Joint Ventures section of the Bill has been internalized within the NHS system. As a result, whilst there has been officer level contact, this contact has been restricted to the applicability or otherwise of the English model in Scotland rather than focusing on a wide range of options. There has been no political engagement on the issues – an omission that is particularly concerning given the fact that COSLA has previously highlighted a similar omission in relation to the NHS Reform (Scotland) Bill.

This lack of prior political engagement gives rise to fears – perhaps unjustified - about a lack of transparency in the approach adopted and a consequent suspicion about the focus on the LIFT (Local Improvement Finance Trust) Scheme.

COSLA feels that the following should have been the subject of prior consultation and will now be seeking clarification from Ministers as to:

- What the partnership schemes are designed to achieve;
- The scale of the intended schemes
- Whether there is a wider strategy behind the proposals (either within an NHS Board area or at national level)

Concerns and Opportunities

The principle of Ministers enabling Health Boards to have access to a greater range of investment sources to support the development of infrastructure and better integration in service planning is
accepted. However, it cannot be assumed that, as a matter of course, local government will benefit in the same manner as the NHS. Similarly, it cannot be assumed, as the financial memorandum suggests, that this section of the Bill will have no financial impact on local authorities.

Although the provisions in this Bill are directly targeted at the NHS, and, it is understood, specifically the general practitioner estate elements of the system, the consequences of enabling this will fall directly within the scope of local government – something COSLA must highlight.

The Executive has been investigating the suitability for Scotland of the LIFT Finance Trusts being implemented in England by the Department of Health on the basis of their potential flexibility for joint premises developments. The Executive has concluded that the decision on the development approach most suitable for each Health Board area in Scotland is one to be taken locally in conjunction with other partners.

Introduction of LIFT type entities may offer an appropriate way forward in some parts of Scotland, particularly where there is an urgent need to find a way to address the strategic planning deficit in closer collaboration with the private sector and other public sector agencies.

In other areas, partners may decide that their objectives for the medium term are already sufficiently well scoped and that a variety of delivery vehicles may offer an appropriate way forward. These could still involve joint ventures with the private sector or wholly within the public sector. It is understood that the Executive intends, once these powers are in place, that all Health Boards and local authorities will be invited to confirm how they intend to deliver their respective infrastructure development strategies to identify whether joint ventures may offer an appropriate vehicle.

An area by area approach is something COSLA would support but again it must be clear that this is in fact the intention and not a covert means of promoting a national approach without proper consultation with COSLA.

For the avoidance of doubt, COSLA see merit in allowing local partnerships to come to a strategic decision based on what suits their needs. The provisions in this section of the Bill will not determine local government’s involvement as the ability to enter into partnerships already exists.

COSLA believes that there is scope through joint ventures to investigate the possibility for enhanced joint working, including capital projects between local authorities and the NHS. As with other areas of joint working COSLA, and local government, are supportive of this provided there is real and demonstrable added value to both parties and the communities they serve. Pressure to enter into joint ventures should not be seen as an expedient vehicle to assist the NHS to overcome any difficulties with securing appropriate capital resources to overhaul an ageing estate. At present the Scottish Executive way of handling this issue is creating a suspicion that this, rather then providing an enabling framework, is the aim.

What should happen now
COSLA has already indicated that we are not necessarily opposed to this aspect of the Bill on ideological grounds. Our concerns are about the need for proper political engagement and a clear understanding on whether or not Ministers have made decision on this being a local decision making process or a national framework. If so should it be the LIFT scheme or are there better way of handling joint investment in infrastructure to enable better service delivery?

In COSLA’s view there now needs to be political engagement and a clear discussion on how to proceed next. That is what is currently missing. We feel that this should involve the Ministers for Health and Local Government and Finance and believe that there are opportunities to enhance partnership work and services to citizens if we secure open dialogue at political rather than officer level.

Finally, COSLA would also be willing to have a discussion of the implications of this element of the Bill. To date, the focus has been on the NHS improving its locally based estate (GP surgeries) and that this will lead to service improvements. Whilst COSLA does not disagree with this as an objective, we are aware that investing in this area of work means either not investing elsewhere or shifting existing priorities. This has yet to be acknowledged and COSLA would wish to make sure
that we were not investing capital at the expense of resources that would otherwise have been
directed at delivering services.

Conclusions
COSLA intends to raise these issues with Scottish Ministers with a view to exploring our concerns
and receiving the clarification and assurances required In connection with these sections of the Bill.

COSLA hopes that this submission, despite its late timing, for which we apologies, is helpful to the
Committee.

Yours sincerely

Alan McKeown
Policy Manager, Health & Social Care Team

SUBMISSION FROM STUC

Joint Ventures

The STUC welcomes the opportunity to give evidence to the Health Committee on this important
issue. The STUC is Scotland’s Trade Union Centre. Its purpose is to co-ordinate, develop and
articulate the views and policies of the Trade Union movement in Scotland. The STUC represents
around 630,000 working people and their families throughout Scotland. Our affiliated organisations
have interests in all sectors of the economy. Our affiliates are strongly represented in the NHS and
health sector generally. Trade union members also have an interest as users and funders of health
services.

Fundamentally the STUC is opposed to private business taking over the ownership, financing and
management of any public sector infrastructure and services and tying the public sector into
exclusive long-term contracts with private sector companies. The STUC and its affiliates supports
the continuing process of improvement and development of Scotland’s public services. We believe
that public services should be run on ethical lines based on the principles of selflessness, integrity,
objectivity, openness, accountability, competence and equality.

However, it is our belief that PPP and PFI undermine these principles as they undermine
accountability, transparency and flexibility. We reiterate our long-standing opposition to the
involvement of the private sector in the delivery of public services and reject the notion that the use
of PFI and PPP is the only or best method of financing the build and delivery of public services. We
remain committed to our stance of opposition to the government’s continued promotion of PFI and
PPP.

We are convinced that the joint ventures model and NHS LIFT programme for primary care as
detailed in this consultation are further variants of PFI and PPP models of investment and will be
extended to all NHS services. We endorse joint working between public sector organisations where
it improves the effectiveness of our public services, and have proposed the establishment of public
sector networks for this purpose. However, when joint working refers to working with the private
sector through joint ventures and NHS LIFT, it is unacceptable.

The STUC is deeply concerned that the commercialisation of the NHS has reached the point of the
Scottish Executive proposing the direct investment of public sector money for the purpose of
making profits for the private sector. Furthermore, we are very concerned that other public services
will be commercialised in this manner.

Specifically the STUC have concerns regarding:
• The requirement of public sector partners i.e. to hold shares and to become members of boards of directors of profit making companies as required under this new venture. We believe this will cause problems with accountability and conflicts of interest.

• The plans for majority shareholding of the private sector in LIFTCOS - as it raises questions on control as it brings new and different commercial aspects to public services.

• The lack of clarity as to how the Joint Ventures will be evaluated and state our belief it will be necessary to fully monitor and review all contractual and governance arrangements in the interests of transparency and accountability

• The ability of national joint venture companies involving Partnership UK to give independent advice to local LIFT projects.

• The affordability and value of money of the LIFT scheme given that participants in the scheme will be required to commit themselves to long term contacts and put extensive resources into the setting up of the scheme and into leasing and maintenance but will not own the building at the end of the contract.

• Possible job losses, which will be sustained through the use of Joint Ventures. As the premises owned by the LIFTCOS will be maintained and serviced by them.

• Potential new issues of capacity and risk with the LIFT schemes and it is unclear how much of this risk will actually be transferred to the private sector or be borne by the public sector.

• Possible escalation of PFI costs during contract negotiations. The risk of such cost increases in LIFT will be borne by the Health Boards and other public sector partners.

• Whether the schemes proposed in last year’s Scottish Executive consultation are to be treated as PPP/PFI schemes and, therefore, be covered by the PPP staffing protocol. We strongly believe that the protocol should apply to all joint ventures involving the private sector and we would seek positive clarification in the Bill.
The Scottish NHS Confederation is the independent representative body for NHS boards and special health boards in Scotland. We are grateful to the committee for this opportunity to give evidence on the Joint Ventures element of the Smoking, Health and Social Care Bill.

The Confederation supports the principle of allowing NHS boards to enter into joint ventures. Extending this ability to the NHS will give boards additional options for the development of premises and facilities and has the potential to enhance partnership working within the public sector by allowing the NHS to take part in the kinds of joint ventures that are already undertaken by local authorities. It could also generate additional resources for health and other public services.

Investment is badly needed for the provision of modern, fit-for-purpose healthcare premises in many parts of Scotland. A range of financial pressures – such as pay modernisation and increased prescribing costs – mean that NHS boards have very little flexibility within their annual resource allocations to invest in facilities development. Although the Scottish Executive has released additional funds for this purpose at various times in recent years, other sources of investment are required to meet the existing need. Having the ability to enter into joint ventures with either public or private sector partners will provide NHS boards with an additional tool for the provision of high quality healthcare facilities and improved access to services for the public.

The potential to use joint venture companies as a vehicle for exploiting intellectual property developed within the NHS is also welcome. This is an untapped resource that the NHS has neither the time nor expertise to take forward. With sensible joint venture arrangements in place, those who do have the expertise in a very complex field can help release the potential on a shared risk and reward basis.

Local authorities already have the power to enter into joint ventures and have used it in a variety of ways. Examples include the Craigmillar Partnership urban regeneration company in Edinburgh and North Ayrshire Ventures Ltd, between North Ayrshire Council and the EDI Group which aim to create community facilities such as roads, schools, housing and office space, to bring employment in to the communities. The new legislation would not only give the NHS the same powers that local authorities already hold, with their attendant flexibilities, they could also, by allowing the NHS to take part in these kinds of partnerships, add a specific health improvement element to local regeneration work.

One of the joint ventures models that could be adopted in Scotland is the NHS LIFT (Local Improvement Finance Trust) model that has already been widely used in England and Northern Ireland. More than 50 LIFT projects are underway or have been approved, ranging from developments of £100,000 to £20 million. Results from the early projects have been encouraging and provide valuable lessons for Scotland. Projects so far have delivered one-stop facilities offering a wide range of health and social care services under one roof. Local authority involvement has extended far beyond social care, however, to include environment and transport considerations – participants have testified that this has helped to break down silo mentalities and nurture a partnership ethic between local service providers. Many are situated in deprived urban areas and are making a significant contribution to local community regeneration. Considerable attention has been paid to ensuring that the new facilities are based on good, user-friendly design, and several new primary care centres have emerged as significant local architectural landmarks.

NHS LIFT is not the only possible joint ventures model, and the English model could certainly not be imported in its entirety to Scotland without some adjustment to take account of our different structures and demography, for example. However, the experience so far demonstrates the potential that joint ventures powers for NHS Scotland could realise. Although the expectation is that the new power will be used mainly to develop new primary care facilities, it would not have to be restricted to that and the potential to extend into other areas of healthcare exists.

Another potential benefit for developing healthcare facilities through joint ventures lies in the choice and flexibility that it would provide for independent primary care contractors, such as GPs, dentists and pharmacists, in allowing them to lease premises from the joint venture company. This could prove an aid to recruitment in remote and rural areas, for example, where the need for independent
contractors to make significant long-term investment in buying, renting or upgrading premises can act as a disincentive.

We are aware that there are objections to what is seen by some as an extension of PFI and private sector involvement in delivering healthcare. The Confederation does not intend to take part in a debate about the rights and wrongs of the NHS working with the private sector. However, in order to clarify the context in which these developments would take place, we would point out that private sector involvement in primary care premises is not new—many GPs and dentists already rent their premises from private sector companies. Furthermore, unlike PFI, joint venture companies are not merely a contracting mechanism, but allow the NHS to enter into long-term partnerships and to see a return on their investment by sharing in any profits generated. Private sector partners would be restricted to the provision of facilities and their maintenance only; they would not be involved in the actual delivery of the service. Crucially, joint venture companies do not have to involve the private sector at all—they can be ‘public-public’ partnerships between the NHS, local authorities and other public sector agencies such as the police, and as such could be a valuable extension of the integrated partnership working that is already being developed through Joint Future and Community Health Partnerships. Finally, we would emphasise that joint ventures are not compulsory. They would merely be another option open to the NHS, and individual boards can choose whether or not to enter into them. NHS boards can continue to pursue premises development through traditional funding routes.

The question of there being a potential conflict of interest for public sector employees or board members sitting on the boards of joint venture companies has also been raised as an objection. The Confederation does not believe that this scenario would, in reality, present any significant problems; the principles of public sector governance by which NHS board members abide would continue to have primacy. However, we recognise that the potential exists in theory, and would recommend that governance arrangements for joint venture companies are carefully reviewed to ensure that conflict does not arise in practice. Protocols could be issued in the form of guidance from the Executive to ensure that there is clarity about roles and a consistent approach across Scotland.

There is clearly a good deal of detail still to be worked out on what form or forms joint venture companies would take and on benefit for the NHS would be maximised and on shared ownership of risk and reward. We would expect Ministers to ensure that the service is kept involved in the further development of these proposals. We would also urge that no ‘one-size-fits-all’ approach is adopted and that flexibility is built into the final system in order to allow local NHS boards to make decisions that respond to their local circumstances in the most appropriate way. On the other hand, given the potential range and number of partners becoming involved in specific joint ventures, there is a danger of arrangements becoming excessively complex. Consideration should be given to making arrangements as streamlined as possible, whilst taking the different approaches of the various partners into account.

SUBMISSION FROM UNISON

Introduction

UNISON Scotland welcomes the opportunity to respond to the call for evidence from the Scottish Parliament’s Health Committee regarding the above Bill. While welcoming some of the general principles and aims of the Bill, UNISON Scotland would like to comment on some particular issues highlighted in the call for evidence.

Part of Bill: Part 5, section 31

Main Objective: Allowing Scottish Executive to participate in joint ventures to provide services and to exploit intellectual property.

Do you agree with the main objective of this part of the bill? No
UNISON Scotland is opposed to private business taking over the ownership, financing and management of any public sector infrastructure and services and tying the public sector into exclusive long-term contracts with private sector companies. There is a concern that such schemes involving the private sector are under misguided pressure to pursue off-balance sheet schemes and this has encouraged the unnecessary transfer of staff.

UNISON Scotland has concerns regarding the requirement of public sector partners i.e. to hold shares and to become members of boards of directors of profit making companies as suggested in this new legislation. We believe this will cause problems with accountability and conflicts of interest.

UNISON Scotland is also concerned that there is no indication as to how the Joint Ventures will be evaluated and we believe it will be necessary to fully monitor and review all contractual and governance arrangements in the interests of transparency and accountability.

UNISON Scotland is concerned at the job losses, which will be sustained through the use of Joint Ventures. The premises owned by the joint venture companies will be maintained and serviced by them. There is also concern that, as in the past with other PFI schemes, costs will be cut and profits increased by worsening staff pay and terms of employment and career opportunities for new staff, so creating a two tier workforce.

There is a further concern that there will be new issues of capacity and risk with the joint venture schemes and it is unclear how much risk will actually be transferred to the private sector. As with any other private company, joint venture companies could fail and so there will be risks in the public sector contracting with them and also in being shareholders.

UNISON Scotland is concerned that the cost of using PFI has tended to escalate during contract negotiations. The risk of such cost increases in joint venture will be borne by the Health Boards and other public sector partners. Therefore a joint venture agreement is likely to make significant claims on the revenue budget of the organisation for many years with a consequence to other services.

For further information please contact:

Matt Smith, Scottish Secretary
The Convener: We move to oral evidence on part 5 of the Smoking, Health and Social Care (Scotland) Bill. The first session deals with section 30, on the authorisation of medical treatment for adults with incapacity. The committee papers include background briefings by the Scottish Parliament information centre on part 5, as well as submissions from a number of those who are present today.

I welcome to the committee the first panel of witnesses, which includes: Dr Alan Jacques, convener of Alzheimer Scotland; Nicola Smith, legal adviser of Enable; and Sandra McDougall, legal officer for the Scottish Association for Mental Health. Can I have brief introductory statements of no more than about two minutes each? You are welcome to forgo making a statement if you wish.

Dr Alan Jacques (Alzheimer Scotland): Thank you for inviting us along today. Alzheimer Scotland is the principal organisation for people with dementia and their carers in Scotland. We have had a long-standing interest in the bill, its progress and its success. We have been delighted overall with the success of the Adults with Incapacity (Scotland) Act 2000, but it has been a disappointment that part 5 of the act has been underused throughout the country, although we are aware of some areas in which it is being used and has worked perfectly well.

We are aware of the reasons why the amendments to the 2000 act have been brought forward in the bill, and we are content with them. However, we see them as part of a wider context of making sure that part 5 of the act works effectively, which involves issues about training and awareness and the way in which part 5 is used.

Sandra McDougall (Scottish Association for Mental Health): I thank the committee for the opportunity to give evidence on behalf of the Scottish Association for Mental Health. For members of the committee who might not be familiar with SAMH, it is both a major provider of services to people with mental health and related difficulties and a campaigning organisation.

Our general position is that there must be convincing reasons for any amendments to the Adults with Incapacity (Scotland) Act 2000. Any changes must have a potential benefit for adults with incapacity and must not be aimed simply at reducing the burden on professionals. Although SAMH is not opposed to the amendments that the
bill seeks to make to the 2000 act, there are provisos attached to that position, which have been set out in more detail in our written submission.

Nicola Smith (Enable): I also thank the committee for giving us the opportunity to give evidence. Enable is the largest voluntary organisation in Scotland of and for people with learning disabilities. We are very much a member-based and member-led organisation. We have more than 4,500 members, most of whom are in 65 branches throughout Scotland. Like the other two organisations that are represented on the panel, we were heavily involved in the alliance that campaigned for the introduction of the Adults with Incapacity (Scotland) Act 2000. We have a legal and information service that regularly gives advice and assistance to people in connection with the act. We recognise that, as the act has been implemented, some unanticipated practical issues have arisen, but we feel that any changes to it should be justified and should be made in the interests of adults with incapacity rather than for the convenience of professionals.

The Convener: Thank you. I invite questions from the committee. Jean Turner will lead off.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Good afternoon. It would seem that you welcome the fact that more people than just general practitioners will be able to issue certificates of incapacity. A concern about training is common to all your submissions. The submission from the Scottish Association for Mental Health refers to research that says that some general practitioners “have expressed a lack of confidence in their skills and abilities to assess capacity”.

It is important that whoever assesses capacity knows how to do so and that the necessary training is in place. I would like to get your feedback on that.

Enable commented:

“We have experience of cases where parents or professional carers are still being asked to sign consent forms for adults over the age of 16.”

There are still some problems with the system as it stands and we are about to extend responsibility to different people. What do you have to say about training?

Nicola Smith: Enable is regularly asked questions about part 5 of the 2000 act, many of which stem from the fact that doctors are apparently not aware of when it would be appropriate for them to sign a certificate. Quite often, parents and carers are still asked to sign consent forms to allow treatment to take place. That concerns us because the act is no longer new—it has been in force for more than two years. It is a bit disappointing that such problems are still being experienced.

We welcome the idea of more people being able to sign certificates because we think that that will lead to quicker treatment for people with learning disabilities. That measure must be backed up by training and awareness raising among professionals.

Dr Jacques: From the beginning, we have said that there would need to be quite a lot of training in relation to the 2000 act. The idea that someone may be incapable of making highly significant decisions about their life is a major matter on which to make a decision.

At the extremes of capacity and incapacity, the issue may be quite simple but, in between, the concepts get extremely complicated. For example, people can change their degree of capacity; they can be capable of making some types of decision but not others; and there can be difficulties with communication. All sorts of factors have to be taken into account. The assessment of capacity is not a simple process of saying that so-and-so is capable of this and not capable of that. There are large training implications that, as far as we are aware, have never been fully addressed. I understand that the issue is being discussed with NHS Education for Scotland but, as has been said, it is a little late in the day for such consideration. Some of the difficulties that we are addressing today would not have arisen if the issue of training had been covered right at the beginning. A lot of work still has to be done on doctors and the other professions that might become involved.

The Convener: Are you saying that the only discussions that you have had about training were held recently with NHS Education for Scotland?

Dr Jacques: I understand that the Executive has been discussing training with NHS Education for Scotland.

The Convener: But you were not included in those discussions.

Dr Jacques: No.

The Convener: Have any of the organisations that you represent been included?

Sandra McDougall: No.

Nicola Smith: No.

Dr Jacques: No. There was a lot of discussion when the 2000 act first came into force, but the issue was shied away from because it is difficult and complex for medical practitioners.

The Convener: Right. If it is complex and difficult for medical practitioners, the implications
of extending the provision well beyond medical practitioners means that it will be equally complex for all the professions on the list at proposed new section 47(1A)(b) of the 2000 act.

Dr Jacques: Yes, but the issues are the same for all of them. We have to consider how we assess reliably somebody’s capacity to make particular types of decision.

Kate Maclean (Dundee West) (Lab): I sat on the previous Justice and Home Affairs Committee when the Adults with Incapacity (Scotland) Act 2000 went through the Parliament. The provisions are complicated, particularly given that people might be capable of taking some decisions but not others. I agree absolutely that training is important, but I wonder what kind of training programmes could be implemented, given the complex nature of the act, and who would be responsible for running them.

Dr Jacques: Those matters would probably be for NHS Education for Scotland. They fall within its remit, and it is well placed to provide training, because it is a multiprofessional organisation that covers all bits of the national health service and can call on specialist expertise from psychiatrists, psychologists and nurses. There is plenty of information around; it is a matter of getting it into a simple, usable form for the wide variety of practitioners involved, which should not be impossible.

The Convener: Would you expect to be consulted about training?

Dr Jacques: Yes.

Nicola Smith: Yes. It is really important that training focuses on the principles of the 2000 act and involves service users. We find that involving service users, such as people with learning disabilities, in delivering training is the best way to get the message across. We feel strongly that they should be involved. We would also like to see training on assessing capacity and on the 2000 act included in the initial training for medical practitioners, nurses, opticians and dentists. For future generations that would mean that the issues were covered at an early stage.

The Convener: If the bill goes through, but the training requirements are addressed no better than they have been, what do you think will happen? Will we be back here in another two years’ time with more problems?

Sandra McDougall: The provisions will probably not be used.

The Convener: So without the training you think that the provisions will not be used.

Sandra McDougall: Yes, or we will find ourselves in the position that has been reflected in research to date, in which general practitioners and such like are saying that despite the fact that the 2000 act has been in force for some time, they do not feel confident about assessing capacity.

Dr Turner: What do you think about physiotherapists being included in the list of people who can assess? Many people will need the services of a physiotherapist. I imagine that, like others, they would like training.

Sandra McDougall: The same arguments apply to physiotherapists as to the other professions that are listed in the bill. I am not sure how the Executive arrived at that list, but I was a bit surprised that it does not include clinical psychologists. At one stage, it was suggested that clinical psychologists should be included in the list, but I am not sure why they are not included.

14:15

Dr Turner: If people were not asked about the list, they would not have been able to highlight any apparent anomalies in it.

The Convener: Can we get a quick run around the witnesses to seek their views on whether the power should be extended to physiotherapists and clinical psychologists?

Dr Jacques: As I understand it, the reason for the list is that certain groups of practitioners arguably provide treatments quite separately from doctors. For example, dentists usually carry on their treatments without reference to doctors. The question is whether we should put in an extra loop by requiring the dentist to consult the patient’s doctor before treating the patient. A similar question should be asked of any other profession that might be added to the list. Whether it is necessary to include a particular profession is a matter of judgment.

In assessing capacity, the question that is asked is not whether a particular treatment is the right one but whether the person can consent to it. The fact that people have not always been clear about that distinction has sometimes clouded the issue.

The Convener: We need guidance on who should be in the bill. There is a question mark over whether physiotherapists and clinical psychologists should be included in the list at proposed new section 47(1A)(b). You seem to be suggesting that the list of professions at paragraph (b) should remain as it is given that patients will be under the care of those professions because of the doctor’s involvement.

Dr Jacques: That may be—

The Convener: You made the suggestion, Dr Jacques—I am just trying to clarify an issue that has been raised with us.
Dr Jacques: I have explained what the issue is, but I could not say whether physiotherapists and clinical psychologists should be included in the list. The issue is whether the profession in question provides a separate treatment or whether the involvement of the doctor is necessary as part of that treatment.

The Convener: We cannot legislate to enable a profession to issue the certificate for one treatment but not for others. The profession must either be totally enabled or not enabled at all.

How do the other two witnesses view the issue?

Nicola Smith: Given that capacity is based on the ability to understand the decision in question, the best person to assess capacity will usually be the person who knows about the treatment and who can explain it. That person should decide whether someone understands the decision. If that person is in any doubt, it would be good practice for them to seek a medical opinion.

A parallel situation exists with powers of attorney. Under a different part of the Adults with Incapacity (Scotland) Act 2000, solicitors can sign a certificate to say that someone is capable of granting a power of attorney. In many cases, it is quite clear whether someone has capacity. In borderline cases, it is good practice for a solicitor to seek a medical opinion.

The Convener: I do not want to get drawn into questions surrounding solicitors. We are trying to pin down whether physiotherapists and clinical psychologists should be included. Basically, you appear not to be fussed whether they are or are not included in the list.

Dr Jacques: I would add only that—like psychiatrists, community psychiatric nurses and trained psychiatric nurses—clinical psychologists would be likely to have the particular skills and interest in the subject of capacity.

The Convener: We will ask all our questions about training before moving on to another subject.

Janis Hughes (Glasgow Rutherglen) (Lab): My question touches on training. The written submission from SAMH states:

“Whilst we can also see an argument for nurses being able to sign incapacity certificates, we believe that this should be restricted to nurses in more senior grades (say grades F and above).”

I assume that SAMH’s suggestion does not preclude the requirement that such nurses would have specific training. Just because a nurse is at grade F or above, that does not mean that the nurse will have had specific training. Can you elaborate on that issue further?

Sandra McDougall: We said that about nurses because we were thinking more in terms of numbers. We imagine that there would be many more nurses involved in the care and treatment of adults with incapacity than there would be members of some of the other groups, such as dentists or opticians. One of our suggestions is that people should undergo an accredited training course but that might not be necessary for all nurses, given that the numbers are greater. If the number of nurses was to be restricted, it might make more sense for more senior nurses to be involved. A senior nurse could issue the certificate of incapacity but delegate some of the responsibility for carrying out care functions to other nurses at more junior grades. That would be permissible under the 2000 act, as long as the more junior nurses were acting under the instructions, or with the approval, of the person who issued the certificate.

The reference to grade F came about as a result of our consideration of NHS grading scales. Grade F seemed to be the more senior nursing grade; below that grade were the newly qualified nurses, auxiliaries and assistants. We thought that grade F reflected someone who had a bit more experience.

Janis Hughes: I understand your point.

To pick up on a point that Ms Smith made, in its evidence the Royal College of Nursing states:

“This may be particularly useful for nurses working with people suffering from dementia who may be better placed to see the incremental changes in capacity.”

You also talked about the people who work most closely with the patients. I understand what you say about why you picked grade F and above but if a more junior graded nurse was better able to assess the level of need of a patient, perhaps you are being a bit prescriptive.

Sandra McDougall: I can see that argument, but just because a more senior nurse was responsible for issuing the certificate, that would not mean that they could not consult other nurses.

Janis Hughes: Fair enough.

I will move on to a question about extending the duration of certificates of incapacity. All three organisations have agreed in principle to accept the need for extended certificates, but only in the case of people with confirmed long-term incapacity. How should those people be assessed? How do you identify people with long-term incapacity? Who would fit into that category?

Dr Jacques: We are not saying that the proposed changes are necessary; we are saying that we are going along with them, which is a slightly different thing.
Janis Hughes: You agree in principle.

Dr Jacques: We are saying that it is okay to make those changes. However, we are quite concerned about the change to which you refer, because we think that a regular reassessment of people’s needs over a long period of time is absolutely central to good care. We would be worried that a provision that makes it okay—or looks as if it is okay—to assess someone only every three years would send out the wrong message. We are saying that we are okay about the proposed change but we are not enthusiastic about it.

We admit and agree that there are people whose mental state—such as severe dementia—might not change and is very unlikely to change for considerable lengths of time, certainly longer than three years. The provision would have to apply to someone whose illness was well established and had been deteriorating over a long period of time already. It would be quite a serious decision to move someone on to assessments every three years. The most important thing is that people who have a long-term illness should be reviewed regularly by a multidisciplinary group that has an interest in their care.

Janis Hughes: Enable’s evidence on that is that it would be good practice to carry out an annual review. However, Enable also believes that three years is acceptable. What would be the difference between carrying out an annual review and continuing with the current practice of issuing annual certificates?

Nicola Smith: That is a valid point. Although we do not object in principle to an extension, we feel that it will be difficult to identify the people for whom a three-year certificate would be appropriate. Indeed, it will not be appropriate for an overwhelming majority of people with learning disabilities. However, we cannot speak for other organisations and groups. It is difficult to imagine a person without capacity who will not be under medical supervision or care for three years. As a result, I agree that if an annual review is being carried out a certificate should be issued at the same time.

Janis Hughes: And that is what you prefer.

Nicola Smith: Yes.

Janis Hughes: But you are not opposed to three-year certificates being issued in certain circumstances.

Nicola Smith: That is right, provided that the guidance and codes are clear about when it would be appropriate to issue such certificates. However, as I have said, I think that they are unlikely to be appropriate for most people with learning disabilities. They might be more applicable to other groups, such as people who have dementia.

Mrs Nanette Milne (North East Scotland) (Con): My questions are for Alzheimer Scotland in particular, but the other witnesses might like to comment on them.

In your submission, you express concern about “continuing reports of inappropriate prescribing of psychotropic medication to people with dementia in care homes”, especially the surreptitious prescribing of such medicine. I, too, have received representations on that matter from an interested person. Will you comment further on your concerns? What should be done to put things right?

Dr Jacques: This is a major issue, and it differs somewhat from the matters that are under discussion today. I am not sure whether the proposed amendments to the 2000 act will improve the situation with regard to excessive use of psychotropic medication and covert medication. If anything, it could be argued that the amendments go slightly in the opposite direction. Indeed, lengthening the period of certification might be seen to encourage very long-term use of medication without review. As far as this issue is concerned, we could take many different steps without necessarily amending the 2000 act.

We must ensure that there is good multidisciplinary assessment and discussion between doctors and nurses about prescribing medicine; assessing the patient’s needs; other forms of treatment and help that might be available; and the question whether such drugs are really necessary. The people who are concerned about the person’s care must sit down and think seriously about the matter; it is not a matter of simply making out a prescription after a quick in-and-out visit. Before we can move forward, we need a culture change that touches on training matters; the organisation of care among the professions, carers and the people with dementia; the review and supervision of such care; and the approach of the monitoring bodies. As a result, a range of issues must be considered to ensure that there is less overuse of psychotropic medicine and less covert medication.

Mrs Milne: What do you think of the suggestion that the matter should be controlled by regulation rather than by a code of practice?

Dr Jacques: That was discussed right at the beginning of the process. We, among others, suggested that a regulation in respect of the longer-term use of psychotropic medication could be made under section 48 of the 2000 act. A requirement could be made for a second opinion in the same way as happens under the Mental Health (Care and Treatment) (Scotland) Act 2003.
Mrs Milne: Presumably, patients could be monitored in the same way.

Dr Jacques: Yes.

Mrs Milne: Does any other organisation wish to comment?

14:30

Nicola Smith: We do not have a strong view on the issue; we have not discussed it in any detail. From the comments that have been made, however, it sounds as if the issue needs to be looked at a bit more deeply.

Sandra McDougall: We believe that a second opinion would be desirable. The arguments that have just been made were put forward before. I think that the argument against comes down to resource implications. A great many people would be covered by the measure, which means that a large number of second opinions would be required. Resource issues mean that the measure has not been included in the regulations so far.

Dr Jacques: One other related issue, particularly in relation to covert medication, is the interface between the bill and the Mental Health (Care and Treatment) (Scotland) Act 2003. There is considerable need for guidance for practitioners on when the bill will apply and when the 2003 act will apply. That will need to be covered in the codes of practice for the 2003 act.

Mrs Milne: Clearly, there is an overlap.

The Convener: No other member has a question. Shona Robison was late in arriving and I am not sure whether she wants to come in on anything. We have covered most of the key issues that were raised in the submissions.

Shona Robison (Dundee East) (SNP): No.

The Convener: Okay, thanks.

Does any witness want to make a closing statement?

Sandra McDougall: I included the extension of the duration of incapacity certificates in our submission, but perhaps I should emphasise that SAMH does not believe that such extension is appropriate when the sole cause of incapacity is mental illness; someone’s capacity can fluctuate greatly over a period of time.

The Convener: Thank you. I thank the three witnesses for coming before the committee and for their written evidence.

I welcome the second panel of witnesses on part 5. Dr Mairi Scott is chair of the Royal College of General Practitioners Scotland; Pat Dawson is head of policy and communications for the Royal College of Nursing; and Robert Hamilton is from the British Dental Association. I ask you to make brief introductory statements of no more than a minute or two, after which we will ask questions.

Dr Mairi Scott (Royal College of General Practitioners): In our written evidence, we stress that we support the level of protection that the Adults with Incapacity (Scotland) Act 2000 gives, and has given, to vulnerable people. Our response is about the practicalities of the act and the need to ensure that it is complied with appropriately and properly. Two of the amendments in the bill will help in that respect.

The extension of the authority to grant a certificate is an appropriate and quite sensible amendment to the 2000 act, given the way in which the health service now works, in multiprofessional and multidisciplinary teams. The extension to the duration of the certificate will help enormously with workload implications. There is a safety net to allow the revoking of the three-year certificate, should a patient’s condition change. That is a sensible legislative measure.

Pat Dawson (Royal College of Nursing): Good afternoon. The RCN takes a similar view. We feel that there will be some devil in the detail around the codes relating to implementation, but we are broadly supportive of both the main changes to the Adults with Incapacity (Scotland) Act 2000 that are set out in the bill.

Robert Hamilton (British Dental Association): Our view is very similar. The British Dental Association supports the general principles of the Adults with Incapacity (Scotland) Act 2000. However, in practice, some of its provisions have been unnecessarily disadvantageous to the client, especially with regard to dental treatment. In some instances, delays can be caused in the provision of treatment for pain or appropriate care. We therefore support the provision that will enable suitably trained dentists to authorise certificates.

The Convener: Thank you.

Issues have been raised in respect of the adequacy of training for general practitioners, which will have to be extended to the professional groups that will be included under the new legislation.

Dr Turner: You probably heard the previous witnesses say that training is important, and you have all said that in your written evidence. Where should that training take place? I imagine that there may be a cost to training and workforce planning in the implementation of training.

Robert Hamilton: Some training on the issuing of certificates is included in the undergraduate syllabus for dentistry. There is further training in the general professional training syllabus on graduation, when dentists undergo one or two
years of post-qualification education. I have spoken to the people at NHS Education for Scotland, who are preparing something to cover the necessary training for dentistry; they will introduce that fairly soon.

The Convener: Are you saying that it is sufficient to include the training in the degree courses?

Robert Hamilton: No. It is probably more appropriate to have the training in the general professional training and possibly even further on, once dentists are fully qualified.

Pat Dawson: I am aware that NHS Education for Scotland is considering the preparation of multidisciplinary education in relation to the issue. With colleagues, I have searched for a nursing tool and have been able to provide the committee with an existing tool around assessing capacity. As members may know, legislation on mental health and mental capacity is being considered by the Westminster Parliament, and there might be products of that review down south.

Our regulatory body is looking at both the review of the pre-registration programme and the advanced practice, both of which may be areas in which the preparation and training elements could usefully be put in the context of this extension to the role of the nurse. We are content that, through working in collaboration with NES and others in Scotland, such tools and training can be provided. There is, of course, a cost element, and we have identified that in our evidence.

Dr Scott: I agree that the training should sit with NHS Education for Scotland and that it should be multidisciplinary. I see no reason why it should not be, and the provision of such training would seem to be a sensible use of resources.

The training would take place during basic specialty training. In reality, unless the young doctor had had experience in psychiatry during that time, it would take place during the year that they spent attached to the practice. As you know, we have said before that that training period is too short. We are well aware of the difficulties and have been looking to extend the training period for some time, but we need support from the Scottish Executive to do that. That training is additional, and to do more of it would require more time.

The Convener: Do you recognise the issues that were raised by the previous witnesses in respect of parents or professional carers being asked to sign consent forms for people over the age of 16? Do you recognise that the training has perhaps, so far, not been sufficient for the purposes of the 2000 act?

Dr Scott: It would be interesting to know where the examples came from—whether or not they came from general practice. I am not sure about that.

The Convener: I assume that they must have come from general practice—that is where the power lies at the moment. Is that not correct?

Dr Scott: They might have come from other areas of the health service. Other practitioners can sign under parts of the 2000 act. Having said all that, if what you say is the case, that is a training issue. You are absolutely right: it could simply be a matter of confusion, which could be sorted out quite straightforwardly.

Shona Robison: I note from the RCN’s evidence the point about the key role of the nurse consultant. Could you say a little more about the barriers that exist in that area?

Pat Dawson: Towards the end of the committee’s discussion with the previous witness panel, I heard some comment about the potential grade or competency of staff who might be asked to take up the new power. We would point out that the provision is not set out in any restrictive way. I understand where the previous witnesses were coming from, but the provision will apply to nurses in specific roles with specific expertise; they have quite an expert skill. At this stage, we would not necessarily want the provision to apply to all pre-registration education. The power would be used by those nurses who work with the particular client groups for whom the 2000 act applies.

Our organisation’s ambitions for the further development of nurse consultants are quite right. However, I draw the committee’s attention to the appendix that the Scottish Executive has supplied by way of further evidence, which says:

"in general, it is envisaged that nurse practitioners, practice nurses and nurse consultants are the groups most likely to use these powers."

We accept that nurse practitioners and nurse consultants have a degree of autonomy—the new role of nurse consultants emphasises that—but we suspect that other areas of practice will be relevant. Those areas will concern not necessarily practice nurses but, more important, nurses who work with people with learning disabilities, psychiatric nurses, nurses who work in palliative care and the range of specialist nurses who work in clinical practice with degenerative diseases. Although the provision might promote the role of nurse consultants, we do not see it as a route to restrict the application of the role concerned to those with certain job titles.

Dr Turner: Are any difficulties being experienced with how things work in practice at present, with respect to feedback being given to the general practitioner—the family doctor—of the patient who requires the certificate? There is a requirement to have information on the patient’s
medical history, and there is a need for continuing communication with the GP, so that they are aware of everything that is going on with the patient.

Robert Hamilton: Having asked around the country, I am aware that there are a number of difficulties in dentistry in that respect. When a certificate or authority is asked for, the general medical practitioner will sometimes not sign it, for some reason. There have been problems in obtaining certificates to enable treatment to be given. I could not really say what the reasons for that are. Perhaps the doctors do not feel competent about authorising dental treatment.

We envisage that most of the dentists who would be concerned by the provisions would be community dental officers and senior dental officers, who have a specific remit for the treatment of people with learning disabilities or dementia. I have spoken to general dental practitioners, who feel that they would have a lesser role in this area. I reiterate that, in community dental services, the communication with general medical practitioners and the situation with obtaining medical histories is fairly good in the main.

Kate Maclean: Can you clarify that? Surely the GP is being asked to decide about a person’s capacity, not about any dental treatment that is required. I cannot understand why doctors would be reluctant to make such decisions.

Robert Hamilton: In certain areas, the certificates that we request are not forthcoming, and we do not always get feedback on why that has been the case. That delays treatment, and it means that a further phone call to the medical practitioner is required.

The Convener: Perhaps Dr Scott should be brought in on that point.

14:45

Dr Scott: There is an issue about consent and understanding procedures. If the GP felt that they could not adequately explain the procedure and that they could not respond to questions from the patient to ensure that they had understood it, they would have difficulty in being the person who signed the certificate. That is why we support the suggestion that the dentist—-or whoever delivers the treatment—should explain the treatment appropriately to the patient. Proper explanation requires the person who is doing the explaining to check that the explanation has been understood and to respond to any questions that the patient might have. The process is complex and the legislation would ensure that that problem area was covered.

Janis Hughes: The Royal College of General Practitioners says:

“Currently the Adults with Incapacity Act limits responsibility for assessment of incapacity to medical practitioners only. The RCGP believes this is inappropriate as it includes all registered medical practitioners regardless of the nature of their professional experience and training, while excluding others such as appropriately trained specialists, clinicians and clinical psychologists.”

Is the suggestion, therefore, that there should be extra training for medical practitioners who do not have experience in the area of incapacity?

Dr Scott: There are medical practitioners who have no need of such training. For example, laboratory specialists will not be called on to make the kind of decisions that we are talking about unless they are delivering specific care to patients or are investigating them in some way. However, there are other professional groups—such as community psychiatric nurses—for whom such training would be extremely appropriate.

Janis Hughes: I believe that the Royal College of General Practitioners, unlike the previous witnesses, strongly supports the extension of the certificates’ duration to three years. Could you comment on some of the evidence that we have heard on annual assessments and the other downsides to having three-year certificates?

Dr Scott: The issue concerned linking regular review to the provision of a certificate. Clearly, the cases of patients who are incapacitated at that level for three years will need to be reviewed regularly—probably more frequently than annually, in terms of their clinical care. That review should be multidisciplinary, because those patients have complex needs.

Completing a certificate is quite time consuming because there is a legal requirement to check certain things—it would take between 45 minutes and an hour to do it properly, or a shorter time if the practitioner knew the patient. Remembering, each June, for example, that it was time to redo the certificate and completing all the associated work would, in some ways, distort the flow of care because it would be an additional thing that people had to do. However, I agree totally that regular review of such patients is good clinical practice and I hope that that is being done.

Janis Hughes: Do you have any concerns about extending the duration to three years?

Dr Scott: No. The extension has the caveat that, if the patient’s condition changes, the certificate can be withdrawn.

Mrs Milne: I wanted to probe with Dr Scott the issue of the use of psychotropic drugs in care homes. I presume that that issue concerns GPs more than anyone else. The witness from Alzheimer Scotland suggested that it would be
appropriate to have two medical opinions before such drugs were prescribed. Do you have any comment to make on the general principles of prescribing such drugs in care homes and on who should make the decision to prescribe them?

Dr Scott: That is not part of the issue on which we were asked to give evidence. Therefore, my response is tempered by the fact that I would like to see the evidence that Alzheimer Scotland and others have before making an informed comment.

In general terms, we do not want inappropriate prescription of powerful medicines to take place. It should not be encouraged in any way and part of proper professional care would be to ensure that that does not happen.

The Convener: That covers most of the issues that members wanted to be raised. Since all three witnesses are pretty much in agreement with the proposals, I will give them the opportunity to talk about any specific experience that they have of the existing system not working and why they think that it should be changed.

Robert Hamilton: There have been instances in which care home staff have drawn our attention to a resident who has an abscess and we have been concerned about the individual’s capacity to consent to the treatment. However, when we have asked for a certificate to enable us to deal with the matter, there has been a delay. It can take up to two weeks to get a certificate from a doctor, and that is not appropriate for someone who is in pain, especially as the procedure is fairly straightforward.

Loss of dentures is also a problem, as there can be delays. If someone with Alzheimer’s disease loses dentures, that can be significant, because the ability to wear dentures is learned and they can lose the concept of wearing dentures. The delay can be important, so we should at least make a quick start on replacing the dentures.

The Convener: Is Pat Dawson aware of any examples from the nursing profession?

Pat Dawson: When we rooted around for evidence for the consultation before the bill was introduced, a large number of issues came to us on the flu vaccinations. However, I will comment on paragraph 15 of annex A of the Scottish Executive’s supplementary evidence. I am a little concerned that it says:

“the Code of Practice will set out the circumstances in which it would be appropriate for nurses and other proposed signatories to issue certificates.”

I hope that that is not a signal that the Executive wants to implement a restrictive practice with lists of people and named individuals who can issue certificates. We have all tried to put forward the expanding and emerging new ways of working in the health service. We have autonomy and regulatory practice that protect the patient in addition to what is proposed in the bill. The changes should be more enabling than restrictive.

Dr Scott: The flu vaccination is probably the best example in which the workload implications were considerable. There are practices that have a much higher burden of the elderly because of the number of nursing homes in the area, so the impact can be quite disproportionate. As Pat Dawson and Robert Hamilton said, we need to try to ensure that patients get good care in a reasonable timeframe and that is not prohibited by a legal process that, by its nature, can be slower than we would want it to be.

The Convener: That deals with everything. I thank the witnesses for coming to the committee.

We have a gap while we wait for the next sets of witnesses, so the meeting will continue in private for item 3. I advise all members of the public that the meeting will resume in public at approximately 10 minutes to 4.

14:53

Meeting continued in private.

15:51

Meeting continued in public.

The Convener: We reconvene the meeting to discuss sections 31 and 32 of the bill. The first panel of witnesses comprises David Fox from Turner & Townsend Management Solutions and Howard Forster from EC Harris. I understand that Alex Macleod of Skanska is ill and is unlikely to arrive. I ask for brief introductory statements of just a minute or two from each witness before we ask questions.

David Fox (Turner & Townsend Management Solutions): I am happy to kick off—I will give the story so far. After an initial bedding-down period of the procurement route in England, the local improvement finance trust joint venture model has developed from being a purely health-focused model to one that delivers other services on a best-value basis, including social care and care for the elderly, and libraries and sports facilities. It also creates third-party opportunities.

With political will, the model has encouraged joint thinking throughout public sector departments, which has resulted in multiple use of space and allows the public sector pound to work harder. Many projects are in their early stages, so value for money is being assessed continually because many benefits follow the establishment of improved facilities and delivery of services after the settling-in period.
That said, we believe that room for improvement exists. Despite the apparent success, there is certainly room for improvement in Scotland, especially because Scotland is upstream of implementation in England and is ideally placed to benefit from that. Partnerships for health have highlighted many aspects for improvement that have been incorporated in their later projects, but the new market in Scotland offers the opportunity to do more than just to tinker around the edges.

In developing a Scottish model, we would consider simplification of what is a complex model for relatively simple facilities, provision of assurance of continuing opportunities that will encourage the private sector to invest for the long term and design of individual schemes so that scheme sizes are attractive to bidders but will also deliver value for money. We support the development in Scotland of joint ventures that would be delivered in a manner that reflects Scotland’s needs and which also benefits from the lessons of England.

**Howard Forster (E C Harris):** I am a partner at E C Harris, which has been involved in more than 17 schemes in the south and therefore has practical hands-on experience of NHS local improvement finance trusts in operation.

We ran a session in Scotland last year with a cross-section of the market, and from experience we believe that the proposed joint ventures model will bring significant opportunities and benefits, particularly in urban regeneration. To support those comments, I state that from practical experience we observe that, in particular, the planning structure that supports NHS LIFT has enabled local authorities and health service organisations to come together—in many instances for the first time—to consider joint planning of their estates. In doing so, greater impact has been made than would be achieved by simply replacing primary care accommodation.

We have seen a number of significant examples of that in Merseyside and farther afield, which have contributed to wider urban regeneration agenda and supported sustainable communities. From practical experience, we support the introduction of a model that would encourage wider discussion among public sector organisations and which would enable them to enter into joint planning and delivery of physical assets.

**Shona Robison:** I have questions on two aspects of the contracts, relating to risk and cost increases during contract negotiations. On the first issue, can you outline where the bulk of the risk lies, should a joint venture company fail? Who picks up the cost burden?

**David Fox:** In terms of a joint venture company, many of the principles are similar to those of private finance initiative projects, in that the contracts are designed to ensure that the public sector stays whole and that the impact is, at worst, a delay in implementing the project through a retendering process, either for the LIFT partner or perhaps for a contractor. There are examples from the PFI industry in which the provisions within PFI contracts, which are reflected in the LIFT contract, have been used successfully in such circumstances. In fact, close to here, in East Lothian, and in Tower Hamlets in London, the provisions of the contract have been used to replace a failing contractor who was providing the construction service, in a situation where the works were carried out in parallel with step-in by the public sector. The provisions were such that the public sector was compensated and a new contractor was put in place.

**Shona Robison:** Who compensated the public sector?

**David Fox:** The public sector was compensated through the clawback mechanism.

**Shona Robison:** Was clawback from the failing contractor?

**David Fox:** It was, in effect, from the funders. The funders provide the capital and also a degree of equity support. In the case to which I referred, an SPV—a special purpose vehicle—was involved. The provisions in the contract in that case allowed the public sector to step in, maintain the construction process and retender. Effectively, the value of retendering and construction works was handed over to the new successful contractor, net of any costs. Such provisions are normally in place within a PFI-type contract. Howard Forster may want to enhance that answer—or otherwise, given his intimate knowledge.

**Howard Forster:** In the NHS LIFT structure, design and construction risks are distributed through subcontracts. The cost of any delay in construction is borne by the subcontractor building partner, and is passed down through the subcontracts.

Similarly, the risks that are associated with life-cycle maintenance and provision of facilities management are passed down through an FM contract; the risks are borne by the FM supplier. As in a PFI contract, the joint venture vehicle is protected from any of the risks’ coming back to it by the provisions of those two contracts.

16:00

**Shona Robison:** What is your view of the contracts, given that public money is involved in them? Do you think that they should be made
public so that everyone can see the provisions in them in advance of any problems that arise?

David Fox: It is fair to say that the model contract is a public document, which is available on the websites of Partnerships UK and, I believe, the Parliament, although I may be corrected on that. However, contracts for individual projects reflect many of the bespoke items that are specific to those projects and there is some commercial confidentiality attached to them. I noticed smiles when I mentioned commercial confidentiality—the base provisions are public knowledge, but the specifics about particular sites are kept confidential.

Howard Forster: NHS LIFT adopts the same standard for PFI contracts, with some minor modifications. The provisions are now widely understood and are—

The Convener: That may be the problem, of course.

Howard Forster: I accept that.

Shona Robison: Unison Scotland has given evidence to the committee in writing and will appear before us later today. In its evidence, it says:

“the cost of using PFI has tended to escalate during contract negotiations. The risk of such cost increases in a joint venture will be borne by the … public sector”.

Do you have a view on that?

Howard Forster: In the LIFT market, the average time between the placing of an advert in the Official Journal of the European Communities and the financial close is about 17 months. That period is relatively short compared with the periods that have traditionally been borne in similar PFI negotiations. To my knowledge, the cost escalation in the schemes in which we have been involved has been relatively limited. In the mainstream PFI market, cost escalations are mainly due to delays in projects and inflationary pressures during those delays. That has not been apparent in the LIFT market; on the whole, the first 42 schemes that have been bid on have been straightforward. Although they represent a spectrum of schemes, most are relatively small and have been well thought through by the public sector before they come to the market. Because the client has a clear grasp of what it wants, the risk of its changing the brief is relatively small, according to my experience of 17 or so LIFT schemes.

David Fox: The experience to which Unison referred certainly matches our experience of early PFI-type schemes. At that time, there was perhaps not much understanding of the balance to be struck between obtaining a price from the market in the tenders and ascertaining for how long that price should be maintained, be it six months, a year, 18 months or whatever. If we want a price to be maintained for at least a year, interest will be built into it. As the industry matures, there is greater understanding of that balance and—which is probably more important—of the fact that the scope of projects must be more comprehensively and robustly developed, thought out and reflected in the specification. The specifications of many of the original PFI and LIFT projects—dare I say it—left a bit to be desired. Many of the cost escalations, apart from inflation, reflected things that had been missed out of contracts.

Shona Robison: Do you regard the contract for the new Edinburgh royal infirmary as an example of that?

David Fox: It was one of the first projects in Scotland to be carried out under PFI. I am sure that lessons have been learned from that contract and reflected in subsequent contracts. However, I do not have intimate knowledge of the contract and therefore cannot comment on it.

Shona Robison: You will appreciate the public unease about that contract, given some of the difficulties that were experienced with the model of PFI that was used. There might be some scepticism about what improvements have been made in respect of PFI.

David Fox: In order to alleviate such scepticism and to give comfort to elected representatives such as yourselves and to the industry in general, the Scottish Executive must be complimented for implementing what it calls the key stage review process, which is closely modelled on the gateway process that the Office of the Deputy Prime Minister and the Office of Government Commerce—the OGC—have implemented. At key stages in the development of a contract—before the issue of tender documents, before the naming of the preferred bidder and before the close of the contract—an independent review of the documentation and work to date is carried out. In the Executive’s case, that has been done by Partnerships UK.

That review throws up issues that are associated with previous problems and it ensures that promoters of projects get it right. Problems must be revisited before a project goes out to tender or before a preferred bidder is appointed. That represents the spreading of best practice by experts in the field to promoters who might be less experienced and it is one of the means by which we in the industry intend to avoid repeating the problems of previous years.

Shona Robison: What is the percentage of profit that a company could expect to make under the new model of contract?
David Fox: I cannot comment specifically on LIFT, although Howard Forster might be able to do so. For a typical PFI project, the level of return, as it would be termed, would commonly be between 12 per cent and 13 per cent. I stress, however, that that is over 30 years—that does not refer to a one-year contract. 13 per cent over 30 years might not sound like an awful lot, but that is attractive to the marketplace. There is a long-term opportunity and there are opportunities to establish partnerships in the event of expansions of a project, through change mechanisms. That is effectively a win-win situation for both parties.

I ask Howard Forster to comment on LIFT.

Howard Forster: The experience of LIFT to date has been broadly similar to that.

The Convener: I invite any other specific questions on the subject of cost increases and risk.

Dr Turner: I have a question relating to something that Shona Robison said.

The Convener: Is it to do with cost increases and risks?

Dr Turner: It is to do with outline business cases not being perfect. Does business cases’ not being perfect have anything to do with the fact that you might get only one contractor bidding? The idea is that a project should be cost effective. As many bidders as possible would be wanted, but it costs companies a lot of money to bid. If an outline business case were not up to standard, would the UK organisation—I have forgotten the name of the company.

David Fox: Partnerships UK.

Dr Turner: Does Partnerships UK sort out business cases that are perhaps not perfect? As you said, costs would escalate if a project was to go ahead despite the business case’s not being complete at the beginning, in which case the builders would find out that they would have to add in this, that and the next thing.

David Fox: I will start; Howard Forster can perhaps add to what I will say. Every outline business case in the UK is now reviewed independently. In England, cases go through what is called the projects review group; in Scotland, they go through the Scottish Executive.

Each business case is rigorously analysed by independent bodies, predominantly Partnerships UK, which is the body in which the general expertise in the United Kingdom market is most concentrated. That process highlights gaps or aspects that should be in place but are not—for example, not all the land might have been acquired or not all the planning permissions be in place—and gives bidders much more confidence that when a project comes to the marketplace it is robust, comprehensive and well developed, and that there will be a relatively smooth run through the procurement process. In other words, the risk of abortive bid costs is much reduced.

Howard Forster: Mature design is now expected at the outline business-case stage. It is expected that, before an advert is placed to invite tenders, the scheme will have been developed to the extent that departmental layouts and sample room layouts are in the design. One would go to the marketplace when one arrives at an outline business case that has that degree of certainty of design. That is expected in NHS LIFT in England and throughout the PFI market in healthcare.

Dr Turner touched on the number of bidders for a project. The LIFT market is different, because the nature of the projects is different and has attracted a much wider market than traditionally bids for the major PFI health projects. To my knowledge, it is something in the order of 19 bidders. In addition to the more traditional firms that bid for PFI contracts, many have come out of what is described as the third-party development market; some are property-led companies and some have been housing associations, such as Bradford and Northern Housing Association, which has rebranded and is now called the Accent Group. An interesting range of different types of proposal have come from the market. To my knowledge, there was a minimum of two bidders on the 42 projects in the LIFT market. I think that the last project to come to market attracted the fewest bids, but in all the earlier waves the lists were eight bidders or more long. The market has been attractive to bidders.

Dr Turner: Is that because the projects are smaller than hospitals?

Howard Forster: I think so. Relatively speaking, the initial bid costs are less against a reasonable deal volume.

David Fox: I suspect that you are thinking about the more limited tender lists that we have had in Scotland over recent years. The capital value of construction works within a LIFT project is attractive to a much wider range of contractors because of the type of relationship and the fact that the contract is spread over a number of years. Perhaps only a limited number of contractors could carry some of the recent education projects that have had a capital cost value of £90 million to £100 million, whereas the smaller year-by-year value in a LIFT-type project makes such projects more attractive to a much wider range of contractors, which increases the number of contractors that bid and, hence, the competitive pressure that creates value for money.
Carolyn Leckie (Central Scotland) (SSP): Three aspects of the consultation document that you submitted to the committee make me worried about the risk to the public sector. I should say that I am a member of Unison and have direct experience of the impact of privatisation on the health services. In the document, you refer to facilities management’s not being included in LIFT projects, which indicates that it is perceived as being too much of a risk to the private partners. Will you expand a wee bit on that?

Another paragraph mentions “the critical mass required to make the LIFT model viable and hence attractive to private sector investors.”

That is obviously about diminishing the risk to the private sector. Could you give detail on what you mean by that? What is the impact on local services? How much makes a “critical mass”? Does that mean that there will be reductions in access to local services?

You also say:

“Each phase should ideally be profitable as a stand-alone venture”.

Obviously, that again relates to concerns about minimising risk to private sector profits. Could you expand on that and on what its impact would be on the public sector?

16:15

Rather than give us a projection over 30 years, could you tell us what has been the impact so far of LIFT schemes, with which you have been involved in England, on the growth of profits for the companies involved? Similarly, what has been the impact on the public sector in respect of terms and conditions, service provision and so on?

The Convener: It would be helpful if you left jobs until we have dealt with cost increases and risks.

Howard Forster: I believe that the first question was about FM. I did not think that Carolyn Leckie’s other questions were all related to cost increases and risks, but that they were all different.

The Convener: Indeed. If you could confine your answers to the questions that relate specifically to cost increases and risks, we will mop up some of the other issues later.

Howard Forster: I am not sure that any of the questions directly relate to cost increases. I can respond to each question in turn, however.

The Convener: That would keep us moving.

Howard Forster: FM content in NHS LIFT schemes is limited to hard facilities management, such as building services. It has not so far been extended to soft facilities management. It is probably worth saying that limited services have been delivered to general practice facilities in primary care over the period. You should bear it in mind that the market is already mixed. A number of general practice premises are in private sector ownership and are run by GPs; they might not have any facilities management services. To some extent, the services are being newly provided to the primary care market.

On whether the absence of FM in the marketplace would be an issue, the answer is—on the whole—no. For some of the batched primary care schemes that are coming onto the market and which are not LIFT schemes—such as in Stockport in south Manchester—there would be a market for working with private sector organisations on design, construction and replacement of facilities and the associated financing outwith FM contracts. There would be a market if FM provision were not included, although FM is relatively new in the primary care market. In saying that, I am setting aside any concerns relating to off-balance sheet issues and so on. I am not an accountant, so I would not want to comment on what that would do to a risk profile. Regardless of whether FM was excluded from NHS LIFT schemes or not, the market would be attractive. The market is different to the one relating to major health care private-finance initiatives.

The second question related to critical mass. It is fair to say that there is a minimum bid cost associated with LIFT schemes, which has so far been of the order of £500,000 to £1 million. Certainly, before a preferred bid is arrived at, individual schemes will have cost the private sector between £250,000 and £500,000. Clearly, if a bidder is about to make that sort of investment and can expect to win only one in three bids, the bidder would want to ensure that the overall value of the projects that would be secured in that market is reasonable.

The 42 LIFT projects that are currently on the market vary enormously in terms of value. For example, in the Manchester, Salford and Trafford LIFT scheme, many primary care trusts have come together to procure jointly, whereas Dudley South Primary Care Trust might have only three to five schemes. I come back to my earlier point; such schemes are still attractive to the marketplace and the marketplace still responds.

Because of the geography of Scotland, different scales and types of procurement would be needed. My expectation, based on experience, is that there would still be good competition and at least two bidders if the value of the deal were more than £10 million to £15 million overall. That might represent three or four primary care premises; the cost of building a typical primary...
care facility is between £3 million and £5 million for the scale on which they are built these days.

The third question was about profitability and how it looks currently. It is impossible to say. The first schemes have just been completed, so it is too early to offer a view and certainly too early to make observations. The first built projects are just being completed now within NHS LIFT in England. The only figures are those that have been modelled; they are broadly comparable to PFI marketing.

I am not quite sure what the point about growth in profits was about.

Carolyn Leckie: What have the benefits been so far?

Howard Forster: There have been very few because construction has just started and the facilities are not finished. Even the comparison between the estimate of how much a building will cost versus its actual cost, which is a risk borne by the private sector, is yet to be evidenced and understood. It is probably just a little bit too early to be asking those questions.

Carolyn Leckie: Are the share prices increasing?

David Fox: I cannot comment in detail on NHS LIFT, but I can give you a typical example of a PFI project. I stated earlier that, over a 30-year period, a PFI project would provide a return of something like 13 per cent. It is important to note that until year 20 to year 22 of a 30-year contract, the special purpose vehicle of the successful company is in the red; it is making a loss and it goes into profit only in the final few years of the contract. I would be surprised if the LIFT projects were any different, although I could be proved wrong as I do not have intimate knowledge of that particular vehicle.

Carolyn Leckie: You did not answer the question about guarantees and pipeline workload in each phase being profitable as a stand-alone venture. How do you envisage that working? Is that to take account of the worries that the project would not be profitable?

Howard Forster: No. The nature of a LIFT procurement is that a partner is appointed—by way of competition—for two or three projects out of a batch of projects. A batch might contain as few as five projects or as many as 30. Each individual project within the overall project will be a contract in its own right. Each contract needs to be bankable and able to secure external funding, and it must go through the same due diligence tests as any PFI contract. The contracts must be robust in the way that they respond to public sector governance and value for money tests; they must also respond robustly to private sector tests such as cash flow protections and ensuring that the contracts distribute risk appropriately. Each tranche of the overall LIFT relationship has to be robust. That goes without saying.

Private sector involvement is partly about profit, but it also has wider objectives. I refer to what was known as the Bradford and Northern Housing Association—now the Accent Group—which distributed its profits to its other objectives. It was not about return for individuals, companies or share value.

David Fox: To provide a bit of comfort on your first point about FM and FM services, the evidence from the Scottish Trades Union Congress identified that Scotland has the staffing protocol. That is not a feature to the same extent in the English market and it is one example of how NHS LIFT, as developed in England, would have to be adapted for the Scottish marketplace. There will be other issues, because we are considering a Scottish solution, not just the importation of an English solution that may or may not be appropriate.

The Convener: You talked about staffing protocols. Kate Maclean has a question on jobs.

Kate Maclean: Your report mentions that the employment protocol will probably affect the pricing model. The small paragraph about staff-side issues states that the staff side is stronger in Scotland and that that might create difficulties. People are concerned that job losses may occur as a result of the use of joint ventures and that two-tier workforces would be created in certain premises. Has that happened in England? Will you expand on that? I could find no other references to staffing or job issues in the report.

Howard Forster: To be clear, that document comes from the observations of the 70 people who attended the seminar, who were from public and private sector organisations, including staff-side organisations. We tried to give a representative view. The document represents a range of views and does not necessarily contain my personal observations of the market.

So far, NHS LIFT has not had the impact that you describe. As I said, we need to understand the nature of the premises and the existing services that support them. We are talking about GP practices extending into much wider functions because, as things stand, many premises do not have facilities management services at all. New services would be introduced under the proposals.

On a separate issue, one of the affordability constraints for primary care organisations in using the lease plus arrangements within the LIFT scheme, rather than the previous arrangements, is that new services are being introduced. Facilities management, guaranteed replacement and
grounds maintenance are relatively new services. Where they existed previously, they were generally managed by individual practices, which made their own arrangements. Most of the LIFT companies with which I have dealt are interested in using local suppliers to manage existing services, but on the whole the services are absolutely new.

One can see that from the state of primary care facilities in the UK. The 2,500 GP practices throughout the UK are not being regularly repaired or maintained and no life-cycle replacement is taking place. As a result, we have a huge backlog of maintenance and buildings that are decaying and not fit for purpose. However, the situation will improve, because we are securing some of the required services through the new contracts, and on the whole that is for the first time in the primary care market. Therefore, the changes will not have an adverse effect on existing staff because there are no existing staff.

Kate Maclean: So existing public sector workers will not be transferred to joint-venture companies.

Howard Forster: That may happen for limited numbers of staff. I do not know the profile for primary care in Scotland so I cannot provide specifics, but, if that happened, the same provisions as for any transfer of undertakings would apply. However, from my experience, such cases will be limited. So far, I have not observed that as an issue in any of the 42 schemes in the NHS LIFT marketplace.

Carolyn Leckie: You did not quite answer my earlier question. The scheme has obviously had impacts. The issue is not just about terms and conditions and the employment protocol, because that does not relate to final salary pension schemes. What has the impact been on such schemes in England? Another issue is staffing levels and ratios. Historically, the contracting out of cleaning services has resulted in staffing ratios plummeting. Since the introduction of the LIFT schemes in England what has happened to the numbers in various staff groups compared to patient turnover?

Howard Forster: As far as NHS LIFTs are concerned, the answer to the latter part of your question is fairly straightforward: as there are no soft facilities management services, none of the contracts includes any cleaning or catering services. For the reason that I have just given, those services are in many cases brand new. I have to say that I have not come across that issue in the public or private sector.

16:30

Carolyn Leckie: Have you compared the terms and conditions of new staff involved in new services with those of the NHS or local government workforce? Studies into PFI and overall staffing levels carried out by Allyson Pollock and others have highlighted that, although the scheme might not directly employ people, there are indirect impacts because of the costs to the authority of funding the contract. Have you considered the impact on overall staffing levels in public authorities?

Howard Forster: As none of these facilities is operational—one might be operational in south-east London—it is too early to make such observations.

Carolyn Leckie: Do you think that there will be an impact and, if so, have you taken any steps to avoid it? Do you think that a reduction in overall staffing levels would be a bad thing?

Howard Forster: What I said is that, so far, there has been no such impact. It has not presented itself as an issue. It is still too early to make those comparisons. The private sector has to go to an employment marketplace and attract an appropriately skilled staff to deliver what are on the whole new services to facilities that, historically, have not had those services delivered.

Carolyn Leckie: On what terms and conditions are those staff being recruited, and how do they compare with those of staff in public bodies?

Howard Forster: I do not know the detail of the terms and conditions.

The Convener: Would they vary from project to project?

David Fox: As far as staffing levels, pensions, wage rates and so on are concerned, we have the staffing protocol, which came into being a short while ago and which the Executive has implemented on all relevant PFI projects. No doubt your good selves will make your views known to the Executive on the question whether the protocol should be similarly applied to any LIFT joint ventures that might come along. Certainly, since the creation of the staffing protocol, one of the key themes in the projects in which I have been involved has centred on staffing levels, the protection of pensions either through admitted body status or through broadly comparable schemes and the avoidance of a two-tier workforce. Indeed, that has been reflected in the project documentation issued to the various contractors. I would be surprised if this situation were any different.

Janis Hughes: You said that no soft FM services are included in English LIFT models. Have there been any discussions about doing that in Scotland?

Howard Forster: Not that I am aware of. However, to my knowledge—I have worked on 17
deals—only hard FM services have been included in NHS LIFT market deals. I cannot say that absolutely and would need to test it out, but I think that that statement is correct.

Carolyn Leckie: The E C Harris report says that most people agreed that soft FM services should be included, so that is something that you are obviously aspiring to.

You also said that public bodies were involved in the consultation. However, when I counted them, I found that 14 out of 58 consultees were public bodies and the rest were involved in private finance, construction and so on. As a result, the document will reflect those interests.

I have to say that I am not sure about the accuracy of the report. The veracity of your argument is brought into question by the comment:

“Overall it was believed that there was not as much deprivation in Scotland and so they are starting from a better position”.

How on earth did you reach that conclusion?

Howard Forster: Clearly, any audience that discusses such a matter will have a bias. The audience was not perfectly balanced because we sent out an open invitation for the session and those who wanted to attend came along. We certainly did not exclude anyone and, as we have said, we extended the invitation specifically to staff-side organisations, which did not attend.

Returning to the first point, I welcome the idea of providing soft FM services in primary care premises where they do not exist at the moment. The member referred to a marketplace, but, as I said, I am talking in general not about the Scottish health care market, but about what that looks like in the primary care setting and in the provision of primary care facilities.

Currently in primary care provision in the UK, buildings are not being maintained and are not receiving the soft and hard FM services that are typically received in other markets in other parts of the health care sector. The issue is one of levelling-up. On the whole, I would welcome the introduction of new services to facilities that have not benefited and also to primary care services that have not benefited from that sort of provision in the past.

The Convener: I call Shona Robison for a last brief question.

Shona Robison: In your report, under the heading “Political Climate”, you say—no doubt you are stating a fact—that

“The Scots are generally more hostile to PFI/PPP than their southern counterparts.”

You go on to say:

“However, the fact that the public sector stands to benefit from potential profits through participation in the joint venture vehicle may prove a selling point.”

Are there any examples of the public sector making such a profit?

Howard Forster: As I said, it is too early to be drawing conclusions—

Shona Robison: How likely is it?

Howard Forster: In NHS LIFT, the public sector has 40 per cent of the shareholding of the joint venture vehicle, which means that it has a 40 per cent share in any benefits that accrue in that arrangement. That is different to anything that has gone before in terms of other PPP models. It gives the public sector a stake and a share in that and gives it influence over the distribution and use of the profit.

I refer to the Bradford and Northern Housing Association and its objectives. The committee might like to engage in a conversation with Bradford and Northern Housing about its operation. Certainly, its motives are neither share value nor profit in the sense that those are understood, but of redistributing value into the wider regeneration objectives of the organisation. Although the benefit of LIFT is beginning to prove itself, it is too early to offer specific numbers or observations.

The Convener: Although Nanette Milne is interested in examples south of the border, they have been discussed consistently throughout the questioning. We have quite limited time. Is there anything further that you wish to raise on the subject, Nanette?

Mrs Milne: I have a question that leads on from what was just said. You spoke about differences of scale and so forth. I notice that under the “Consultation Point Conclusions” heading on page 11 that you say that

“It may be appropriate to implement 1 or 2 pilots in geographically distinct areas”.

Perhaps lessons from England could be learned for the pilots. Will you elaborate on that?

Howard Forster: In the main, the first 42 LIFT schemes in England were directed at the major towns or inner city conurbations. I think that it is fair to say that, although it was not universally the case. The next nine schemes, which come under what is described as the fourth wave, cover Kent, for example. Possibly the schemes in the fourth wave are more comparable to some of the geographies in Scotland.

I apologise for the fact that some of the comments in the report are naive. As I said, the report represents the views of those who were in
the room. I apologise if I am coming across as being naive about the geography of Scotland. That said, the observations of the people in the room and of the private sector, are that it would be very different to bid, let us say, for a Glasgow or greater Glasgow scheme than it would be to look at one in a more rural community where general practice was distributed over a much wider geography. It is likely and sensible to suppose that the planning and approach to that scheme would be different.

I think that the group was saying, “Would it not be sensible to try that out.” The suggestion was for some pathfinder schemes that could explore the two extremes to see what they would look like and how Scottish planning partnerships could be involved in the process. That is part of the recommendations. It is likely that the way in which Scotland would engage other wider public sector stakeholders within the process would be different, and sensibly so.

I imagine that the issues that arose in Kent, such as the need to involve the ambulance service more formally within the partnership, are more relevant in wider rural settings than in city settings where adjacency issues are easier—albeit not easy—to overcome and where access to facilities is less of an issue. Those points are reflected in the observations in our submission.

David Fox: In the Scottish context, there are a couple of linked points that we have already discussed. First, we can learn from the recent wave of education PPP projects, in which the interest of bidders varied depending on the value of the projects and their geographical complexity. We need to consider the right balance between bidder interest—bigger tender lists help to drive value for money—and the ability of bidders to deliver projects.

At the moment, we are perhaps at the starting point for the next stage that the Executive team will need to consider. Taking account of those experiences, they will need to consider which trusts—

Mrs Milne: I must interrupt you. When you say “trusts”, do you mean health boards?

Howard Forster: Yes, he means health boards.

David Fox: Sorry. People will need to take account of the experience of education projects and of the consultation process that has already taken place. They will need to assess what is the ideal combination of project value and geographical spread that will maximise interest from potential bidders and thereby drive the competitive pressure that will deliver value for money.

Some health boards might opt for a combined project similar to the Manchester, Salford and Trafford LIFT. Although those are substantial conurbations, it was felt that a combined project would be better at driving value for money. Such an exercise needs to happen, but it would need to be consulted on and tested before it goes ahead.

Mrs Milne: What was included in the Manchester, Salford and Trafford project? What did the project comprise—

The Convener: Nanette, please speak more clearly into your microphone; the rest of us cannot hear a word that you are saying.

Mrs Milne: Sorry. What facilities were produced by the Manchester, Salford and Trafford project?

David Fox: The Manchester, Salford and Trafford LIFT is a large-scale but reasonably typical LIFT project that will provide facilities in which primary care trust services can be delivered in the Manchester and Salford areas. The facilities include GP surgeries. Because our company was involved in assisting the successful bidder for that project, I know that that LIFT has presented an excellent opportunity to combine health and many other related public sector services, so that the space is multi-used and works harder for the public purse. That is a successful example of how a LIFT can drive efficiencies so that there is more cash to put elsewhere.

Janis Hughes: My questions are on community planning. In his introduction, Mr Forster said that the LIFT model would be more beneficial than more orthodox methods in providing primary care services. Will he elaborate on why the LIFT model is more beneficial?

Howard Forster: There are two aspects to that.

First, the model fills a gap in the planning process for primary care accommodation by replacing the current mix of different approaches by which GPs might replace their accommodation. For example, GPs might previously have rented accommodation that was designed and built for them by a private sector organisation, or they might have worked with the public sector health organisation—the health board in Scotland or primary care trust in England—or, alternatively, they might have held their general practice surgeries in part of their own house. In many cases, the accommodation needs of GP practices would be considered in the light of their practice population, but in the absence of wider considerations pertaining to the whole town or area. However, the NHS LIFT model has accelerated the process whereby primary care providers—principally, general practitioners but also optometrists, pharmacists and other providers within primary care—are brought together in the planning process. They are surrounded with the capacity and skills to help them to think about their
future needs for their premises. Historically, that did not really happen.

16:45

The other aspect of that is the point that was just made about mass. In St Helens, a primary school—Ravenscroft Community Primary School in Knowsley, which is well worth a visit and is being constructed as we speak—came together with the primary care trust and the two sites were combined. The primary care site that was up the road has now been moved to the primary school site, and a common access has been created. A community centre has been put in the middle of that. Maximum use is being made of the land, and those community functions are being brought together. The local community is engaged in the school and there is no vandalism of the school—there never was, but the old GP practice was vandalised every week. There have been benefits to bringing the community closer to primary care provision.

Another example in St Helens involves the church. The Archdiocese of Liverpool has given over one of its sites for a GP practice. That has attracted other investment—residential and retail investment—and is having an impact on the overall regeneration of Duke Street, west of the town centre. Those are two examples of where wider planning has occurred and where the deficit in planning, even within the health care sector, has been dealt with.

Janis Hughes: I hear what you are saying. Both the examples that you have given are in England, but you say in your report that the framework is different in Scotland. That is why we have devolution—because we have different ways of dealing with things here and different issues to address. I was a bit concerned about your comment that

“There is a need to develop the link between local and strategic planning, which was perceived to be missing from the current LIFT process.”

The committee knows only too well from previous experience about the lack of strategic planning in the NHS and how vital it is that things are planned strategically. It concerns me to hear you acknowledge that there are gaps and that strategic planning has perhaps not been addressed properly in this process.

Howard Forster: Some people who attended the consultation observed that. My personal experience is that the process has been more joined up than I have seen historically within a primary care setting. I think that you have an approach to infrastructure that gives you an advantage over some parts of England. I agree with that. I have observed that and that was mentioned in the conversation that we had at the consultation. Your strategic partnerships are perhaps stronger here and better suited to this model, and you already have experience of joint venture structures.

In many parts of England, it was new for organisations to come together in that way. Even within primary care, as I say, there was a deficit in planning. Historical structural changes had perhaps led to the loss of some of the skills around that; nevertheless, we have seen the benefit of joint planning with local authorities, local education authorities, education providers generally, the faith school sector and the church sector. It has been very practical to do that, and I have offered those practical experiences. The schemes that I have been involved in have been better than I have seen previously, but there is a long way to go. We are trying to ensure that those opportunities are considered systematically in every scheme that is developed; however, realistically, that is probably not where we are now.

The Convener: How old is the oldest of the schemes in England to which you refer?

Howard Forster: The schemes that I am involved in—

The Convener: I mean the ones with which you are familiar. You have referred to schemes south of the border, but you have also said that it is too soon for us to look to them for examples. How far down the line is the oldest model of this kind in England?

Howard Forster: The first financial close was 18 months ago, and the facility is now complete in London. The schemes that I have been involved in are under construction and are not yet complete; however, it is early. The LIFT market in England is roughly three to four years old. The process for bidding is 17 months to financial close and it takes 12 months to construct the larger schemes. It is not likely that, over the past three to four years, there have been a huge number of such schemes.

The Convener: Is it true that only a handful of schemes have been completed in England?

Howard Forster: That is correct.

The Convener: Under this model, the public sector provides the shareholders and directors. In the handful of LIFT schemes that have been completed, have issues of accountability and conflicts of interest been raised, especially in relation to the public sector directors?

Howard Forster: It has been a major issue regarding how the primary care trusts and other public sector organisations have set up the LIFTs. The governance arrangements for strategic partnering boards, what the shareholder
agreement does and how it affects individuals have been much discussed. We should bear in mind the fact that Partnerships UK has been closely involved in the procurement and setting up of LIFT companies. That means that a Government body has supported the process and considered the issues.

The Convener: Have there been any subsequent controversies or arguments? Have any concerns been expressed?

Howard Forster: I imagine that concerns will be expressed at some point, but to my knowledge that has not yet happened in the marketplace.

The Convener: Thank you for your attendance. You are welcome to take a seat at the back of the room and to listen to the evidence that is given by the next panel of witnesses. If you want to leave, you may do so.

David Fox: I would like to clarify some evidence that I gave earlier. When talking about risk, I gave the example of East Lothian. East Lothian was not an example of there being a step-in on the SPV. The SPV was still in place—it re-tendered and carried the cost associated with that. The project arrangements in the example that I gave applied south of the border.

The Convener: I welcome our next panel of witnesses. They are Alan McKeown, health and social care team leader for the Convention of Scottish Local Authorities; Tim Huntingford, chief executive of West Dunbartonshire Council and joint chair of the joint premises project board of COSLA; Hilary Robertson, director of the Scottish NHS Confederation; and Susan Aitken, policy executive of West Dunbartonshire Council and Scottish Local Authorities; Tim Huntingford, chief social care team leader for the Convention of Scottish NHS Confederation; and Susan Aitken, policy executive of West Dunbartonshire Council and Scottish Local Authorities; Tim Huntingford, chief social care team leader for the Convention of Scottish NHS Confederation; and Susan Aitken, policy executive of

We are in favour of the provisions in the bill, but wish to ensure full local authority buy-in to produce developments that are flexible and responsive to local needs and circumstances. LIFT may be one model but it is not the only one. COSLA feels that it is for local partnerships to determine their strategies and approaches to the issue.

Hilary Robertson (Scottish NHS Confederation): From discussions with our members, we are confident that there is general support for the principle of joint ventures as outlined in the bill. Joint ventures would give boards another option for the development of premises and facilities, without removing any of the existing options. That would result in a welcome increase in flexibility. The application of joint ventures to the exploitation of intellectual property is very welcome. That is currently an untapped resource.

Much detail has still to be worked out. We are talking about a power that boards do not have at the moment, so there is no practical experience in the NHS. We would welcome the NHS being closely involved in developing the proposals.

The Convener: The session will not work if all four panellists answer every question, so I would be grateful if the witnesses could do what they did with their introductions. I will ensure that each organisation gets a fair crack of the whip. If committee members want to ask a specific question of an individual, please make that clear.

Shona Robison: The panellists heard the previous discussions about risk and increasing cost. I want to ask both the Scottish NHS Confederation and COSLA how, as guardians of the public purse, they can ensure that the public sector does not, in LIFT contracts, take more responsibility for risk than it should do. When things go wrong, how can we guarantee that the public purse will not bear the brunt?

Tim Huntingford: I cannot give any guarantees. That is the kind of detail that will need to be worked out. When local authorities, the health service and the private sector work together, the devil will be in the detail. Local authorities are gaining experience of that through the huge upsurge in PPP contracts for the regeneration of schools. Lessons can be learned and I hope that they will be applied.

Shona Robison: You say that lessons can be learned. Obviously, delays and quality issues have arisen in some areas with the schools programme. Have lessons been learned?

Tim Huntingford: I think so, yes. We are becoming much more skilled as more and more people become knowledgeable. As several previous witnesses have said, a considerable body of knowledge is developing elsewhere in the
United Kingdom. We can build on that to try to ensure that lessons are learned and mistakes avoided.

Susan Aitken (Scottish NHS Confederation): We would agree with that, and with the point that the devil will be in the detail. Governance arrangements, and arrangements concerning the balance and sharing of risk and reward among the range of partners, will require a lot of work.

The NHS came rather late in the day to joint ventures, which gives us some advantages. We can learn lessons that Scottish local authorities have already learned from being involved in joint ventures. Through the LIFT scheme in England, we have learned that we can use the best bits of models and discard the bits that have not worked. We can get the best of both worlds.

A lot of work remains to be done. Our members—the NHS boards—are enthusiastic and see a lot of potential in the joint ventures model, but at the moment it is just potential. A lot of detail has still to be worked out.

The Convener: Are there particular things from south of the border that you have already decided are not appropriate for Scotland?

17:00

Tim Huntingford: I have limited knowledge in that area. In the early days in England, one of the problems was that the LIFT model was heavily health oriented. The sort of developments that have been referred to started in later phases. Local authorities and other partners have joined in to make truly joint ventures—as previous witnesses have said, developments in the early days were mainly to do with primary care premises. People have talked the talk about partnership down south, but they have only latterly started to implement partnerships in reality. That is an important lesson for us in Scotland.

Susan Aitken: So far, there is nothing specific that we absolutely must actively avoid, but there are certainly things that cannot be transferred wholesale. Obviously, there are different structures in Scotland. Previous witnesses have alluded to the very different geography here, and NHS LIFT projects have tended to be in inner city areas. One of the main issues in Scotland is primary care premises in remote and rural areas, so we will develop our own model and start from scratch in many ways.

I echo what COSLA said about partnership. Some later LIFT projects have involved a much wider range of services, including library services. There have been local authority environmental and leisure services and a much wider range of things on board; we would look to emulate that.

That has already started in Scotland in projects that have been developed through more traditional funding routes—the committee may have heard of the Dalmellington area centre in East Ayshire, for example, which was a joint NHS-local authority project. NHS and local authority services and other community services come under a one-stop shop premises. There are other projects in West Lothian and other parts of the country. Therefore, there are already partnership models with a wide range of services to benefit the community that we can consider.

Kate Maclean: I want to ask the same question about jobs that I asked the previous panel. Do you have any concerns about workforce issues? In particular, I want to ask COSLA about having premises in which there are staff who are employed by a joint venture company and staff who are employed by a local authority. In the Scottish Commission for the Regulation of Care, for example, difficulties were caused by two sets of public sector employees coming together. Do you foresee any such difficulties with the proposals that we are considering?

Alan McKeown (Convention of Scottish Local Authorities): We have experience of such issues in the joint future work that has been done between local authorities and NHS bodies on matters such as terms and conditions, pay and holidays. That has proved to be a bit of a stumbling block, but we have managed to work our way through it. We would want to consider where the differences lie in our work and how we would overcome them. We would not want there to be dramatically different terms and conditions and rights and responsibilities for employees. We would try to even things out as much as we possibly could.

Kate Maclean: Local authorities are still trying to work through single status. The proposals in the bill seem to add another dimension that might create even more difficulties.

Alan McKeown: I do not think that we will rush into LIFT or LIFT-type schemes. As we pointed out, the potential is there, but there is a long way to go in our discussions, which are currently at the officer level. Our submission says that we have not yet had political discussions. We need to go through a level of detail honestly and openly, but that is yet to happen. You are right to say that single status is being worked through. Tim Huntingford can talk more about that than I can, but there are many issues to be worked through.

Carolyn Leckie: I do not know whether you heard the previous evidence session, during which questions and concerns about jobs were referred to. The E C Harris consultation document says that, as a result of links with local authorities,
“LIFT in Scotland will be even more flexible with more exciting outputs.”

Do you know what it means by that, and does that statement cause you any concern?

The companies have expressed a wish that soft facilities management be included. Will you rule that out? I have experience of the joint future initiative from an NHS point of view, and I know well that lines of accountability have not been sorted out; there are vast differences in terms and conditions between occupational therapists in local authority employment and occupational therapists in NHS employment. Will all those issues be negotiated and resolved with the trade unions before any contracts are entered into?

In the evidence that we have heard today from all sides, the response to a number of questions has been, “The jury’s still out. There isn’t enough evidence.” If we cannot assess the impact on staffing levels, service provision, terms and conditions, and lines of accountability, does that not indicate that the bill is premature? We have been unable to work out what the problems are, because there is not enough evidence or experience.

On the specific question—

**The Convener:** Carolyn, could you focus your questions? I am worried that they are not being followed.

**Carolyn Leckie:** I am worried that I will not get back in.

Will you rule out facilities management? What detailed discussions have you had on the impact on terms and conditions and service provision? Is there any evidence of the efficacy of the schemes?

**The Convener:** Can you get to a set of questions that the witnesses can answer? If you simply go on and on, that will ensure that you will not get back in.

**Carolyn Leckie:** The questions are quite specific.

**The Convener:** If the witnesses can unpick the questions from that speech, could they try to answer them?

**Carolyn Leckie:** In addition, will you rule out facilities management?

**The Convener:** Carolyn, enough.

**Alan McKeown:** I will try my best.

First, on the legislation, if the bill is enabling, that is fine and that is the end of it. Secondly, on facilities management, staffing, and terms and conditions, of course we will talk to the unions; we always seek to do that. We have a good relationship with the unions through the joint future work. We have sought to build up that relationship and we will continue to do so. It is too early to say what the situation will look like, but there is an absolute guarantee that discussions will take place.

The third point is the opportunities that joint working will bring. It is true that our geographies are different, our governance arrangements are slightly different, and with community health partnerships we have a completely different local feeling, but CHPs are very new. The ink is not even dry on half of the schemes. We have yet to determine whether CHPs will add value, but there is a framework for better working. Through our joint future work, we have the scope to do innovative things in rural, urban and mixed areas. We could look at the full range of services that could be provided from one-stop shops, for example, which would provide exciting opportunities for our communities.

You are right—the job is big. That is because we are at an early stage in the process, and we need detailed discussion at every level to ensure that our governors, who make the decisions on investment, know exactly what they are dealing with. Right now it is too early for that, but that is why groups are being established and why we are giving evidence.

**Carolyn Leckie:** I have one specific question—

**The Convener:** Can the NHS Confederation answer the question as well?

**Susan Aitken:** I concur with Alan McKeown. On trade union involvement, the NHS in Scotland operates on a partnership basis. Without question, the Scottish partnership forum and all the local partnership forums on the staff side and NHS board side will be involved in any discussion about this major development. That goes without saying. It also goes without saying that the staff protocol that will be adopted for joint ventures will be the one that was adopted for PFI. It had not occurred to us that that would not continue. The protocol has been adopted and is accepted across the NHS, so I do not see that being an issue.

I see nothing sinister in there being exciting opportunities for doing even more between the NHS and local authorities. Much potential and enthusiasm exists and there are many ideas out there about partnership working, which we have started in Scotland. The joint future initiative is one element of that and community health partnerships will be another. In some ways, many of the issues are not new. As Alan McKeown said, we are addressing differentials in pay and conditions. That matter has not been resolved, but people know about it. That aspect of the process will continue for joint ventures.
Apart from that, everything is up for discussion, as Alan McKeown said. The bill is certainly not premature; without it, nothing can be considered, because the NHS does not have the power. Local authorities already have the power, but we cannot consider extending partnerships under the proposed model without the bill. The bill is enabling and will compel nobody to participate in joint ventures—for example, it does not assume that all NHS boards will enter into joint ventures. However, without the bill, there would not be much point in discussing the other details, because the NHS would be unable to participate in such projects.

The Convener: Does Carolyn Leckie still have a specific question?

Carolyn Leckie: My question is very specific. Concern was expressed in the consultation report that E C Harris presented to us about the need to achieve critical mass for any projects that people become involved in. A question arises about the antagonism between achieving critical mass and providing rural services, for example. Have you examined that? Do you have concerns? What do you expect to happen? Are rural services in danger?

Susan Aitken: We have not examined that specifically, but my response to the question whether rural services will be in danger is no, because the aim is to provide new services. Existing services are unlikely to be withdrawn—“downgraded” is the common term these days—as a result of such an initiative. In fact, they will be extended and enhanced. If NHS boards enter into joint ventures, they will do so to enhance and develop existing services and to build on what exists.

The Convener: You said that the bill was enabling legislation, and Carolyn Leckie was right to refer to it as all being quite vague. If the bill is passed this year, what is a ballpark figure for when you expect a brick to be laid?

Tim Huntingford: The joint premises project board that I co-chair with a health service chief executive has considered the tension between critical mass and local determination, which needs to be worked through. The evidence suggests that the timescales for developing LIFT schemes in England are reducing. The previous panel said that the first scheme took 18 months to develop, but we are receiving evidence that that period can be reduced to a bit over a year. If the bill were to be passed, the detailed guidance issued and LIFT models adopted, work would probably begin a bit over a year after that.

The Convener: We could be talking about 2007.

Tim Huntingford: Yes.

The Convener: Nanette Milne is interested in what is happening south of the border.

Mrs Milne: Have you noted from schemes south of the border any good or bad examples for what we will do up here?

The Convener: I think that we have asked about that.

Mrs Milne: I suppose that we have.

Susan Aitken: I do not know much about the LIFT projects that have been completed in England, but I know that some of them are expected to make significant contributions to community regeneration by bringing not only services, but new and often well designed user-friendly state-of-the-art buildings into communities that have had no such services before. There seems to be a lot of enthusiasm for that, and I see no reason why we should not seek to emulate that kind of result.

17:15

Tim Huntingford: The partnership needs to be genuine. One of the concerns in Scotland has been that a driving force behind the initiative is the problems that we have in our urban areas, such as Glasgow. Nobody has mentioned it yet, but dentists’ premises are a major problem in Glasgow, because most of them are up a close in tenement buildings.

The Convener: At least Glasgow has dentists.

Tim Huntingford: Yes. Trying to deal with the problem of single-practitioner GPs has been a driving force for the Health Department. From a local authority perspective, we are much more interested in regenerative activities that will bring services together, such as the kind of things that you heard described as happening in St Helens. I am talking about not only local authority social work services, but environmental health, leisure services and other local authority services. We must free up our thinking about what the initiative could deliver, rather than thinking that it is mainly about trying to overcome the backlog of inappropriate primary care premises.

The Convener: I will make an observation about something that puzzles me and on which you might wish to comment. The provisions on joint ventures are obviously significant for COSLA and the Scottish NHS Confederation, but in your evidence so far, you have said repeatedly that you do not know much about what is going on down south. That surprises me. Why do you not know much about it? If that is where some of our evidence should come from, why do you not know more about what is happening there?
Susan Aitken: We know what is happening in that we know about the kind of projects that are being developed—the examples about which your previous witnesses spoke and we have just spoken—and the impact that they can have on community regeneration, for example, but we do not know about the long-term financial impact because there has not yet been a long term. In addition, we are wary of assuming that the LIFT model could be transferred wholesale. It shows potential and is an example of what could be achieved, but there is no assumption that LIFT as it operates in England will be the model that we use in Scotland.

Alan McKeown: In our written submission, we said that a number of issues have been internalised in the NHS system and that external partners have been brought in late in the process if at all. Joint ventures are coming in only at the bill stage, in the same way that the CHPs came in late, and we are playing catch up. Tim Huntingford has been the chair of the joint premises project board only in the past two months; I am now joining the board and we are seeking additional representatives for it. There must be an earlier process and, as Tim Huntingford said, the partnership needs to be genuine. We are concerned that we will be brought into the process late, as has been our experience, and that we will not feel that the partnership is genuine.

The Convener: So you have concerns about that.

Alan McKeown: Yes. We are concerned about late involvement. We accept some responsibility, as we could have done a bit more, but there has been no political engagement at this stage, just as there was limited engagement on the CHP debate. If joint ventures are to be truly successful, that political engagement must happen quickly and openly. An area-by-area strategic approach is fine, but if critical mass is a key issue and we are to have regional boards around Scotland, that is a different ball-game and we need to have an honest discussion about it if it is going to work. We need to get it on the table and discuss the issues that come with it.

The Convener: Are you saying that you have not yet discussed those issues with Government?

Tim Huntingford: There has been some discussion. There has been a very steep learning curve for me, because I have been involved with the joint premises project board only for the past couple of weeks. If I had been asked to give evidence to the committee in three weeks’ time, I would by then have been to England to see LIFT schemes for myself. It was interesting that when the Deputy Minister for Health and Community Care spoke to COSLA leaders about a month ago, primarily about the bill, 99.9 per cent of the discussion was about smoking issues—that was unsurprising—and only fleeting reference was made to the joint ventures provisions. However, those provisions are important for local politicians. We have not yet done enough to alert local politicians to the matter, but the Executive has not done enough, either.

The Convener: The timing of this meeting is not particularly good, given that you have not yet visited the schemes in England. However, if you have observations to make after your visits, please put them in writing to us, if you have the time to do so.

Shona Robison: Would it have been more appropriate for the provisions on joint ventures to have stood alone, rather than be included in a bill that addresses other matters that will dominate discussions? The danger of tagging the provisions on joint ventures on to the bill is that important issues could get lost among other elements of the bill.

Tim Huntingford: That is a fair comment. I do not like the fact that the provisions are included in a health bill that is promoted by the Health Department and discussed in the Health Committee. Where is local government in all that? The proposals should have been sponsored jointly and should not have been tagged on to the bill. I understand why that happened: there was a wish to get on with things. However, the experience of the discussion at the COSLA leaders’ meeting was typical; a vast majority of people do not know that the bill contains the important element that we are discussing.

Hilary Robertson: I will make a brief point. The bill would give powers to the health service that it does not already have, whereas local government already has those powers.

Janis Hughes: The E C Harris consultation concluded that “There is a concern that Community Planning Partnerships could create tensions as they have limited involvement and experience of the planning process for creating physical assets.”

What are COSLA’s views on that and, specifically, on how the community planning process can work with the LIFT model?

Tim Huntingford: The experience of working together is growing and I do not agree that it would be inappropriate for community planning partnerships to consider planning. Community planning partnerships represent the table around which all the agencies can gather and they can facilitate more imaginative buy-in, not only from local authorities and the health service but from many partners. For example, the police might be obvious partners in certain locations.
There is an issue about the size of planning units in relation to developments such as those about which we are talking; that creates another tension. In many ways, community planning partnerships represent the right model and the right forum, but whether CPPs in fairly small local authority areas are the right size in relation to the—dare I say it—critical-mass element of LIFT-type initiatives, is another matter. For example, in my area—West Dunbartonshire—the partnership is split between Greater Glasgow NHS Board and Argyll and Clyde NHS Board, both of which cover other vast territories, so there are questions about whether the community planning partnership would be the right size in relation to the planning considerations of the boards.

Janis Hughes: I expressed concerns to the previous witnesses about the consideration that would be given to strategic planning in the LIFT model. The fact that the local authority that you represent covers an area that is spanned by two health boards means that there would be a greater need for strategic planning, which might perhaps be worked into the process. Could that be beneficial in the longer term?

Tim Huntingford: Strategic planning is very important, but we have not had a great deal of strategic planning to date. A critical part of the joint premises project board’s role in considering proposals will be to consider how the different areas—whatever areas are determined—can be involved in joint asset-management planning to meet current and future needs. That needs to happen in a way that has not happened previously.

The Convener: We have five minutes left before the current panel of witnesses must leave. Jean Turner has a final question.

Dr Turner: Are there any concerns about the possible loss of flexibility that might arise if joint ventures for new health centres involve increased numbers of partners such as schools, libraries, optometrists or any private organisations that one might care to name? I worked in a health centre that became too small within eight years of being built, so I know that things can change within the health service and that, like schools, health centres are required to do different things. Might we lose flexibility by being joined to other partners in what might be a long-term contract with payments?

Susan Aitken: Although independent primary care practitioners could be partners in such ventures, they would not have to be partners because they could lease the premises from the NHS board or from the other partners. In fact, such an arrangement could give more flexibility not only to practitioners—such as GPs, dentists, podiatrists and optometrists—but to the NHS board.

That is where planning comes in. As I said earlier, NHS boards will use such projects to fill identified gaps in services by, for example, providing services where none currently exists, or by improving inadequate and inaccessible services and addressing other problems. In identifying needs and gaps, the planning process would very much inform the design of premises and facilities. The aim would be that, at the design stage, flexibility would be built in for future health care needs so that independent practitioners and other services could still be brought in. All the partners in the venture would be involved in that process.

There are other potential benefits for practitioners. In deprived urban areas and in remote rural areas that are currently experiencing a shortage of dentists, one disincentive that practitioners face is that, if there are no premises currently available, they may need to make a big investment by entering a long-term lease for premises or by purchasing new premises. Joint venture arrangements could provide flexibility for such practitioners by allowing them to lease facilities for shorter periods without their having to commit to long-term investment. For example, in parts of the Highlands that currently have no dental premises, the dentist might otherwise need to build new premises. Some practitioners have found themselves in that position.

Hilary Robertson: The principle behind the proposal is about long-term partnerships. Our expectation is that partnerships will grow and develop. From day one, they will be flexible partnerships rather than the static arrangements that were perhaps first conceived.

The Convener: We will hear no more questions because we are running out of time.

I want to make a point about mobile phones in the committee room. Regardless of whether they are set on mute or vibrate, mobile phones still interfere with the sound system. Members’ phones have been going off for about the past half an hour. Please switch them off rather than simply to mute. Kate Maclean is attempting to look innocent, but it is not working.

Kate Maclean: I have just switched it off.

The Convener: It is not working. Shona Robison was also one of the guilty parties.

Kate Maclean: Bad Dundee girls.

The Convener: Yes—clearly it is an issue with Dundee.

I thank the witnesses for coming along. As I said, if you would like to make any follow-up
centres, it is necessary to group together a range of schemes to achieve a "critical mass" which is used in PFI schemes. We all know from vast experience of a range of PFI schemes how critical mass overrides the local priorities for certain schemes. It may be that a health board has five schemes that are fairly high on its list of capital expenditure. The value-for-money analysis that is allegedly used in PFI schemes is exactly the same as that which is used in LIFT schemes. We all know from vast experience of a range of PFI schemes how those value-for-money exercises have been skewed. The reality is that the additional costs of PFI will simply be replicated in LIFT schemes.

Shona Robison: The NHS Confederation mentioned dental practitioners leasing back premises that a health board private partnership built in the first place. Do you view that in the same way as other potential service developments, or is it more acceptable to Unison?

Dave Watson: No it is not. A LIFT scheme is still a 20-year contract. Somebody must at the end of the day pick up the bill and guarantee the financing. Whatever happens, the public sector picks up the bill—we have seen that time and again. Every scheme has a clause that is usually buried in the annex that states that if the whole scheme goes pear shaped the public sector will pick up the bill. The only guarantee in PFI is that the bankers always get their money.

Kate Maclean: I will ask the same question about jobs as I asked the previous two panels. The first panel does not perceive any difficulty regarding loss of jobs or a two-tier workforce. COSLA, however, acknowledged the difficulties that can arise when trying to operate two sets of terms and conditions in one workplace. Can you expand on the fears that you have in respect of jobs and workforces when efforts are made to harmonise conditions in one set of premises?

Dave Watson: We raised the question of the STUC-Scottish Executive PPP staffing protocol in our response to the initial consultation on LIFT and joint ventures. It is interesting that in none of the Executive responses and summaries has anybody yet confirmed that the protocol would apply to LIFT schemes and similar joint ventures. Our view, having considered the Treasury definition of a PPP scheme, is that it clearly would. I have to say that I am somewhat surprised—and perhaps slightly suspicious—that the Executive has not confirmed that. Clearly, it is very important because the protocol deals with two-tier workforces and with pensions issues. That is a subtle hint to the committee that it should ask a question of the minister.

The comparison with England is difficult. I have the same problems as previous witnesses; to be frank, there are no real LIFT schemes in England—there are only a lot of financial schemes that have been developed on paper.

There are also some differences in Scotland, which leads us to be concerned that more staff might be affected in Scotland. There are more health centres in Scotland, particularly in the major cities, whereas there are more private GP practices down south. Health centres are traditionally health board premises that have health board staff—both soft FM and hard FM, to use the PFI jargon. The other difference between
Scotland and England is that there is far more direct staff provision in Scotland in local authorities and in health boards, whereas in England there has been far more use of contractors. Those differences lead us to be concerned that there might be more staffing problems in Scotland.

Carolyn Leckie: I referred earlier to a comment in the E C Harris report. It states:

“It was believed that as a result LIFT in Scotland will be even more flexible with more exciting outputs.”

That is in respect of the relationship with local authorities. I did not get an answer to my question about what “more exciting outputs” means, but it tends to suggest more extraction of profit. Does that relate to your concerns about terms and conditions?

Dave Watson: Many of the reports are littered with management speak. Phrases such as “flexible certainty”, “purchase provider” and “how schemes might evolve” lead us to be concerned that there are risks. We would expect a rate of return of about 8 or 9 per cent on a normal premises contract that was developed by the NHS. That is typical if a contractor is brought in to build new GP premises. There are no clear figures yet for LIFT. It was previously indicated that the rate of return might be as high as 13 per cent, which is clearly much higher. Our understanding is that PFI schemes can have a rate of return of between 15 and 20 per cent. In other words, the rate of return on private finance deals is almost double that of conventional procurement, so it is clear that profit is an issue.

Unison has published documents—unlike commercial contracts, ours are all published on the website so that people can see them and read the analysis—that members can read and see that we have done a lot of work on refinancing and the costs that are involved in the secondary markets, where people effectively sell on their equity share in some schemes. There have been significant profits made. You do not have to take our word for that; the Public Accounts Committee at Westminster has produced many reports on the matter. There is scope to make additional profits and it is not difficult to do so. A typical PFI scheme might have a Standard & Poor’s rating of BBB, whereas public authorities work on an AAA rating. It simply costs more to borrow money in the private sector than it does in the public sector. The profit is added, which leads to the additional cost of borrowing. That is not terribly clever economics but it is self evident. We will pay more through the LIFT arrangement.

Carolyn Leckie: What is Unison’s position on Shona Robison’s point that the matter is so important that it should be in stand-alone legislation? Are your concerns so fundamental, as mine are, that they undermine your support for the smoking ban?

Dave Watson: As you know, the provision was originally to be included in the forthcoming health service (miscellaneous provisions) bill. We were concerned that as soon as the smoking ban was included, other aspects would not get attention. In fairness to the committee, it is clear that you have identified and examined the various provisions.

To be honest, our position is to ask why have the lessons of PFI schemes to date not been learned. What more do we need to know? Do we need more Skye bridges, more Inverness airports, more Edinburgh royal infirmaries and more filthy sewage works? It is bizarre that the schools in East Lothian were cited earlier as an example; they were a shambles for at least nine months when Ballast Wiltshier Investments went bust. I point out that Ballast Wiltshier was consulted by the Scottish Executive on LIFT projects; I presume that the Executive thought that the company had something to offer the consultation. We have plenty of experience of PFI arrangements; we do not need much more. It seems to be pointless to go through what is a hugely expensive process, given all the people who are involved and the joint boards. Millions of pounds will undoubtedly be spent on consultants’ fees simply to dress up the failures of PFI under the new name of LIFT.

Carolyn Leckie: Will the inclusion of the matter in the bill compromise your support for the smoking ban?

Dave Watson: Absolutely not. Our position on the smoking ban is clear; I will be back here next week to tell you that.

The Convener: I will ask you a slightly different question. Is the issue of sufficient concern for you to argue that we should vote against the bill as a whole? The problem is that it contains provisions for free eye and dental checks, the smoking ban and other things. Do you consider the matter sufficiently important that your advice is that we should reject the bill? I would like to hear John Park’s views on that as well.

Dave Watson: I am not in a position to say that at this stage. We hope that the joint ventures provisions will be amended out. If not, we will have to take a view of the longer term. It is clear that some parts of the bill are important—we have campaigned for a smoking ban in enclosed places for a long time and we supported the earlier member’s bill on the subject. We would be reluctant to argue that the bill should be voted down, but we hope that MSPs will amend it so that the particularly pointless part on joint ventures is not included at the final stage.

John Park (Scottish Trades Union Congress): Our position on smoking is slightly broader
because we take into consideration the various positions of the affiliates of the STUC.

The Convener: I understand that.

John Park: We agree in principle with the proposed ban but, as the committee will hear next week, there are slight differences between the positions of our affiliates. We go through an internal consultation process to reach a final position. Sometimes we reach a position that is clear and sometimes we do not. There would have to be more internal discussions about where we stand and whether we feel strongly enough, given our slightly different position on smoking, to support the bill.

The Convener: We should watch this space.

John Park: Absolutely.

The Convener: Does Nanette Milne want to ask any questions about the position south of the border?

Mrs Milne: No, not at this stage.

Dr Turner: I have a question for John Park. You said that you are afraid of privatisation, but will you elaborate on that?

John Park: Do you want my personal opinion or the STUC’s position on that?

Dr Turner: Both.

John Park: The STUC has a fundamental position, which will remain in place for ever and a day, I imagine. We believe in public services that are publicly funded and underpinned by fair employment practices, and all the good things that go along with that. The committee should understand that, where policy differences exist, we seek to work with the Executive and politicians. We have a PPP staffing protocol and we are prepared to work through matters. We are certainly not against partnership. We find attractive the idea in the E C Harris report that some partnerships might be public-public only. Private sector expertise is not necessarily required to make partnerships work—they can be driven not by profit, but by the desire to deliver excellent services.

17:45

The Convener: The STUC evidence expresses concern about accountability and about conflicts of interest, which might arise in relation to membership of boards and so on. I asked earlier witnesses about that. Are you aware of specific examples from south of the border in which accountability and conflicts of interest have been an issue, or do you just anticipate that the issue will arise?

John Park: Our concern is twofold. We anticipate that conflicts of interest might occur because people will be put into the lions’ den—into situations that they have not been in before and with people who have been in the private sector for a number of years who have been involved in PFI and PPP schemes. There might also be a conflict of interests in working up of bids. If two or more private sector employers are involved, negotiation will take place between the private sector employers as well as with the public sector partners. We must bear it in mind that, if the scheme comes to fruition, issues might arise in the working up of proposals, not only when they are running.

Dave Watson: Members will be aware that, under the companies acts, directors have a fiduciary duty to all shareholders. It is conceivable that problems could occur. In our experience down south, the problems so far have been with letting retail units in some of the early schemes. With a 20-year project, an issue could arise in respect of what should be done if a conflict arises between providing a health-related lease for a new dentist or some other useful health function and a more commercially viable option. I am not saying that there might be tobacconists in health centres, but a clear conflict of interests might arise if somebody offers to pay a much higher rent than a doctor, dentist or some other health-related function. We should remember that the directors will have a fiduciary duty to all shareholders and that the schemes will be weighted 60:40 in favour of the private sector.

Janis Hughes: I declare an interest: I am a member of Unison.

I have concerns about how the LIFT model fits into community planning. Do you have any comments on the strategic planning aspect and about how cognisance can be taken of the NHS’s strategic planning needs?

Dave Watson: Page 6 of the E C Harris report mentions tensions with community planning partnerships. In fairness to the people who attended the seminar—75 per cent of whom were from the private sector—I suspect that by “tensions” they meant lots of awkward local people asking awkward questions. To be frank, that is usually what big private companies say about the planning process, so I suspect that that is the difficulty.

Community planning partnerships are important, particularly in Scotland. The partnerships in Scotland are not replicated in England; England works with more market-oriented public service provision. In Scotland, we have tried to build co-operation throughout the public sector, which is the strength of our community planning process. It is still early days, but our process does not fit the
commercial relationships that have been developed in England as part of the LIFT process. Fundamental questions need to be asked about how commercial designs can be matched with the broader planning arrangements that we are trying to develop in public authorities in Scotland.

The Convener: I ask Carolyn Leckie whether she has any other questions.

Carolyn Leckie: I do not, because the elaborate evidence that has just been presented makes an overwhelming case that contrasts sharply with the evidence that we heard earlier. I ask the witnesses to round up their comments.

The Convener: Carolyn, will you concede that I am the convener of the committee? Before I ask anybody to round up their comments, do other committee members have any further points that they wish to make or questions that they wish to ask?

Members: No.

The Convener: Is there anything that we should have cognisance of that we have not asked you or previous witnesses about?

Dave Watson: There are a few matters that you might wish to consider asking witnesses about at some later stage. One of those is land development, which has been hinted at in some of the documents. In our experience of the work in England, the attractiveness of some schemes has been very much dependent on the ability to develop land for housing, for example, as an earlier witness said. You might examine closely how the schemes sell off health board property to create attractive development opportunities for the private sector.

Another matter that you might want to consider is how LIFT schemes are unlike PFI schemes in Scotland, although they are not always unlike PFI schemes in England. With PFI schemes in Scotland, we have learned the lessons; the property is often handed back to the health board at the end of the scheme. It is perhaps not quite such good value as you might think, but that is what often happens. With LIFT schemes, the property stays with the private company so that, at the end of 20 years, the local partners are not left in a very strong bargaining position. A health centre might have GP surgeries and other facilities in it—social work, for example, could be in there, and we are very keen on having one-stop shops with police and other facilities—but will be in the hands of a private company. That company will have everyone over a barrel unless there is another health centre, police station and everything else just down the road that is ready for them to move into. As a trade union official, I am well versed in bargaining positions; I would not want to be in such a bargaining position at the end of the 20 years.

There are other matters that you might want to ask questions on. I might have missed it, but I cannot see a definition of the word "services" anywhere in the bill. The word "facilities" is defined, but not "services". At one seminar that my colleagues attended, a Department of Health official was quoted as saying that they saw no reason, in principle, why clinical services should not be included in the schemes. I noticed that that possibility was also floated in the Harris report or one of the other reports. In England, a number of big American corporations have been keen to get into primary care by employing large numbers of GPs, for example. If the scope of a scheme is wide enough, there is the possibility that companies will move beyond facilities and into clinical services on that basis. That would be of concern to us.

The other issue that is not mentioned anywhere in the bill is whether the Executive proposes to offer subsidies in the form of either direct subsidies for schemes or subsidies relating to development money or pump-priming cash. There is no mention of that in the documents that I have seen. Our experience elsewhere is that, suddenly, large sums of money—in effect, subsidies—are made available to the various PFI units in the Scottish Executive to promote development of schemes. That money has to come from somewhere. If it goes to management consultants, lawyers and so on to pay for developing a new type of scheme, it does not go to the NHS capital budget to develop schemes in the normal way. In essence, we are saying that conventional borrowing is cheaper and therefore worth considering.

The simple quick way to develop schemes is obviously to allow local authorities to use their prudential borrowing powers to develop the facilities using conventional borrowing. Health boards do not have that power. It is a complex area of health service finance, but it may be worth considering whether health boards could be given similar prudential borrowing powers. The problem with the local authority powers is that the Executive provides subsidy only if they go down the PFI route, which is where the schools problem has arisen. In our view, if prudential borrowing is to work, it has to work on the basis of there being a level playing field for both types of financing.

Those are the main points that have not been covered. As always, we will not be slow in writing to you if anything has been missed out or if anything develops.

The Convener: Okay. As with previous witnesses, if there are things that you wish to draw to our attention before the end of the process, feel...
free to do so. Thank you very much—you are now free to go.

That ends today’s business in public, so I ask members of the public to leave the committee room.

Meeting continued in private until 18:09.
The Scottish Licensed Trade Association (SLTA) represents the interests of over 1800 self-employed licensees throughout Scotland; primarily pubs but also a smaller number of hotels, restaurants, bars and nightclubs.

The SLTA is committed to improving the health, safety and welfare of the staff and customers of its members and supports the objective of reducing their exposure to Environmental Tobacco Smoke (ETS).

The SLTA was a founder member of the Charter Group in Scotland and campaigned vigorously for the adoption of the measures by its members. This enabled the group to exceed all of the targets agreed with the Scottish Executive on the provision of smoking restrictions, with the sole exception of a technical issue on the keeping of paper records (where the target was missed by 1%).

It became apparent at the end of the Charter evaluation that our achievement of the agreed targets was seen as insufficient and that more was required in a short timescale. We believed that it was unlikely that this accelerated uptake could be achieved by voluntary measures, as there were widely perceived commercial disadvantages to those operators restricting or banning smoking – specifically that their smoking customers would move to other outlets who had not adopted restrictions.

As a result we proposed legislation to the Executive that:

Smoking should be banned at the bar counter in all licensed premises.

Smoking should not be permitted in any area where and when hot food is being served.

All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be ratcheted upwards to 40% in year 2 and 50% in year 3.

Every licensed premise should have a smoking policy sign at the entrance.

Smoking should not be permitted in any area of licensed premises from which the public are excluded (i.e. back of house).

At the end of year 3 a review of progress would be made and appropriate further steps taken in the light of public opinion prevailing at that time.

We were very disappointed that this proposal did not appear to be seriously considered by the Executive – which then, with minimal consultation, began vigorous promotion of a total ban in all pubs.

We believe that our proposal has been given no serious consideration by the Executive and that it has substantially more merit than the outright ban proposed in the Smoking, Health and Social Care (Scotland) Bill.

Our specific concerns with the Bill are:

Proportionality to any health threat posed by ETS

The Scientific Committee on Tobacco and Health (SCOTH) in its ‘Secondhand Smoke: Review Of Evidence Since 1998’ (www.advisorybodies.doh.gov.uk/scoth/PDFS/scothnov2004.pdf) set the increased risk of lung cancer from non-smoker exposure to ETS as ‘marginally reduced’ from their previous estimate of 24%. This can be expressed as a relative risk of 1.24, or the risk of contracting lung cancer in any given year as 12.4 in 100,000.
In other words, in a group of 100,000 non-smokers exposed to spouses’ ETS an extra 2.4 people a year may contract lung cancer.

It should be noted that these conclusions are drawn from studies based upon spousal exposure to ETS – not the occasional exposure that customers may get from occasionally visiting a bar or the many staff who work in the industry for a matter of months. In both cases any risk is likely to be much diminished.

It is also worth noting that Baroness Jay in a Commons Written Answer stated that “…A stronger association - of greater than 2 - is more likely to reflect causation than is a weaker association - of less than 2 - as this is more likely to result from methodological biases or to reflect indirect associations that are not causal…”. In other words, if the relative risk was even three or four times higher than that claimed for ETS there would still be doubt as to whether the relationship was ‘causal’.

Even taking no account of the usually low level of staff exposure (most pubs only have a significant amount of smoking in the evening on the later days of the week), and the uncertainty apparently shown by Baroness Jay – both of which we regard as highly relevant – this would equate to a very marginal impact on those employed in Scottish pubs. Assuming 20,000 people work in Scottish pubs and approximately half of whom smoke, 10,000 non-smoking staff could be at risk. This would equate to 0.24 non-smoking staff contracting lung cancer from ETS each year in Scotland. This is not a major or certain health threat; especially if exposure can be limited by the substantial control methods that we have proposed should be enacted.

We find the claims of hundreds of deaths a year of non-smoking bar workers as a result of ETS also to be incredible from our own observations. Across our membership of nearly two thousand licensees we have had literally no feedback at all suggesting that their non-smoking staff or colleagues are dying of lung cancer, for example. If bar workers were at the level of risk indicated by the Executive’s reports we would expect this to be a major issue and concern amongst our members – this is not the case. Our observations absolutely reflect, at worst, the numbers that we have calculated above, not the hundreds of deaths claimed.

Lastly the Health and Safety Executive was tasked to develop an Approved Code of Practice on Passive Smoking at Work. The draft (11 October 1999) stated that (Paragraph 8) ‘Although there is emerging evidence that exposure to tobacco smoke in the workplace may be of itself sufficient to give rise to ill health we cannot, at the present time, be certain of the size or extent of the risk. However we do know that for some people exposure to tobacco smoke can make a pre-existing health problem, like asthma or chronic bronchitis, worse’. The expertise of the HSE in evaluating scientific evidence and risk is substantial and this would appear to be a far more reasonable claim of the health effects of ETS and one that can be borne out by our own experiences.

Whilst staff are seen as having no choice over their exposure, clearly non-smoking customers can choose whether or not to be exposed. With the increasing availability of non-smoking venues, smoking bans where and when hot food is served and the proposed major increase in non-smoking areas we believe that this exposure will be increasingly limited and will pose little or no health threat.

We conclude that action is required to remove or reduce ETS exposure as a source of aggravated medical conditions and annoyance, but that this action should be proportionate to the risks involved and that our proposed regulations cover this very adequately.

Reduction in Smoking Incidence

It is clear from Ireland that there has been a substantial reduction in the duty paid sales of tobacco products and presumably a reduction in consumption following the ban (although this may be affected by some smuggling due to the higher duty). It does not follow however that there is a similar drop in the incidence of tobacco usage (the proportion of the population that smoke) – especially amongst heavier users. In fact the evidence shows that there is little or no effect on smoking incidence amongst regular users.
In Ireland according to independent research agency Millward Brown (November 2004 see Appendix) the incidence of smoking (5+cigarettes a day, adults 18-64) has increased for both men and women after the ban (March 2004).

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<tr>
<td>Men</td>
<td>33%</td>
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<td>Women</td>
<td>36%</td>
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In Norway the Directorate of Health and Social Affairs website shows daily smoker incidence (aged 16-74) reducing from 26.3% to 26% from 2003 to after the ban in 2004, a drop of 0.3%. In the year before that (2002-3) the drop in incidence was from 29.4% to 26.3% a drop of 3.1%. Taken over the five years before the ban the annual average decrease was 1.3%.

In 2003-4, the incidence of smokers aged 16-24 actually increased by 0.9% from 22.8% to 23.7%

From these data you could conclude that the smoking ban markedly decreased or reversed the decline in smoking incidence that was being achieved previously.

Percentage daily smokers, by age. 1995-2004. Observed result and estimated three-year sliding average

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<tr>
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<th>Daily smoker 16-74 years</th>
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<tr>
<td>1995</td>
<td>32.6%</td>
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<td>1996</td>
<td>33.1%</td>
<td>28.6%</td>
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<td>1997</td>
<td>33.6%</td>
<td>30.6%</td>
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<td>1998</td>
<td>33.0%</td>
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<td>1999</td>
<td>32.0%</td>
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<tr>
<td>2000</td>
<td>31.9%</td>
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<td>2001</td>
<td>29.8%</td>
<td>26.8%</td>
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<tr>
<td>2002</td>
<td>29.4%</td>
<td>27.8%</td>
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<tr>
<td>2003</td>
<td>26.3%</td>
<td>22.8%</td>
</tr>
<tr>
<td>2004</td>
<td>26.0%</td>
<td>23.7%</td>
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Source: [http://www.ssb.no/vis/english/subjects/03/01/royk_en/main.html](http://www.ssb.no/vis/english/subjects/03/01/royk_en/main.html)

This suggests that whilst smoking bans may stop the light and very light social smokers to give up, and probably reduce the tobacco consumption of heavier users, it does little if anything to cause regular users to stop. The conclusion must be therefore that those regular users that choose not to visit pubs as the result of a ban will continue to smoke elsewhere – especially in the home.

Displacement of Activities

Although it is too early to assess the Irish ban it is clear that there has been a shift away from using hospitality outlets. This can be seen most clearly in the employment trends.

The Irish Central Statistics Office shows that employment in pubs, bars, hotels and restaurants had been steadily growing up to the ban – average +3.2% over the previous year. In the first six months after the ban employment dived by 6%. The rest of the private sector continued to grow at an increased rate from 0.9% to 2.9% in the same period.
From the November 2004 Millward Brown study (see Appendix) it appears that the total proportion of the population using pubs is more or less stable. From this, given the heavy reliance of the pub sector on ‘regular’ (frequent) users, it is logical to conclude that regulars (who include a high proportion of smokers) are being replaced by other users (who tend to be non-smokers) who visit less frequently. Although we are unaware of any specific data on this it is logical that a high proportion of these people now using pubs less or not at all are spending their time at home – and drinking and smoking there. This has health consequences:

Increase in fire risk: In Ireland this is clearly a problem. Batt O’Keeffe TD, Minister of State at the Department of the Environment, Heritage and Local Government stated (6 December 2004, press please from his Department) ‘I am very concerned about the dangers of cigarette smoking in the home, particularly when combined with alcohol consumption. Initial indications are that the percentage of fire fatalities where the confirmed cause is cigarettes is expected to rise again this year. This is a worrying trend and one which we need to nip in the bud as quickly as possible, particularly following the ban on smoking in public places.” In recent years we are unaware that there have been any fire fatalities in Scottish pubs, so this is a new danger that would result from the Bill becoming law - not a displacement of a current danger.

Increased ETS exposure of minors and other family members: Small children are rarely present in pubs where there is a significant degree of smoking. By contrast they are highly likely to be present in the home. In the event of a ban their exposure can be expected to increase substantially, as is the exposure of other family members. Young children with developing respiratory and other systems could be expected to be particularly vulnerable. Any risks from exposure in the home will typically be greater than in a pub as the space per person is generally smaller and the ventilation worse - leading to less dilution of the ETS.

Increased home drinking: Evidence from Ireland suggests that some drinking has been transferred from the on-trade to take-home. This drinking in an uncontrolled environment is associated with health and social problems.

Uptake by children: children of smokers are more likely to take up smoking than children of non-smokers. A rise in smoking in the home associated with a smoking ban will increase the likelihood that their children will also take up smoking. This is directly against any public health objectives that may underpin this Bill.
Street activity: a high proportion of Scottish pubs, especially those in city centres, are in tenemented blocks with no areas that could potentially be used by smokers outside. The options for the pub user who chooses to smoke are to use another pub that does have an outside area or to stand outside in the street. In some areas, those standing in the street may represent a public nuisance to other pavement users, and will be vulnerable to traffic especially if they spill over the pavement into the roadway.

This is likely to be much more of a problem in Scotland than in Ireland due to the higher density of buildings and the relatively high level of street violence in some city centres.

These people are much better controlled inside a pub than outside it and we envisage substantial public order difficulties and potential injuries as a result.

1. Impact of alternative measures

We are concerned that this Bill implicitly rejects all of the other control mechanisms available. These should have been carefully considered before coming to the conclusion that a smoking ban was the only way forward. We note that harm from ETS is believed to be directly related to the dosage/level of exposure. It therefore follows that techniques that reduce exposure should have a corresponding impact on any harm, however small, from ETS.

Ventilation: Ventilation is a widely used control mechanism against contaminants across all industries. There is no reason why this should not apply to ETS and the pub industry – especially as the vast majority of ETS constituents can be found from other processes.

The 1998 White Paper Smoking Kills (www.archive.official-documents.co.uk/document/cm41/4177/4177.htm) explicitly endorses its effectiveness (Para 7.23) ‘ventilation systems can improve the comfort and welfare of public and employees. The best systems can, provided they are properly operated and maintained, protect non-smokers from exposure to carcinogens’.

Research commissioned by the Association into the effectiveness of ventilation at the Doublet Bar in Glasgow demonstrated conclusively that even relatively inexpensive ventilation greatly reduces the contamination from ETS gases and particles. There are similar studies available from the University of Glamorgan, which demonstrate the same effect in a number of pubs in England and Ireland. Where ETS constituents have known occupational exposure limits (for example particles and carbon monoxide), these are kept well within the acceptable levels.

The peer-reviewed Black Dog study (December 2001 Regulatory Toxicology http://www.ingentaconnect.com) clearly demonstrates that a well-managed ventilation airflow can prevent ETS drifting from a smoking area to a non-smoking area. The synopsis concludes that ‘ventilation techniques for restaurants/pubs with separate smoking and nonsmoking areas are capable of achieving nonsmoking area ETS concentrations that are comparable to those of similar facilities that prohibit smoking outright.’

Separation: Separation of smokers from non-smokers by a wall or partition is also a highly effective means of preventing the exposure of staff or non-smoking customers to ETS. This is especially so if the room is fitted with, even low level, ‘extract’ ventilation which will prevent any ETS from drifting out into the rest of the premises.

Concerns have been expressed that staff would be exposed to ETS if they entered such a room at the end of an evening to collect glasses. In reality there is little problem. ETS contamination is subject to exponential decay as the chart below shows (prepared by the Building Services Research and information Association – BSRIA). Most pubs have a ‘natural’ leakage rate of 1 or more air changes per hour with air seeping through the fabric of the building. This means that the equivalent of all of the air in the room is replaced once each hour with fresh outside air. At this rate – with no mechanical ventilation – the concentration would reduce by about 85% in two hours. At even a low rate of ventilation such as 5 air changes per hour, the contamination would be reduced to this level in about 30 minutes and effectively to zero within an hour.
Loss of jobs and amenity
Research commissioned by the AOB Group, of which the Association is a member, carried out by the Centre for Economics and Business Research (London) to review the economic impact of the proposed ban on both the licensed trade and the beer industry in Scotland found that:

- Employment in the licensed trade can be expected to decline by 2,300 jobs initially (page 5 refers)
- About 142 average sized licensed premises may close as a result of decreased trade (page 5 refers)

The loss of employment is likely to have a negative effect on the health and welfare of the people involved. This will be especially so for the c.140 licensees who will lose not just their jobs, but also their homes and their savings.

The loss of the pubs, which are likely to be in remote or economically deprived areas with few centres for community life, will have a marked and negative impact upon the lives of their regular customers who use it as an extension of their own home. This would be especially true of older people and some people who are emotionally disturbed for whom the pub is the only place at which they can meet other people. We believe that the health (physical and psychological) of these marginalised groups will be significantly and negatively affected by a ban that will force the closure of their ‘local’.

Evaluating alternatives to the ban
We are very concerned that the Executive appears not to have considered our alternative proposals seriously, if at all, in developing the draft Bill.

Our proposals are far more in line with public sentiment than the proposed ban. The Scottish Executive’s own research (MRUK 2004) found that just 18% of those surveyed supported a total smoking ban.

This percentage is borne out by the annual research carried out by the Office of National Statistics at the UK level in its latest (2003) report, which showed just 20% in favour of a ban in pubs, as the graph below indicates.
Suggested restrictions on smoking in pubs

Our proposals will deliver the result that voters want at the moment. Our plan allows for a review of progress to be taken in the light of public opinion prevailing at the end of the third year. Our further plans would clearly reflect these public preferences.

In our view this is both reasonable and sensible.

Summary

The S.L.T.A. welcomes the introduction of measures to restrict smoking in public places. Our concerns are with the approach adopted by the Scottish Executive and are broadly divided into four areas as follows:

this legislation assumes, without adequate research and contrary to recent international reports that the best way to improve public health is to impose an outright ban.

the outright ban will lead to public disorder, litter and extra public nuisance incidents, particularly at weekends and in city centre bars.

3. no research has been conducted into similar bans worldwide, since Ireland, Norway and New Zealand are the only countries where such a ban exists.

4. it is too early to assess the impact in Ireland.

5. The public does not want, and is not ready for, a ban on smoking in all pubs.

We are concerned at the speed with which the Executive has proceeded with this measure since announcing its decision to introduce a total smoking ban in enclosed public spaces on 10th November 2004. We support increasing smoking restrictions and increasing the number of smoke free areas, but we believe the Executive should take more time to truly consider whether an
An outright ban is the most effective way to tackle the smoking issue, particularly given the ban’s intended introduction in Spring 2006. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

At the Finance Committee meeting which The S.L.T.A. attended in February 2005, it was stated that the Police in Scotland will not enforce the ban, that local councils will require substantial additional funding to enforce the ban and that a major recruitment exercise will need to be undertaken to ensure that officials can patrol pubs the length and breadth of Scotland. The only measures that local councils and the Police have for controlling noise in the street, and litter, are already inadequate to meet current demand. They will require a massive additional investment to solve these problems. We believe that sufficient research is required to assess the cost of implementation.

The Executive’s own MRUK opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in pubs, despite a majority favouring increased restrictions on smoking – but the public do not want, and are not ready for an all-out ban. Even the Executive’s own consultation on a Smoking Ban showed only 18% in favour of a total ban on smoking in pubs. The importance of public acceptance cannot be overstated. Compliance is crucial in terms of enforcing a ban and avoiding public confrontation with officials.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will safeguard the nation’s health, avoid the shift in smoking to the home, protect the hospitality and licensed trade industries and will prove enforceable. Approximately 85% of health problems caused by Environmental Tobacco Smoke are derived from domestic situations and it is quite possible that the outright ban approach will result in greater health problems as a consequence.

We urge the Committee to reconsider exemptions for the licensed trade and to take the time to adequately research the implications of this legislation before it is rushed through the Parliament.

Colin A. Wilkinson
Secretary

SUBMISSION BY TOBACCO MANUFACTURERS’ ASSOCIATION (TMA)

TMA Briefing Note

The Tobacco Manufacturers’ Association (TMA) has been invited to give oral evidence to the Committee. The TMA will be represented by Christopher Ogden, Director of Trade and Industry Affairs who will be accompanied by Dr Steven Stotesbury, Senior Scientist at Imperial Tobacco Limited.

The TMA has, to date, submitted for the attention of the Committee:

Submission on Prohibition of Smoking in Regulated Areas (Scotland) Bill April 2004

Supplementary Written Evidence on Prohibition of Smoking in Regulated Areas (Scotland) Bill July 2004

Response to the Scottish Executive’s Consultation on Reducing Exposure to Second-Hand Smoke September 2004

Response to the Smoking, Health and Social Welfare (Scotland) Bill February 2005

ETS – A Summary of the TMA’s Position February 2005

Smoking and Health (Scotland) Bill – TMA Fact sheet for MSPs February 2005.
Tobacco is a Legal Product.

The manufacture, sale (provided the customer is not under 16 years of age), purchase and use of tobacco products are legal activities. Smoking is a matter of informed adult choice. As far as under-aged persons are concerned the TMA is active in supporting youth access prevention programmes. The TMA is a key stakeholder in the CitizenCard proof of age scheme, the largest of its kind in the UK, and contributes significant resource to the No ID No Sale campaign to assist retailers in refusing sales to children.

Smoking in Work and Public Places

According to the latest available data from the Office of National Statistics 50% of people work in places where smoking is prohibited and 38% work in places where smoking is permitted only in designated areas. These arrangements have been agreed between employers and employees and their representatives on a voluntary basis. 4% of people work on their own and therefore determine their own smoking policy. This leaves 8% who work in places where smoking is permitted throughout, not exclusively but partly in the hospitality sector and in outdoor environments e.g. building sites. It is therefore important to get the issue of smoking in the workplace into proper perspective. It is also accepted that many work places are also public places in the sense that they are places which the public may enter by choice or otherwise.

The Evidence on Environmental Tobacco Smoke (ETS)

All proposals to prohibit or regulate smoking in work or public places are based on the premise that ETS causes death and serious disease in non-smokers. The TMA considers that the evidence, taken as a whole, does not establish that ETS causes disease and does not justify the prohibition of smoking. Our detailed analysis of ETS research has previously been submitted to the Committee.

Even if it is assumed that ETS causes serious diseases, there is no obvious reason why it should be necessary to introduce stricter measures than those already in place for, as examples, the risk of exposure to radioactive contamination, workplace noise, radiofrequency radiation or carcinogens generally. In all these cases regulation does not seek zero exposure but rather reductions to levels that are reasonably achievable or which fall below certain minimum dose thresholds. Legislation should be proportionate to the need that it aims to address. Proportionate regulation is more likely to command public respect and is easier to enforce. The European Commission, for example, advises that regulation should not automatically “aim at zero risk, something which rarely exists. In some cases, a total ban may not be a proportional response to a potential risk”.

What the Scottish People Want.

The poll conducted by the Scottish Executive in 2004 on smoking in public places produced results that were unrepresentative of the population of Scotland as a whole as the respondents were self-selecting. Opinion surveys that have used nationally representative and standard sampling techniques (of the UK as a whole in 2004 and of Scotland specifically in 2005) have shown that rather than a majority being in favour of a complete ban, the majority are in fact in favour of exemptions for pubs, bars and clubs.

The TMA acknowledges that tobacco smoke can be irritating to non-smokers but believes that this can be addressed through voluntary means. An accommodation to cater for individuality, freedom of choice and social justice should be sought rather than punitive legislation which will criminalise smokers.

8 February 2005
Introduction

In April 2004, we submitted written evidence to the Health Committee of the Parliament on the Prohibition of Smoking in Regulated Areas (Scotland) Bill proposed by Mr Stewart Maxwell MSP. Following the giving of oral evidence to the Committee in June, at the request of the Committee, we provided supplementary written evidence in July. When we responded to the Scottish Executive’s consultation ‘Reducing Exposure to Second-hand Smoking’, we consolidated and updated our earlier submissions to the Health Committee. We trust that those previous, comprehensive and detailed submissions will be taken into account by the Committee in its consideration of the Smoking, Health and Social Care (Scotland) Bill, (the “Bill”).

Publication of the Bill was accompanied by the documents required under Rule 9.3 of the Parliament’s Standing Orders, and research papers and reports published by the Scottish Executive and NHS Health Scotland. Nonetheless, as requested, the evidence presented here is very brief. It is confined to Part 1 of the Bill and key observations on the accompanying, supporting documents.

Part 1 of the Bill

As the long title of the Bill makes clear, Part 1 has no relationship whatsoever to the remainder of the Bill, which is principally concerned with details of the provision of health and social care services in Scotland. In our opinion, Part 1 does not sit comfortably with the remainder of the Bill. We believe that if the Executive legislate in this area then it should be the subject of a stand-alone Bill.

To a substantial extent, Part 1 is also only enabling legislation. It creates the offences of smoking (clause 4), knowingly permitting smoking (clause 1) and not conspicuously displaying prescribed notices (clause 3), in enclosed ‘no-smoking premises’ or parts of premises. Beyond that, it reveals little about the reach of the ban that might be imposed and leaves a gaping hole to be filled by the exercise of the powers that it gives to Ministers to make regulations on definitions and other matters of fundamental relevance and importance to any prohibition.

We do not believe that this is right or acceptable. As Part 1 stands, the Parliament is effectively being asked only to agree to the principle that a ban, of indeterminate nature, is imposed, without any reliable, concurrent knowledge of the essential detail. Ministers may seek to provide reassurance, by stating the intention to publish draft regulations during the course of the parliamentary proceedings on the Bill. However, there is no guarantee that such indications will bear fruit and, in any event, it prompts the question, why is the Bill itself not more explicit at the outset?

The policy basis of the Bill

The policy reason for Part 1 of the Bill is stated in the Policy Memorandum to be the protection of public health, where it is said (para 10): “The scientific evidence of the health risks of second-hand smoke is clear and irrefutable”. The principal evidence that is cited in support of this belief is the reports of the SCOTH and the research commissioned by the Executive and NHS Scotland from Glasgow and Aberdeen universities. We strongly dispute the claim of ‘clarity and irrefutability’ and the reports that are cited in support of this assertion.

In our previous evidence on legislative proposals in Scotland referred to above, we provided detailed evidence on the epidemiological studies and meta-analyses that have been undertaken and published on environmental tobacco smoke and health. In that evidence, we explained why, there was no justification for the kind of prohibition that the Bill would permit, and which Ministers

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have indicated they intend to introduce. We took great care to provide that evidence in an objective manner that would enable the reader to make his or her own judgement.

The research and reports commissioned and published by the Scottish Executive and NHS Scotland

The research commissioned by Glasgow University, carried out by Professor Hole aims to estimate the number of deaths from "the major smoking-related causes of death in Scottish adults which can be attributed to passive smoking." His report draws on various published meta-analyses and seeks to relate their risk findings to the Scottish situation.

Nowhere in this report is the evidence for a relationship between environmental tobacco smoke and various diseases examined. Instead it is one of many assumptions made from the outset. The exercise is fraught with sparse information and data, and the necessity to make a number of assumptions.

The evidence for environmental tobacco smoke being a cause of disease is inconclusive. Furthermore, it is difficult to estimate the degree of exposure to environmental tobacco smoke in the population, with any reliability.

Professor Hole’s report cannot be regarded as providing reliable estimates of the impact of environmental tobacco smoke on the health of Scotland’s population.

The Aberdeen University review of the evidence on the health and economic impact of the regulation of smoking in public places must also be put into a proper perspective. The review provides scant information on data sources and methodology, and is replete with assumptions that are highly contestable, all of which makes detailed critical analysis impossible. Its conclusions are speculative, imprecise by their very nature, and unreliable.

Regulatory impact assessments, with which the review approximates, as does the financial memorandum to the Bill, are notoriously unreliable when, of necessity, they are largely speculative in terms of data and conclusions. That fact would be ‘clearly and irrefutably’ demonstrated were they to be followed-up, after an appropriate period, by an assessment of the real, actual effect of the measure in question.

The Policy Memorandum at paras 23 to 27 identifies the steps that were taken by the Executive to consult the public. To coincide with the publication of the Bill, the Executive released four, separate research reports evaluating attitudes to smoking. These reports, commissioned from a variety of private sector research agencies, used different methodological and sampling techniques among both general and specific target population groups. These included an Omnibus survey, a youth consultation exercise, focus groups and a broader public consultation exercise.

Shortcomings in the methodologies deployed compromise the certainty with which conclusions can be drawn from the data. The surveys actually reached conclusions that are diametrically opposed to the position in support of which they were adduced. Far from demonstrating universal public support for an outright ban on smoking in public places, the four reports actually demonstrate strong backing for the introduction of new restrictions but not a blanket ban, and restrictions moderated by exemptions to new legislation.

In the Omnibus survey, of those "in favour of an outright ban" (54%), 66% thought that there should be exemptions, the majority (57%) spontaneously suggesting that pubs should be exempted from any ban and 21% suggesting that clubs be exempted. Only a small minority (24%) were actually in favour of an outright ban without any exemptions.

The youth consultation comprised one national and four regional polls. This consultation had serious design and other methodological shortcomings, but the findings were that a sizeable majority (66%) of the total sample believed that there should be places where smoking was permitted.

Amongst the unspecified twelve focus groups, designed to put qualitative flesh on the bones of quantitative omnibus research, the findings included the telling statement that “... it is by no means
straightforward as to exactly what level of change should be introduced. Many people that we spoke to in the focus groups are not in favour of a total ban for a number of reasons.”

The public consultation received a response rate of just under 9% (53,474 completed questionnaires from 600,000 distributed). Given the self-selective nature of the sample, it is unsurprising that 80% of respondents were in favour of a law to make enclosed public spaces smoke-free, with only 18% opposed. On exemptions, the overall response from both individuals and organisations was 35% in favour, 56% opposed. However, many more individuals responded than organisations, and merging the responses conceals the fact that of the organisations which responded to the poll, only 42% were in favour of an outright ban, 44% were opposed.

In short, all four of the pieces of research commissioned by the Scottish Executive were flawed methodologically and statistically. The flaws included: over and under-representation by gender, age, region or smoker status; the aggregation of results across different methodologies and across different groups of participants; the ignoring of possible question framing and context effects; and the use of self-selecting rather than truly representative samples.

In line with other surveys of public opinion, both in the UK as a whole (Forest/Populus 2004) and of Scotland specifically (Forest/Populus 2005), around two-thirds of those polled in the Qualitative Scottish Executive surveys supported a ban when presented with a “ban/support” option. However, when representative samples were asked whether they supported exemptions, the figures reverse – around two-thirds, of either those in favour of a total ban or of the whole sample, were found to be in favour of exemptions. These findings show that the Scottish Executive’s proposed comprehensive ban is out of line with public opinion.

The abandonment of the voluntary approach
At paragraph 12 of the Policy Memorandum, there is an attempt to justify the abandonment of the voluntary approach to the regulation of smoking. There, the Executive acknowledges that much progress has been made through the voluntary approach, albeit less pronounced in the hospitality sector. In the next sentence, the Executive states: “This has led to the conclusion that legislative action is now required if we are to make any real progress in this area.” This is not an obvious and necessary conclusion. Indeed, the progress achieved should surely be regarded as evidence to support continuation of the voluntary approach, albeit perhaps with more ambitious targets and determination on the part of the hospitality sector.

We understand that owners and operators in the hospitality sector believe that they should be allowed to run their own businesses without undue interference. They will obviously do that in their own best commercial interests, having due regard for the health, safety and welfare of their employees, and the wishes and preferences of their customers and clienteles. As the public expresses – through the giving of their own custom and through opinion polls – their wish for more non-smoking facilities, those facilities have been and are increasingly being provided. Market mechanisms are well able and suited to determine the most appropriate smoking policies, whether in Scotland or elsewhere in the United Kingdom. We believe that it is wrong to dismiss the merits of voluntarily adopted self-regulation and to ignore the substantial disadvantages of compulsion through legislation, for example that it creates criminal offences.

In order further to justify legislation, however, the Policy Memorandum states that an approach to create separate smoking and non-smoking areas within leisure and hospitality premises “is difficult to justify on public health grounds given that there is no defined safe level of exposure to second-hand smoke…” and that “a complete ban on smoking in all enclosed public places would provide the most comprehensive protection to public health and also has the advantage of being simpler to implement.”

Even if is assumed that environmental tobacco smoke causes serious diseases, there is no obvious reason why it should be necessary to introduce stricter treatment than, for example, the risk of exposure to radioactive contamination, workplace noise, radiofrequency radiation or carcinogens generally. In all those cases, regulation does not seek zero exposure, but rather reductions to levels which are as low as reasonably achievable, or which fall below certain minimum dose thresholds. Legislation should be proportionate to the need that it aims to address. Proportionate regulation is more likely to command public respect and is easier to enforce.
European regulation, for example, should not automatically “aim at zero risk, something which rarely exists. In some cases, a total ban may not be a proportional response to a potential risk.”

Conclusions

Our overriding concern is that the Scottish Executive has not yet had the opportunity to examine and review the essential fundamental and scientific evidence before making such an important policy decision.

Furthermore, we are concerned that this proposed legislation does not reflect the views of the Scottish people. The Executive’s own consultation process highlighted the fact that the public were against a blanket ban but recognised a need for greater restrictions. We would urge the Executive to take on board the public’s views and encourage more no-smoking areas in Scotland, whilst allowing smoking to be permitted in certain places.

Finally, we would question the validity and appropriateness of the legislation. If its purpose is the health, safety and welfare of employees then the Scottish Parliament lacks competence to legislate in this area.

We trust that here we have clearly explained, albeit very briefly, why we disagree with the bill. Should the Committee wish, we would be pleased to appear to give oral evidence.

SUBMISSION BY COAL INDUSTRY SOCIAL WELFARE ORGANISATION (CISWO)

The COAL INDUSTRY SOCIAL WELFARE ORGANISATION (CISWO) is a National Charity (registration 1015581) concerned with promoting Social Welfare in Mining Communities and assisting miners, retired or redundant mineworkers and their dependants, offering information advice and support to enhance quality of life. CISWO (Scotland) promotes community regeneration and development through professional support, in partnership with others, to 53 Miners Welfare Schemes and other coalfield charities/community organisations and groups. Striving to empower people and communities through confidential client/beneficiary support and project development promoting social inclusion. CISWO is a member of the COMMITTEE OF REGISTERED CLUB’S ASSOCIATION (CORCA).

CISWO (Scotland) welcomes the opportunity to respond to the call for evidence from the Scottish Parliament’s Health Committee regarding the above Bill.

CISWO (Scotland) agrees with the main objective of part 1 of the Bill prohibiting smoking in enclosed public places.

CISWO (Scotland) supports a ban on smoking in enclosed public spaces not just in terms of the general health benefits to non-smokers but also with regard to the implications on worker health and safety. Believing that under basic health and safety principles employers must protect the health of employees and provide a healthy and safe working environment. Taking the example of Clubs, this duty of care to employees should extend to members, volunteers and user groups. Accordingly, the prohibition of smoking in enclosed public spaces is a basic health and safety matter. As a result of this legislation people will finally be able to socialise and work in smoke-free environments which will not damage their health.

CISWO (Scotland) acknowledges there are wide and differing views being expressed in relation to the Bill and its potential impact both positive and negative on Registered Club facilities. For example there are some Club Management Committees and members who would prefer CISWO not to support the Bill and instead lobby the Parliament to make amendments along the more diluted proposals south of the border. This is not unexpected, bearing in mind many of our communities are entrenched in a traditional culture where smoking is enjoyed by many and to some, is an extremely important part of social life particularly for the older generation. Some are
genuinely anxious how individual smokers are going to cope in their daily lives with such restrictions. Concern has also been expressed that the Bill may inadvertently cause the closure of some important community clubs if the restrictions impact on income needed to sustain the facility. Some continue to ignore the facts that smoking can be an addiction which craves nicotine and is harmful to those around them and are happily supporting the pro-smoking lobby.

On the other hand there are CISWO Club’s already partnering Health Professionals and Agencies to provide practical support within their premises for members and their wider community. With encouragement some clubs are already preparing for the new legislation by organising and providing individual and group support and advice, smoking cessation courses and nicotine replacement initiatives. Helping to deliver Peer education, healthy lifestyle and harm reduction. Encouraging and challenging cultural preconceptions about smoking. Bearing in mind the majority of the population are already non-smoking, coupled with the attraction of being able to enjoy socialising in a smoke free environment should ensure a more secure future for many facilities in the medium to long term. However, carefully managing and supporting this radical change will be critical in the short term. Some are clearly up for the challenge while others may never be.

CISWO (Scotland) believes the pro-smoking lobby present flawed arguments in their proposals for alternative legislation using tactics to mislead the public on the dangers of second-hand smoke. Legislation on smoking is required because voluntary regulation has not worked and a major cultural shift is required towards ensuring non-smoking becomes the norm in Scotland, which only legislation will achieve. As the evidence for the harmful effects of second-hand smoking is overwhelming, it is wholly inappropriate to argue that a person’s right to clean air should be overridden to accommodate a smoker. Many of those who have been closely associated with the Coal Mining Industry have been at the forefront of putting health and safety before profit. The Coal Mining Industry has prohibited smoking underground for decades recognising the real risk of gas explosion. This legislation will recognise the real risk from tobacco smoke and put the Scottish Nation’s Health and Safety before the tobacco industry or profit.

CISWO (Scotland) is committed to working closely with the Scottish Executive and Health Trusts to encourage more Miners Welfare Facilities to help lead the way in providing practical and effective support to smokers who may want to cut down or stop altogether. Focusing at the heart of traditional working class coalfield communities, where the need for support is particularly high. When one family is spared the devastation and horror of losing a loved one prematurely through smoking related disease, the Scottish Parliament will have justified implementing this brave and innovative legislation.

Ian JS McAlpine
Regional Manager
CISWO (Scotland)

SUBMISSION BY BRITISH HOSPITALITY ASSOCIATION SCOTLAND COMMITTEE

1. Introduction

The British Hospitality Association Scotland (BHA) welcomes the opportunity to submit evidence on the Smoking, Health and Social Care (Scotland) Bill. The BHA is also a member of the National Smoke Free Areas Implementation Group established to advise the Scottish Executive on the implementation of smoke free areas.

The BHA has been representing the hotel, restaurant and catering industry for over 90 years. Some 3000 establishments in Scotland, across all sections of the industry, are represented by the BHA – not just group-owned properties, but also hundreds of individually owned hotels and restaurants.

The BHA is a signatory of the Scottish Executive’s Voluntary Charter on Smoking in Public Places and we are a member of the corresponding group in England and Wales. As a member of these groups we have sought to ensure that the hospitality industry recognises that the majority of the
population are non-smokers and that this is reflected in the policies of the industry as a whole. The
overriding aim of the BHA is the creation of an environment where non-smokers are not adversely
affected by the effects of passive smoking.

As stated in evidence on the Prohibition of Smoking in Regulated Areas (Scotland) Bill the BHA
position was that if the Voluntary Charter no longer commanded ministerial or public support, the
only realistic policy option was a total ban on smoking in public places as has been announced by
the Scottish Executive.

2. General Principles

The BHA supported the Voluntary Charter as long as it continued to enjoy industry and government
support. It is the position of the BHA that if the voluntary charter is no longer supported in this way
a total ban on smoking in places of employment is the only logical step open to government.
Therefore, as the voluntary charter is no longer supported by the Scottish Executive we support the
main objective of the Smoking, Health and Social Care (Scotland) Bill in prohibiting smoking in all
enclosed public spaces.

2.1 Detailed Comment

The BHA supports the Bill on the following grounds: -

- It is unambiguous and Scotland-wide making enforcement easier and preventing
  regional discrepancies; if optional powers were devolved to local authorities to set their
  own rules in relation to smoking this would confuse customers, tourists and operators
  and has the potential to distort the market place.

- The legislation is straight forward to implement and enforce unlike the proposed
  legislation in England.

- The Bill as currently drafted splits responsibility and penalties equitably between
  operators and customers. However, consideration should be given to greater penalties
  being placed on those individuals who smoke in areas of employment rather than
  penalising management or more senior employees for the offences of others.

- The Bill is even-handed as it applies equally to hospitality establishments where food
  is served and to other workplaces.

- The Bill as currently drafted provides clear health benefits, which the Prohibition of
  Smoking in Regulated Areas (Scotland) Bill did not.

2.2 Concerns

2.2.1 Hotel Bedrooms

The Bill does not address the issue of hotel rooms which are traditionally viewed as private places
and where if a guest chose to smoke, despite a restriction, it would be impossible for the hotel
management to know that an offence was being committed until after the event and as such wholly
inequitable and inappropriate to penalise management in such circumstances. It would also be
inequitable for local authority officers to have powers to enter an hotel bedroom, possibly by
force, to check whether an offence was being or had been committed. The BHA is strongly of the
view that an exemption in the case of hotel bedrooms requires, as in the Irish Republic, to be
contained on the ‘face’ of the Bill.

2.2.2 Bodies Corporate etc.

The structure of some BHA member businesses involves premises being leased from them or
managed on their behalf. As currently drafted section 7 appears to suggest that owners or head
landlords may be proceeded against even in circumstances where they are not in day to day
control of the business. This is not compatible with natural justice and should be addressed.
2.2.3 Impact on Recruitment

The hospitality industry is facing well documented recruitment difficulties which we as an industry are working hard to address. However, by making employees liable for prosecution and fines it is possible that the Bill will undermine strenuous efforts to make the hospitality sector a more attractive career option.

SUBMISSION BY COSLA

Introduction

1. COSLA, as the umbrella organisation representing 31 of Scotland’s councils, welcomes this opportunity to submit evidence to the Health Committee on the Smoking, Health and Social Care (Scotland) Bill. This submission will concentrate on the smoking ban elements of the Bill from the local authority perspective.

2. COSLA has already submitted written evidence and given oral evidence on the financial implications of the Bill to the Finance Committee. A copy of the submission to the Finance Committee is annexed as elements in that, although primarily cost focussed, are relevant.

COSLA Position

3. COSLA:
   o Supports the introduction of the ban
   o Recognises the health improvement benefits that will follow the ban
   o Is committed to playing its part in implementation
   o Requires full funding for its member councils to cover implementation

Principles

4. COSLA supports the principle of the ban on smoking in enclosed public spaces and regards it as a major step in advancing the health improvement agenda which is one of our member councils’ priorities.

5. Support for the Bill is contingent on the Scottish Executive providing councils with full funding to allow for the successful implementation of the Act. This represents standard COSLA policy in respect of all new legislation and was reiterated as part of our spending review submission in 2004.

Comments

6. COSLA would wish to comment on a range of associated issues:

Phasing

While there is an appreciation of the arguments in favour of a phased implementation of a ban, in view of the over-riding health arguments for a ban, and Scotland’s health record as one of the poorest in Western Europe, any phasing arrangements would not be supported. Immediate implementation will help raise awareness, avoid confusion and send the correct, positive message. A phased introduction would lead to practical difficulties with enforcement.

Possible Exemptions

COSLA recognises that possible exemptions to the smoking ban is a key area to be debated and one of the most difficult to address. Amongst councils there is a range of views about what should be exempted, with residential homes and day care centres featuring most frequently on the lists of those councils favouring exemptions. It is accepted that an exemption would not represent carte blanche for smoking to continue indefinitely; that it should be subject to review; and that smoking cessation work should continue with people living in any exempted areas.

Staff working in areas where smoking is permitted

Councils as employers will be required to consider specifically the position of members of staff required to work in areas where smoking is permitted and where they could be subjected to second hand smoke.
**Benefits arising from the Ban**

It is accepted that it will take time for the benefits stemming from the ban – as with most health improvement measures - to be evidenced. The step is, however, an important move forward, which will impact positively on the health of Scotland’s people, and is not to be viewed as a ‘quick fix’

**Rural areas**

The impact of a total ban could be particularly severe in isolated, rural areas both from the economic and socialisation perspectives. The social opportunities offered by pubs should not be underestimated as a means of reducing social isolation which is recognised as having an adverse effect on health.

**Smoking Cessation Work**

An increased demand for smoking cessation services can be anticipated in the run up to and following the implementation of the ban. While it is recognised that the ban is a ban on smoking in enclosed areas, not a ban on smoking, cessation work is regarded as an extremely important area for councils as employers and will be included in council estimates for the cost of implementation. Councils are often the largest employers in the local authority area and by supporting staff to give up smoking the council may indirectly be influencing others in the wider community to stop, with staff possibly passing on to friends and family members what they have learned through smoking cessation initiatives in the workplace.

**Enforcement**

The likely shortage in Environmental Health Officers to enforce the legislation has already been highlighted to the Scottish Executive and will the subject of separate discussion. The Committee should, however, be aware that councils are already experiencing difficulties in recruitment – a position that will be exacerbated by the requirements of the new legislation.

3. COSLA would be happy to give oral evidence to supplement this submission if the Committee would find that helpful.

February 2005

- COSLA Submission to the Scottish Parliament Finance Committee

**Purpose**

The purpose of this paper is to provide the Scottish Parliament’s Finance Committee with an outline estimate of the costs associated with the introduction, implementation and continuing enforcement of a ban on smoking in wholly enclosed public spaces as proposed by the Smoking, Health and Social Care (Scotland) Bill. The Committee is asked to note that these are preliminary costs that COSLA will refine with its member councils. The costs will, in addition, be discussed with the Scottish Executive.

**Principles**

4. COSLA supports the principle of the ban on smoking in enclosed public spaces and regards it as a major step in advancing the health improvement agenda which is one of our member councils’ priorities.

5. Support for the principles and goals of the Bill is dependent on the Scottish Executive providing full funding to allow for the successful implementation of the Act. This is standard COSLA policy and was reiterated as part of our spending review submission in 2004.

**The Financial Memorandum**

6. As usual, as required by the Parliamentary process, the Financial Memorandum was published with the Bill itself but in the absence of the detailed Regulations that will accompany the new legislation. This has caused practical problems in costing the implementation of the smoking ban and means that, at best, COSLA's current estimate can only be an estimate. Costing new legislation is an important part of the legislative process, for all parties involved, but it is particularly
important to ensure the integrity of any new legislation and its efficacy. Against this background COSLA’s member councils have provided the best estimates possible. The Committee is asked to recognise this and also the fact, that, at this stage, the interpretation of costs will vary between authorities. Any inconsistencies in approach will be addressed as estimates are refined.

7. Work with COSLA member councils has produced an initial first year estimate for the implementation of the ban of smoking in public places. Based on figures available, we believe that the total cost in 2005/6 and 2006/7 is in the region of £6 million.

8. With regard to the other elements of the Bill, the financial memorandum states that no major financial implications have been identified for local government at this stage. However, the cost neutral description of the section relating to Joint Ventures should be treated with some caution. It is felt that, in the long term, this could have implications for local authorities and COSLA would wish to reserve its position on this element of the Bill.

9. The commentary in Executive’s Financial Memorandum on the banning of smoking in public places reflects the uncertainty which all parties feel surrounds the financial elements of the Bill. It rightly states that the implementation costs for local authorities have yet to be determined and will be linked to the detail of the Regulations which have yet to be drafted. It also recognises that additional costs in the early years are likely, an open acknowledgement that is welcome. It is therefore against this background that this evidence has been prepared and the Committee will recognise that the figures used are estimates only. However, experience does indicate that where councils have given detailed estimates, the outturn costs are unlikely to vary significantly.

10. The evidence has been prepared within a short timescale to meet the Committee’s deadline and there has been little opportunity for cross checking, either at Council or COSLA level. When the Regulations are available, it is intended to repeat this exercise against the more detailed background the Regulations will provide and COSLA will be happy to make the information from this available to the Committee.

11. As indicated in the introduction to this paper, COSLA will also be working with the Scottish Executive on these financial estimates.

12. One specific point emanating from the Financial Memorandum that COSLA would like to raise relates to the generally held view that enforcement costs will diminish over time. This is accepted, but there are concerns that it may take longer than anticipated for opposition to the ban to fade. To ensure the success of the ban therefore ongoing commitment is needed from all parties involved. The ban is not a ‘quick fix’ but the beginning of what will be a sustained campaign against the damaging effects of smoking on health. The investment of sufficient resources both initially and on an ongoing basis will be essential.

13. What will not be available with the Regulations and in the next year or so with actual experience of implementation is firm evidence of the financial benefits of the legislation. Some of these benefits to health will be long term and COSLA would prefer to leave it to statisticians to attempt to quantify the cost benefits to employers, the NHS and individuals, of living and working in a smoke free environment. What is clear, however, is that there will be real benefits which must be borne in mind when considering the cost of implementing the legislation.

Individual Issues

14. COSLA would wish to comment on and highlight a number of individual issues with financial implications. These are:

Staff

15. There is already an acknowledged shortage of Environmental Health Officers – a situation likely to be exacerbated given the age profile of the profession. This is an issue the Scottish Executive has already agreed to discuss. It is a fact, however, that the enforcement needs of the smoking ban will create further demands and difficulties on council staff with considerable efforts being required for recruitment. It is recognised that fully qualified EHOs will not necessarily be required for all elements of the resulting workload and enforcement officers will be employed too –
typically authorised/technical officers. This will very much be a matter for individual authorities to determine and current staffing arrangements will be a factor.

16. The possibility of combining smoking legislation duties with existing EHO officer work and with enforcement officers to be responsible for liquor license standards work will be considered by individual authorities, but decisions here will be on an individual authority basis. (For example, in one authority it is not envisaged that the Liquor Licence Standard Officer will be involved in the enforcement of the smoking ban in licensed premises. This post is considered to be a liaison and advisory link between the Licensing Board and licensees and accordingly will at most report breaches of licensing conditions to the Board. It is considered that a direct involvement in enforcement would compromise this link.) Discussions are also taking place between COSLA and the HSE regarding respective responsibilities, possible cross over etc but these discussions are at a preliminary stage.

17. There are concerns that the Executive will only fund enforcement for an initial period and that funding will then decrease with revenue consequences for councils.

18. ‘Lone working’ will not be an option given the need for corroboration and the nature of the premises to be visited allied to the police position that they are not able to commit resources to assist in the enforcement of a ban.

19. Much of the work will be of an ‘out of hour’ nature – overtime payments will be the norm.

20. For rural councils, (and notably islands authorities) given the geography of their areas, there will be particular organisational issues to be addressed and extra expenses incurred.

21. The introduction of the new legislation, if the planned timetable is achieved, will more or less co-incide with the introduction of the new EU Food Hygiene Regulations (from 1 January 2006) which will also place significant additional burdens on environmental staff.

Lead in time
22. Assuming the implementation date for the legislation will be 1 April 2006, work will be required prior to that and expenditure incurred in the current financial year. Ideally staff should be in post some months before the legislation goes live. Publicity and consultations with businesses should ideally be allowed a generous timeframe.

Street Cleaning
23. An increase in street cleaning – particularly in city centres – has been identified by elected members as a likely outcome of the ban. At the moment cigarette litter is a particular issue at the entrance to shopping centres and large office complexes and it is a problem that is expected to increase once the legislation is enacted.

24. There are differing views, however, as to the additional burden this will impose on councils and as with many of the issues relating to enforcement of the ban, advance quantification of their impact is not an exact science. Where streets are not swept in the evenings this might need to be reviewed. If cleaning is required in other than city centre areas, any noise caused by the sweepers will be a consideration. Cigarette related litter is difficult to deal with by mechanical sweeping and is labour intensive. What is clear is the view that responsibility for the immediate environs of premises such as pubs, clubs and restaurants should lie with proprietors allied to a licensing condition that licensees provide cigarette disposal facilities and/or local cleaning at licensed premises. Capital costs for the provision of additional litter bins are anticipated by many councils and to this must be added the cost of their installation and servicing.

Training
25. Training will be required not only for all staff involved, but also for elected members. A central training resource (perhaps a bespoke, module-based course) that can be delivered remotely has been suggested.
26. Training should include: enforcement; how to deal with confrontational situations/aggression/assertiveness; court room training; statement taking, record keeping; use of computers and relevant programmes

Publicity materials
27. These will be required on both a national and local basis and, as usual, in minority languages etc. Clarification is awaited as to how the £2M expenditure identified by the Scottish Executive for ‘communication ahead of implementation’ will be used. It is hoped that a proportion at least will be allocated to the central production of materials that can in turn be individually badged by councils.

Income generated from fines
28. It is not anticipated that income generated from fines will be high, but that income should be retained by councils for use, for example, to:- offset the cost of implementing the legislation, for smoking cessation services or for sports grants in keeping with the public health theme.

Start up Costs
29. These will include: advertising and employment of new staff; the development of enforcement strategies; preparation for training for enforcement and front-line staff, elected members and senior management; briefing of administrative and managerial staff and training of existing and new enforcement staff; promotion/publication of the new law and councils’ approach to enforcement, associated management of Freedom of Information and the provision of information to the public and businesses (recognised that the Scottish Executive could provide some materials centrally for badging by individual councils); use of existing EHO staff to provide advice on the ban in the run up to implementation.

30. Inspections will require to be at a higher level initially, but it is anticipated that the need for these will decline to a lower, constant rate over time.

Exemptions
31. Depending on any exemptions agreed later through Regulations, there could be financial implications for councils’ social work and housing services, eg to upgrade premises, the introduction of transitional arrangements as part of a move towards smoke-free status as well as a need for continuing support to protect workforce and client health in them. Private agencies used by councils as care providers could pass on costs to councils as service users.

Practical Experience
32. Councils’ experience of implementing similar legislation – eg dog fouling – is varied. In one council, 20-25% of fines are unpaid. The cost of pursuing these through Sheriff Officers is not cost effective.

Conclusion
33. The financial comment and estimates contained in this paper have been based on the information available to date, in some cases projected scenarios and best estimates. COSLA would welcome the opportunity to return to the Committee with more detailed financial information once its member councils have had the opportunity to consider the full implications of the new legislation in light of the detailed regulations.

February 2005
<table>
<thead>
<tr>
<th>Council</th>
<th>Estimated Costs (2006/07) + prep costs</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>114,000</td>
<td>Probably 75k in future years; 5000 premises; 2 FT officers; 24k start up</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>109,100</td>
<td>1 senior officer; 2 authorised officers; admin asst + 10k essential training</td>
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<tr>
<td>Angus</td>
<td>108,000</td>
<td>Includes start up costs in 05/06; for 05/06 - Senior EHO/EHO on out of hours conditions (33k); links with other enforcement teams – 5k; publicity + comms materials – 2k; for 06/07 – 08/09 – Senior EHO – 45k; 2 PT EOs – 20k; publicity, comms – 5k. 22.7k pa estimate after 06/07</td>
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<td>Argyll &amp; Bute</td>
<td>145,000</td>
<td>Includes ICT set up costs of 10k + 4k for publicity materials, assuming central provision of some materials</td>
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<td>Clackmannanshire</td>
<td>52,000</td>
<td>25k staffing (AP3); 15k street cleaning; training 2k publicity etc 10k; admin – 15k</td>
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<tr>
<td>Comhairle nan Eilean Siar</td>
<td>55,000</td>
<td>Initial recruitment training + indirect costs + possible legal &amp; admin costs</td>
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<td>Dumfries &amp; Galloway</td>
<td>159,900</td>
<td>5-6000 premises (includes food premises + other where H &amp; S enforced) 4FT officers (1 co-ordinator + 3 tech officers); for first 18-24 months reducing to 2 (co-ordinator + 1 tech officer) in next 18-24 months. + admin backup</td>
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<td>Dundee City</td>
<td>95,500</td>
<td>includes 1 EHO (37,000); 1 Enforcement Officer – 25,000; Staff, training, overtime, travel, IT, local publicity + 5k initial set up</td>
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<td>East Ayrshire</td>
<td>135,000</td>
<td>2 EHOs; Includes oncost; 10k for training + other operational costs + 10k street cleaning, litter bin provision</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>143,500</td>
<td>2 EHOs - 72k. accommodation – 13k; elected member training 1k – 2.5k; publicity; 5k additional street cleaning 50k</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>230,000</td>
<td>17,000 premises currently inspected – a further 3,000 expected to fall within the smoking legislation; 173k for staff (1 EHO: 1 EC; 2 Env Wardens; 2 EOs (night team); 230k - other costs (16k recurring overheads; 1k elected member training; 30k staff communication and signing) 10k publicity.</td>
</tr>
<tr>
<td>Fife</td>
<td>420,000</td>
<td>2 FT EHOs per area, reducing to 1 FTO per area as legislation beds in – 180kv for years 1 and 2, 90k thereafter; includes costs for mechanical sweepers (80k) + additional manpower; + additional litter bins</td>
</tr>
<tr>
<td>Glasgow</td>
<td>896,000</td>
<td>192k of this for first year only; 40k for initial 3 years. Covers additional EHOs – 1 team leaders + 5 enforcement assts + admin support – 250k for 3 years; legal support; technical &amp; admin support; monitoring; publicity &amp; info materials; + additional street cleaning – 144k pa.</td>
</tr>
<tr>
<td>Highland</td>
<td>184,000</td>
<td>Staff only costs – 4 additional staff; 4,500 premises, but 1500 estimated to require active regulation. Other costs to be added later - admin, re signage</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>140,000</td>
<td>Includes 40k in 05/06 for preparatory work</td>
</tr>
<tr>
<td>Moray</td>
<td>126,500</td>
<td>Covers 4 officers (poss qualified technical officers) – 117k; training for new and existing staff and also Licensing Board members – 4k; implementation in council premises – 1k; printing of fixed penalty notices + establishment of systems – 3.5k. NOT included, but expected to be substantial – additional street cleaning costs and also publicity materials which it is felt should be produced by the Executive.</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>40,000</td>
<td>1 EHO only costed + training</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td></td>
<td>Using Irish experience as model; 8,600 premises – risk assessment required in some form to determine priority for visits; specialist unit will be required, managed by an EHO and initially staffed by at least 6 technical officers on short term contracts; flexible working patterns and out of hours working</td>
</tr>
<tr>
<td>Orkney</td>
<td>128,000</td>
<td>Based on 2 officers at 30k, including out of hours working, training, mileage and publicity. Pre-implementation costs included cover training, consultations with businesses, training for elected members. NOT included is cost of employing EHOs in lead in period pre-April 06.</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>312,500</td>
<td>5-6 staff at AP3;4; training; staff time + management costs; equipment – mobile phones, laptop PCs, printer etc; hire equipment (2 vans + running costs); publicity; admin (clerical support; job adverts; accommodation etc). Includes training, street cleaning costs and miscellaneous additional costs</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>196,000</td>
<td>Includes 1 senior warden + 4 wardens + vehicles, training transport, recruitment – 155k; 1 AP111 officer – 35k; training 3.5k; signage 1.5k publicity 1k</td>
</tr>
<tr>
<td>Shetland</td>
<td>75,100</td>
<td>2 EHOs at higher salary point (36,869) assumed; training £600; mileage costs</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>302,200</td>
<td>Covers additional staff + overtime, additional litter warden, training + publicity – 81k; additional street cleaning – 56k; provision of bins and their servicing – 182k</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>470,000</td>
<td>Includes 170,000 for lead in work; costs for years 2 + 3 reducing to 230k; anticipated 6965 premises</td>
</tr>
<tr>
<td>Stirling</td>
<td>132,500</td>
<td>Senior EHO SCP 39-42); 3 EHOs SCP 31-38 Admin support (SCP 13-15); training; office accommodation</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>190,000</td>
<td>76k for start up + 114k in 05/06 covering recruitment, training of 2 EHO + 2 student EHOs, publicity + other misc costs; 113k and 114k in following 2 years; further 20% reduction anticipated in 09/10.</td>
</tr>
<tr>
<td>West Lothian</td>
<td>75,000</td>
<td>Includes staff (AP4); training, promotional work; 5000 premises</td>
</tr>
</tbody>
</table>
• comments are summaries only extrapolated from detailed submissions. Where councils have provided low and high estimates of staff costs, these have been averaged.

Notes:
‘Start up’ costs typically include: development of enforcement strategy; training of front-line staff, elected members and senior management; briefing admin and managerial staff; promotion/publication costs- eg staff time, postage, officer time for preparing and presenting seminars, press releases, briefings etc; advance advice provision by EHO staff; recruitment costs; accommodation and equipment costs

Enforcement costs typically include: initial high volume of inspections, decreasing over time; out of hours working; provision of advice; responding to complaints; monitoring; technical and admin support.

SUBMISSION BY THE CITY OF EDINBURGH COUNCIL

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?
The main objectives in Part 1 of the Smoking, Health and Social Care (Scotland) Bill are strongly supported. Support is based on:

• The Bill providing the opportunity to develop existing policies and strategies of the Council. For example, “Working for a Healthier Edinburgh: Edinburgh Joint Health Improvement Plan 2003-06” which highlights reducing smoking and tobacco-related harm as a priority area for action and notes the risks of exposure to Environmental Tobacco Smoke. Another example is provided by the Education Department’s “Improving Health, Health Strategy 2004-07” which focuses on lifestyle choices for teenage girls where action on smoking is required. This policy will become the responsibility of the Children and Families Department from April 2005.

• The Council promotes workplace-based health improvement via the Scotland’s Health at Work (SHAW) initiative and has implemented specific control of smoking at work policy. These examples are compatible with the objectives of the Bill.

• The legislation provides an opportunity to simplify Council policy on control of smoking at work, particularly in relation to letting of premises for meetings and events.

• The Local Government in Scotland Act which defines a power of “community well-being”. The Council’s work to improve health relates to this power, and the proposed legislation would reinforce these initiatives.

If not, why not?
Not applicable.

Are there any other comments you would like to make?
The Council welcomes the additional clarity provided by the Bill including:

• A statement that those having management of no-smoking premises can only be expected to prevent smoking by lawful and reasonably practicable means.
• Defined responsibilities of managers and/or owners of premises and individual smokers and the associated penalties incurred when the law is infringed.

• A statement on the powers of an authorised officer.

However, it is recognised that detailed discussions will be required in relation to the drafting of regulations, with particular reference to:

• Guidance on signage. The Council has concerns about signage outside listed buildings.

• Exemptions from the requirements to maintain no-smoking premises. There is clearly a need for detailed consultation with local authorities. Previous evidence has identified issues in relation to residential homes, social work day centres, hostels and provision of services within individuals’ homes.

• Definitions need to be clearly stated and understood - for example, the meaning of ‘wholly enclosed public place’.

Further clarity on these issues would be welcome, together with the opportunity to respond to the proposed regulations.

Resourcing must fully meet any additional costs and statutory burdens for local authorities. The City of Edinburgh Council currently has responsibility for health and safety enforcement at 17,000 premises; it is anticipated that a further 3,000 HSE premises will fall within the scope of the legislation.

Detailed costs have been provided to COSLA and evidence provided to the Finance Committee on Tuesday 8 February 2005, in relation to the Financial Memorandum associated with the Bill.

To provide adequate staffing resources, it is estimated that the City of Edinburgh Council will require:

<table>
<thead>
<tr>
<th>Year</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>173</td>
<td>178</td>
<td>184</td>
<td>189</td>
</tr>
</tbody>
</table>

Additional resources will also be required for communications, signage and provision of information on smoking cessation help and support.

SUBMISSION BY THE ROYAL ENVIRONMENTAL HEALTH INSTITUTE OF SCOTLAND

Part of Bill:


Main Objective:

Prohibiting smoking in enclosed public places.

Do you agree with the main objective of this part of the bill?

Yes.

If yes, why?

There is overwhelming and robust epidemiological and other medical evidence to prove that smoking and exposure to Environmental Tobacco Smoke (ETS) are harmful to human health.
ETS is known to contain 4,000 chemicals, some of which have irritant properties and some 60 of which are known or suspected carcinogens. The World Health Organisation’s International Agency for Research on Cancer (IARC) identified ETS as being ‘carcinogenic to humans’. ETS has also been labelled a ‘class A human carcinogen’ by the United States of America’s Environmental Protection Agency. In November 2004, the Scientific Committee on Tobacco and Health (SCOTH) Committee summarised additional research that had been published since their initial report in 1998. The Committee concludes that knowledge of the health hazards associated with exposure to ETS has consolidated over the past five years and that more recent evidence strengthens previous estimates of the size of health risks. The Committee also concluded that ETS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to; and that ETS represents a substantial public health hazard.

The medical case alone for a ban on smoking in public places and in the workplace is beyond dispute. In 2003 the Chief Medical Officer for Scotland stated that ‘smoking is the single biggest cause of preventable premature death and ill-health in Scotland’. Over 13,000 people die every year in Scotland from tobacco use.

There is no doubt that if tobacco were now to be subject to the UK’s approval for use process approval would not be granted. There are no safe limits for exposure to carcinogens: only a policy of elimination of ETS from public places and from workplaces will protect and improve public health in Scotland.

Are there any other comments you would like to make?

The Bill mentions that the class of premises to be covered, will be prescribed by regulations, as will the premises that are to be excluded. The Institute believes that only a total ban on smoking in public and work places will be effective. The Health and Safety at Work etc. Act 1974 does not provide adequate protection for workers against tobacco carcinogens present in both mainstream and ETS. The rights of employees and users of the premises should be protected irrespective of the activity. A comprehensive ban will also be fairer to industry, as all sectors will be equally affected, rather than one group being seen to have an unfair disadvantage. Therefore the Institute is strongly against granting exemptions to private clubs, or pubs which do not serve prepared food, and is concerned that establishments could exploit exemptions to circumvent the law. The Institute believes that ideally there should be no exemptions from compliance with any legislation introduced to ban smoking in public and work places.

The Institute welcomes the introduction of the requirement for warning notices in and on no-smoking premises to be conspicuously displayed and recommends that regulations, relating to the format of such notices and referred to in section 3), be introduced.

The Institute welcomes the possible introduction of regulations relating to the definition or elaboration of the expressions listed in section 4 and for the definition or elaboration of ‘premises’ in section 4 The Institute believes that clear and unequivocal definitions must be provided to ensure the proper enforcement of compliance.

The Institute believes that should smoking on public transport become an offence the issues surrounding compliance on cross border (Scotland/England and England/Scotland) public transport will require to be addressed.

The Institute welcomes the introduction of the power to serve Fixed Penalty Notices on individual smokers and on individuals having control of enclosed spaces. The Institute considers that there may be safety implications for Environmental Health Officers and other enforcement staff who may be required to serve Fixed Penalty Notices on individuals, in public houses and clubs, who may be under the influence of alcohol. The Institute would draw the Parliament’s attention to the Irish experience where Environmental Health Officers deal, in the main, with publicans and licensees and require them to ensure compliance. Environmental Health Officers in the Irish Republic undertake inspections incognito and return next day to tackle the publican and/or licensee. This approach removes the problem of Environmental Health Officers serving Fixed Penalty Notices in potentially dangerous situations. An alternative course of action would be for officers to report the matter to the Licensing Board who could then consider the matter as a possible breach of the
conditions of license. The introduction of a phone line in the Irish Republic allowed individuals to make anonymous complaints about non-compliance to a central location. It is believed that this service, known locally as the ‘clipe line’, was largely responsible for the very high compliance rates reported in the Republic of Ireland.

Finally, the Institute believes that the introduction of any legislation should be preceded by a high profile media campaign which would raise awareness of the impending legal requirements. This form of education would, it is hoped, reduce the number of offenders and ensure high levels of compliance from day one.

SUBMISSION BY ASH SCOTLAND

This submission is from ASH Scotland. We understand that the Health Committee has access to, and will be taking account of, evidence submitted to the Scottish Executive as part of their public consultation on smoking in public places last year. On this basis, the current submission makes reference solely to research that has been accessed and/or published since 30th September 2004.

We ask to be called to give oral evidence to the Health committee.

Name: Maureen Moore, Chief Executive, ASH Scotland
Address: ASH Scotland, 8 Frederick Street, Edinburgh EH2 2HB
Part of Bill: Part 1
Main Objective: Prohibiting Smoking in Enclosed Public Places

Do you agree with the main objective of this part of the bill? YES

This is a Bill that which will dramatically improve Scotland’s health. It has been estimated that second-hand smoke (SHS) kills up to 1,000 people every year in the UK; with some studies suggesting the figure is even higher than this. Introduction of the new legislation for smoke-free enclosed public places in Scotland will benefit everyone.

Do you have any other comments? YES

New research evidence on the health risks associated with exposure to SHS
There is an established body of international medical and scientific evidence that documents the health risks associated with SHS. This evidence continues to accumulate at an alarming rate.

The International Agency for Research on Cancer (IARC) Monograph Working Group on Tobacco Smoke and Involuntary Smoking is a scientific working group of 29 experts from 12 countries convened by the World Health Organisation. This working group have now published the long-awaited 1,500 page review of all published evidence related to passive tobacco smoking and cancer, concluding that second-hand smoke is carcinogenic to humans. As early as 1993, the Philip Morris Tobacco Company made preparations to mount a strenuous and well-funded effort to subvert the IARC monograph and associated IARC studies, as they feared that their findings would lead to increased smoke-free restrictions in Europe. Their attempts to undermine IARC’s work via industry-directed research, mass media and public communication campaigns, and preventing

ASH REFERENCES
increased smoking restrictions, failed. In addition, further scientific research has since been published that reinforces the conclusions of the IARC Monograph Working Group, that second-hand smoke is carcinogenic to humans.\(^9\)

In 1998, The Scientific Committee on Tobacco and Health (SCOTH) issued a report which concluded that exposure to SHS causes lung cancer and heart disease in adult non-smokers, and a variety of conditions including respiratory disease, cot death and middle ear disease in children. In November 2004, the Committee published an additional report, summarising research that has been published since 1998, to examine whether any further revision to SCOTH's conclusions is required. This was in response to the tobacco industry and their allies who still deny the health risks associated with SHS. The Committee concludes that knowledge of the health hazards associated with exposure to SHS has consolidated over the past five years; that more recent evidence strengthens earlier estimates of the size of health risks. The evidence published since 1998 continues to point to a causal effect of exposure to SHS on risk of lung cancer – estimated increased relative risk remains at 24%. The weight of evidence regarding a causal effect of exposure to SHS on the risk of ischaemic heart disease is now stronger – increased associated risk is now estimated to be in the order of 25%. Published evidence continues to point to a strong link between exposure to SHS and adverse health effects in children – the committee conclude that smoking in the presence of children is a cause of serious respiratory illness and asthma attacks. Sudden infant death syndrome is also associated with exposure to SHS, and this association is judged to be one of cause and effect. The evidence published since 1998 also points to an association between SHS and respiratory symptoms and reduced lung function in adults. The Committee conclude that SHS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to; and that SHS represents a substantial public health hazard.\(^10\)

Recent research also suggests that children who are exposed to SHS are at a higher risk of developing lung cancer as adults. In one of the most comprehensive Europe-wide studies into the health effects of second-hand smoke of its kind, researchers have found that children exposed to second-hand smoke on a daily basis, and for many hours, face over three times the risk of lung cancer than those who grow up in smoke-free environments.\(^5\)

SHS exposure in pregnant women has recently been shown to adversely affect pregnancy by increasing foetal mortality and preterm delivery at higher exposure levels, and slowing foetal growth across all levels of SHS exposure.\(^11\) Bronchiolitis is a common cause of hospital admission among babies and young children in Scotland, and severity is increased in those who are exposed to SHS.\(^12\) The links between SHS and asthma are well documented. In addition a recent report has demonstrated that children with asthma whose parents smoke at home are at least twice as likely to have asthma symptoms all year compared to children of non-smokers.\(^13\) Recent research has also suggested that exposure to SHS may lead to abnormal tissue repair; delaying wound repair, preventing the formation of the healing tissue, and increasing the possibility of fibrosis and excess scarring.\(^14\)

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\(^{14}\) Wong, L.S. et al. (2004). Effects of second-hand smoke on structure and function of fibroblasts, cells that are critical for tissue repair and remodelling. BMC Cell Biology, 5, 13.
Recently discovered tobacco industry documents demonstrate that second-hand smoke may be even more harmful, volume for volume, than directly inhaled cigarette smoke. Yet the tobacco industry continues to place the highest priority on preventing the introduction of restrictions on smoking in public places, and remain equally active in spreading misinformation about the effects of legislation that has already been introduced successfully in other countries.

Short-term Positive Impacts of Introducing Smoke-free Legislation: International Evidence

Since the Scottish Executive’s consultation on smoking in enclosed public places ended, a number of studies and reports have been published which suggest that improvements related to health and to indoor air quality can occur within months of policy implementation.

a) Increased Health Benefits: Reduced Tobacco Consumption

Opponents of smoke-free legislation have suggested that smokers in smoke-free workplaces compensate for being without cigarettes whilst at work by smoking more at lunch, during breaks, or after work. However, recent research has shown that employees in workplaces with no smoking restrictions smoke on average three more cigarettes a day than those whose workplaces are smoke-free.

In the Republic of Ireland, renewed commitment to tobacco control – including the introduction of smoke-free public places – has seen smoking rates plummet from 31% to 25% in just four years. In the six months after their legislation was introduced, an estimated 7000 Irish smokers had given up smoking. These figures have not been matched in the North, where smoking rates remain static. Up to 26,000 people rang the national Smoker’s Quitline in the past 14 months, with most calls received in the run up to legislation coming into force. Prior to this, an average of about 6,000 calls a year were received. Some one billion fewer cigarettes were sold in the Republic of Ireland last year, a 15% decrease on 2003. The Department of Finance acknowledges it is too early to say whether all of this decrease can be attributed to smoke-free legislation, but state that smoke-free workplaces and enclosed public places play a significant role. Similarly, although smoke-free legislation in Italy was only introduced on January 10th 2005, Italian cigarette sales are reported to have already fallen by 23%.

Recently published figures show that Scotland now has the highest proportion of smokers in the UK. 31% of Scots are smokers compared to 27% in Wales and 25% in England. It should be recognised that there is a substantial benefit to be gained from smoke-free legislation in terms of the impact it will have on active smoking rates. A recent review of smoke-free workplaces in the USA, Australia and Canada estimated that smoke-free legislation reduces smoking prevalence by 4%, and overall tobacco consumption by 30%. A modest reduction in active smoking rates would have major benefits in terms of reducing numbers of deaths among the Scottish population generally.

The hospitality and tobacco industry continue to voice concerns regarding a ‘dramatic escalation a possible rise in smoking in the home’ as an immediate consequence of the introduction of smoke-free enclosed public places. However, evidence from countries such as the USA, Canada and Australia suggests that the introduction of legislation for smoke-free workplaces and enclosed public places...
public places may have the effect of enhancing protection from SHS in the home. For example, in Australia, the introduction of legislation for smoke-free workplaces during the 1990's was accompanied by a steep increase in the proportion of adults who avoided exposing children to tobacco smoke at home. Among households with children, the proportion with smoking restrictions increased overall from 25% in 1989 to 59% in 1997. In households where one adult smoked, the proportion with smoking restrictions increased from 17% to 53%, and in households where both adults smoked, the proportion with smoking restrictions increased from 2% to 32%.²⁴

Young children are thought to face the highest levels of exposure to second-hand smoke in the home. Increasing the percentage of tobacco-free homes is generally not amenable to legislation, but scientists point out that this can be achieved by a combination of mass media campaigns and smoking restrictions in enclosed public places and the workplace.²⁵ A recent US survey demonstrated that most US parents still do not have a clear understanding of the adverse health effects of exposure to second-hand smoke on children, despite what has been established in published scientific research literature. Media campaigns are required to increase adults’ awareness of the of the dangers of secondhand smoke, and should be used in conjunction with smoke-free legislation to ensure the greatest protection for young people from the adverse health effects of second-hand smoke exposure. Smoke-free legislation will clearly support current smokers attempting to quit, and denormalise smoking in society, so that future generations do not get addicted to smoking.

b) Improved Air Quality
Travers et al²⁶ assessed changes in air quality that occurred in 20 hospitality venues in western New York where SHS exposure was observed at baseline. The findings indicate that, on average, levels of respirable suspended particles (RSPs – an accepted marker for SHS levels that are known to increase risk of respiratory disease, cancer, heart disease and stroke) decreased 84% in these venues within the first 4 months after the law took effect. Similarly, James Repace measured air quality in eight hospitality venues in Delaware; at baseline under conditions of unrestricted smoking, and again 2 months after the introduction of smoke-free legislation. Before legislation was introduced, all venues were heavily polluted, with indoor RSP levels averaging 20 times that of outdoor background levels. The health of hospitality workers was significantly endangered by second-hand smoke pollution. However, 2 months after the introduction of legislation, indoor air quality levels were indistinguishable from those measured outdoors.²⁷

Recent research claiming to investigate the real effectiveness of ventilation in pubs using field studies has been widely publicised by the Licensed Trade as demonstrating that ventilation IS a solution to SHS.²⁸ The research, carried out by Dr Andrew Geens (University of Glamorgan) measured levels of carbon dioxide, carbon monoxide and airborne particulates cross a number of UK venues including The Doublet (Glasgow), and the Phoenix (a smoke-free pub in Glasgow). Measurements were taken mostly during busy evenings, with ventilation turned on, and with ventilation turned off. Air quality in the Phoenix pub was monitored over a week, with the ventilation on continuously, in order to provide a comparative indicator of air quality in a non-smoking environment. The study concluded that simple, low-cost ventilation systems can reduce SHS dramatically; and in some areas air quality can be made as good as in a non-smoking pub. The study also concludes that particles and gases are kept well within occupational limits, even at peak times in busy pubs with no smoking restrictions.²⁴

However, a number of factors require consideration when interpreting these findings.

The study is far from independent. Atmosphere Improves Results (AIR) co-ordinated funding from the Scottish Licensed Trade Association (SLTA) for the research. It is common knowledge that AIR is a tobacco industry funded organisation. The licensee of the Doublet pub is Alistair Don. He is also President of the Scottish Licensed Trade Association. The Doublet was also the site of the first SLTA sponsored "pub users' ballot" on smoking, and the "Freedom2Choose" press launch. The spokesman for "Freedom2Choose", Rod Bullough works in the head office of Cumbria Vending Services, which supplies cigarette vending machines.

Dr Geens concludes that monitored particles and gases were kept well within occupational limits, even at peak times in busy pubs with no smoking restrictions. However, there are no known safe limits for SHS exposure, and no UK occupational limits for SHS exposure. The American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) sets standards for ventilation rates. These standards are so widely accepted that they are often written into laws and regulations. They are the industry norms throughout North America and many other parts of the world. Up until 1999, ASHRAE provided ventilation standards to remove the odours from second-hand smoke. However, they then accepted the evidence from other authorities that there is no acceptable level of exposure to the chemicals found in cigarette smoke, and rescinded those standards on health grounds. The main marker measures used in Dr Geen's study were Carbon Monoxide and particulate matter at PM 2.5, with Carbon Dioxide used as a control measure. However, the smaller particulate components and harmful gases in SHS that pose the greatest health concerns were not measured. Recent controlled experiments have shown that the air pollution emitted by cigarettes is 10 times greater than diesel exhaust. These experiments have also demonstrated that comparative pollution levels for the tiniest particles – the most dangerous to health, are even greater.

Dr Geen's study suggests that there is no significant difference between particulate matter (PM 2.5) averages between the Doublet pub, when ventilation is switched on, and the smoke-free Phoenix pub. Graphs representing both sets of averages are used to demonstrate that ventilation IS therefore a solution to SHS. However, the graphs use different axis scales to plot the same points, and in doing so, the particulate matter averages appear similar. However, when the same axis scales are used, the supposed 'similarity' between particulate measures in the two pubs disappears (see Appendix 1, page 17). In fact, using the same axis scales to plot points, particulate matter averages are actually between 3 and 10 times higher for the ventilated Doublet pub, when compared with the smoke-free Phoenix pub. This study, though widely publicised and quoted by the Licensed Trade, has not yet been published, and is currently being peer reviewed. There is a substantial body of published work on ventilation, carried out independently of the hospitality and tobacco industry, which shows how SHS cannot be effectively removed from the air.

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29 The Tobacco Manufacturer's Association funding of AIR and Dr Geen's consultancy are documented at [http://www.airinitiative.com/press.asp?id=109](http://www.airinitiative.com/press.asp?id=109)
house expertise on the subject of ventilation, we are familiar with the independent research conducted in this area, and our comments are based on knowledge of this literature. There are many reputable experts within the field of ventilation, and we suggest the Committee seeks their advice and input should they have questions regarding these issues.

The Scottish Licensed Trade - Proposed Legislation
The licensed trade umbrella group, Against an Outright Ban (AOB) represents the SLTA, the Scottish Beer and Pub Association, and other pub groups based in Scotland. In May 2004 they outlined proposals for implementation of a 5-point plan, across a 3-year period, as an alternative to the comprehensive legislation that the First Minister outlined in November 2004. The SLTA’s Chief Executive, Paul Waterson, believes that the 5-point plan would provide a “major contribution to improve health prospects in Scotland”.40 This alternative approach proposes that:

1. Smoking be banned at the bar counter in all licensed premises.
2. Smoking be banned in any area where and when hot food is served.
3. Smoking be banned in any area from which the public is excluded
4. Licensed premises must allocate
   a. 30% of total floor space to a non-smoking area in year one
   b. 40% in year two, and
   c. 50% in year three. This would be followed by a further review
5. Licensed premises must display a smoking policy at the entrance in order that customers can see the facilities available before they enter.

These proposals are very similar to those in the Voluntary Charter, which has failed to deliver significant protection to hospitality workers in Scotland. Even where designated smoking areas are provided, they often continue to expose people in the vicinity to ETS, and they increase the exposure to smoke by concentrating smokers in the one place. Neither the current Voluntary Charter, or the proposed five-point plan are based on evidence on how to protect health, either for staff in the leisure industry, or for the public who use these facilities. Scotland currently has fewer smoke-free workplaces than the rest of the UK41; 31% of working women and 21% of working men had been exposed to other people’s smoke at work in the week preceding the most recent Scottish Health Survey.42 These results confirm that the voluntary approach has not significantly increased protection from ETS. Voluntary agreements have proved ineffective in other areas of tobacco control policy, such as advertising. Voluntary approaches are not relied upon to control any other carcinogen in the workplace. In short, voluntary approaches simply do not work.

ASH Scotland believes that encouraging partial action by businesses in place of comprehensive legislation would be a backward step. Hospitality workers, children and other members of the public would not be adequately protected from the harmful health effects of SHS. Any efforts to provide partial protection from SHS remain flawed, as there is no safe level of exposure to second-hand smoke.43

Inherent in the licensed trade proposals is the assumption that ventilation in bars could protect the public from the harmful effects of SHS. Although good ventilation systems can help reduce the irritability of smoke, they do not eliminate its poisonous components. Only 15% of second-hand smoke is in the form of particles that are visible to the eye. Ventilation filters trap these particles, making a room look less smoky and feel more comfortable to be in. However, tobacco smoke contains 4,000 toxins and more than 50 cancer-causing substances. Many of these are odourless, invisible gases, which cannot be removed by ventilation systems.44 Dr Geens recently stated: “You

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can do what you like with ventilation so long as you are prepared to spend the money”. Indeed, many businesses end up installing expensive ventilation systems in the mistaken belief that they are protecting staff and the public from the ill effects of SHS. Scientific evidence has demonstrated that there is no ventilation system that fully removes harmful gases that are present in SHS.45

Research has demonstrated that the current ventilation standards promoted by AIR (Atmosphere Improves Results) are inadequate. They state that a minimum of 12 air changes per hour is required for an average sized room, in order to judge ventilated air as ‘safe’. Based on this recommended ventilation rate for a pub at full occupancy, it is estimated that 5 out of every 100 bar staff will die from job-related passive smoking-induced heart disease or lung cancer during his or her working life.46

Those who continue to advocate ventilation as an appropriate solution to the health hazards of SHS have argued that indoor air pollution could be further reduced through higher ventilation rates. For example, Dr Geens recently stated that “Air changes per hour are virtually unlimited”. It is true that ventilation rates may be increased, and that air changes per hour are virtually unlimited. However, efforts to reduce indoor air pollution through higher ventilation rates does not lead to a measurable improvement of indoor air quality, as increased ventilation rates have no significant influence on the air concentration of tobacco components.47 Furthermore, SHS and ventilation expert Prof. James Repace has estimated that it would require in excess of 10,000 air changes per hour to produce levels of risk acceptable to bar staff from SHS.48 This would be equivalent to a tornado-like gale, and this is clearly unachievable.

Enforcement and Implementation
Opponents of smoke-free laws have proclaimed that difficulties with enforcement and implementation make such laws unworkable. The Office of Tobacco Control has recently announced that in the six months since smoke-free legislation was introduced in the Republic of Ireland, on average over 94% of premises inspected were compliant with the law. Compliance levels are reported at 94% in hotels, 99% in restaurants, and 91% in licensed premises.49 These figures demonstrate that smoke-free legislation is both viable and largely self-enforcing.

Maximising Compliance: An International Perspective
The New York State Health Department recently announced the first independent evaluation of New York’s tobacco control programme. The report contains a number of recommendations that Scotland should consider very carefully in order to maximise effectiveness in implementing smoke-free enclosed public places. In order to counter the near limitless marketing resources of the tobacco industry, the report emphasises the need for a pragmatic approach that is solidly based in evidence-based strategies and is consistent with best practices. It highlights the need for a strategic planning process, and for increased resources to expand and improve smoking cessation services. The report also emphasises the necessity of an effective, co-ordinated mass-media marketing and advertising campaign, which should be (in line with best practice) high in emotional impact in order to garner attention among the public.50 ASH Scotland considers that such steps are crucial for the Scottish Parliament to consider in its strategic planning of implementation of the Bill.

45 British Medical Association (2002). Towards smoke-free public places.
46 A Killer on the Loose. An Action on Smoking and Health special investigation into the threat of passive smoking to the UK workforce. ASH (Action on Smoking and Health), 2003.
The New York City Department of Health and Mental Hygiene is responsible for enforcing the Smoke-Free Air Act. To inform the public and employers of the new law, the Department developed a brochure explaining how to comply with the Act, and met with employers, building owners and operators, restaurant association members and community organisations to provide information about the law. The Department also sent ‘No Smoking’ signs to more than 20,000 establishments. Information on compliance is available and regularly updated on the Department website. These educational efforts have resulted in remarkably high compliance with the new smoke-free workplace law. Of the more than 12,000 establishments inspected in the first three months after the law went into effect, the Department has only issued 177 violations, mostly for failure to have a “No Smoking” sign posted or for the presence of ashtrays. This suggests that businesses are observing smoke-free workplace requirements, and that the law is largely self-enforcing.

To ensure compliance, provision for enforcement must be in place which will identify what the offences are, who enforcement action may be taken against and who the legislation will be enforced by. This legislative provision should be adequately resourced, to ensure the effectiveness of any controls. Another good example of such provision is the Republic of Ireland’s Office of Tobacco Control (OTC). The role of the OTC is to support the Republic’s smoke-free policy by discharging a variety of functions which includes enforcing the tobacco control laws, operating the Smoke-Free Compliance telephone line, conducting research into tobacco and communicating the findings, and organising a national inspection programme. The Republic’s government is quoted as saying they expected a 90% compliance rate with the measure when it was newly introduced. On the 31st May 2004, the OTC published its first report on compliance for one month after the smoke-free workplace legislation was introduced. The report found that 97% of premises inspected were compliant with the new law. In their six-month progress report, 94% of premises inspected were reported to be compliant with the law. The slight decrease in compliance levels from one to six months reflects the concentration of inspections at six months on non-compliant premises, together with enforcement actions requiring repeat inspections.

Time Delays and Exemptions: Learning from International Experience
Very few countries with smoke-free legislation have contemplated the notion of time delays in the process of implementation. Considering the limited evidence that is available from those countries that have, this comes as no surprise.

a) Time Delays: International Evidence
Time delays have caused great confusion in the Saskatchewan province of Canada. Five days after the introduction of Saskatchewan’s law, many bar and restaurant owners are still allowing patrons to light up. Some say they feel they have the right after hearing the province won’t be ticketing offenders for the first 60 days. This ‘grace period’ has encouraged challenges to the law, and misunderstandings concerning how the law works and how it affects business. Time delays also hindered the introduction of legislation in Italy by almost two years.

The option of postponing introduction of new law provides the hospitality trade and tobacco industry with increased ammunition, giving them time to step up attempts to scupper the

53 Republic of Ireland Office of Tobacco Control website. Online at http://www.otc.ie/ (Accessed 19/01/05)
54 ‘Ireland implements Europe’s toughest smoking ban’. Online at http://www.able2know.com/forums/about21568.html
57 ‘Canada: Saskatchewan: Despite ban, some businesses still permit smoking.’ Message posted on Globalink News and Information, 07 January 2005.
58 Message posted on Globalink (05/01/05). Available online at: http://member.globalink.org/msg/murrell.shtml (Accessed 05/01/05).
introduction of legislation. The tobacco industry has a vested interest in opposing legislation and, as previously experienced in New York and Ireland, they actively support groups attempting to derail smoke-free laws before they are introduced. Restaurant and bar owners continue to argue that custom will fall and the law will be difficult to enforce. Opponents continue to advocate for compromises such as ventilated rooms or designated smoking areas, which we already know to be wholly ineffective measures. An Aberdeen License Trade Official has recently called on pubs to consider introducing a voluntary smoking ban, in order to help stop Scotland-wide legislation being introduced in 2006.\footnote{Pub urged to consider voluntary smoking ban.' This is North Scotland news report (07/01/05). Available online at: \url{http://www.thisisnorthscotland.co.uk/displayNode.jsp?nodeId=149235&command=displayContent&sourceNode=149218&contentPK=11613474&moduleName=InternalSearch&keyword=smoke&formname=sidebarsearch} (Accessed 07/01/05)

Forest, the tobacco industry funded front group, has recently appointed a Scottish spokesman, who is reportedly attempting to combat moves to outlaw smoking in enclosed public places, and trying to persuade MSPs to introduce a system that offers greater choice to smokers.\footnote{Group recruits champion for Scots smokers}. Both the Scottish Licensed Trade Association, and the Tobacco Manufacturer’s Association, have recently indicated they are examining the possibility of mounting legal challenges against the legislation.\footnote{McConnell faces retreat on smoking ban. This is The Sunday Times – Scotland. December 12th 2004. Available online at: \url{http://www.timesonline.co.uk/article/0,,2090-1400506,00.html} (Accessed 05/01/05)} The threat of legal action is a delaying tactic, intended to overturn the introduction of smoke-free enclosed public places in Scotland.

b) Exempting Private Clubs from Legislation: International Evidence

There are already some deliberations regarding the possible exemption of private clubs from smoke-free legislation. In Idaho, most restaurants and pubs are now smoke-free, but private clubs are exempt from smoke-free legislation. Some establishments have been converted into private clubs, charging drinkers a minimal fee to join. Not only are they exploiting the exemption loophole, they are undoubtedly undermining what would otherwise be an effective piece of legislation.\footnote{Private Clubs in Idaho are Skirting New Smoking Ban. ASH Press Release, 08 October 2004. Available online at: \url{http://www.no-smoking.org/august04/08-10-04-2.html} (Accessed 07/01/05)}

In Utah, smoking is prohibited in most indoor locales except private clubs, which were given an exemption as part of a political compromise under the 1995 Utah Clean Air Act. Some 10 years later, residents, governors and members of the general public are still debating whether private clubs should be smoke-free, in advance of the Legislature next year.\footnote{Private S.L. clubs feud over proposed smoking ban. Would a universal ban be fair – or oppressive? 05 December 2004, Utah News. Online at: \url{http://deseretnews.com/dn/view/0,1249,595110176,00.html} (Accessed 07/01/05)}

In Delaware, private clubs are exempt from the state’s indoor smoke free legislation. Prior to the introduction of legislation, state officials carefully defined what constitutes a private club, and as a result it is almost impossible for pub and bar owners to convert their premises in order to escape legislation.\footnote{Draft details smoking-ban exemptions. State working on definition of private clubs.} In New Zealand, smoke-free provisions apply in all private clubs where the club employs people, serves food, or has a liquor or gambling license.\footnote{Smokefree law in New Zealand. Ministry of Health Website: \url{http://www/moh.govt.nz} (Accessed 07/01/05)} This creates a level playing field with other businesses with the same license or employer obligations, and the same potential clientele. In New Zealand, the Health Select Committee recommended the removal of the exemptions that allowed smoking in certain licensed premises, for consistency in protecting all workers from the harmful effects of SHS.\footnote{Smokefree law in New Zealand. Ministry of Health Website: \url{http://www/moh.govt.nz} (Accessed 07/01/05)}
Even organisations with strong links to the tobacco industry, such as the Empire State Tavern Association, and the SLTA, state that smoke-free legislation should be applied even-handedly, to bars, pubs and private clubs.\(^{66}\)\(^{67}\)

c) ASH Scotland’s Position on Private Clubs
It is much easier for the public to understand a ‘one rule applies to all’ smoke-free provision. A level playing field is considered fairer and easier to implement. Legislation that applies equally to all enclosed public places has the additional advantage of requiring minimal lead time, since no building alterations need to be made nor equipment installed. This is clearly the most effective way to reduce the health risks caused by tobacco and exposure to SHS.

If the issue of private clubs has to be further discussed and debated we suggest that Parliament must consider most carefully the definition of what constitutes a private club that could be exempt from legislation.

The international evidence is clear that comprehensive legislation works most effectively in other countries. In order to effectively reduce the health risks caused by tobacco and exposure to SHS, legislation must be standardised across areas and establishments.

d) Other Possible Exemptions
Other possible exemptions that may be considered include police and prison cells, secure hospitals, hotel and bed-and-breakfast rooms, and hospices.

e) Current Guidelines
Current guidelines for local authorities on tobacco at work state staff should be protected from second-hand smoke, and that each local authority should give serious consideration as how it is going to protect its entire staff, in the variety of settings in which they work. The guidelines identify settings (other than office premises) in which the development and implementation of a comprehensive tobacco policy is important, including schools and youth community centres, residential homes for the elderly, domiciliary care, local authority venues where food and/or alcohol are served, and residential accommodation for young people. The guidelines continue that all organisations should have the goal of becoming completely smoke-free workplaces.\(^{68}\)

Current guidelines for effective tobacco policy in the NHS state that health care trusts have a duty to protect the health of staff and patients and not subject them to hazardous environments and materials, and this includes protecting them from second-hand smoke. The guidelines also recommend that a commitment to helping staff and patients to give up smoking is an essential part of an effective tobacco policy, and that any patient or staff member should be able to access an ongoing programme of cessation help if they wish to.\(^{69}\)

f) ASH Scotland’s Position on Other Possible Exemptions
Exemptions to any law introduced on smoke-free enclosed public places would result in only partial protection of staff and the general public – smokers and non-smokers – from the health risks of passive smoking. Exemptions may lead to lead to the marginalisation of some sectors of society and parts of the workforce, effectively implying that their health is less important. If legislation is not put in place to protect all workers from SHS then employers risk being exposed to litigation.

If exemptions are to be considered, they should be minimal exemptions for evidence-based reasons, and be time limited or with defined and monitored criteria. For example, in the Republic of Ireland, prisons, nursing homes, psychiatric hospitals and hotel bedrooms are exempt from smoke-
free legislation. This is to accommodate people who would be regarded as ‘dwelling’ in these places. Even though these exempt institutions are not obliged to enforce the legislation, all employers still have the right to enforce it, and are free to do so if they wish. In making any such decisions, it is crucial to remember that a dwelling place for some is a workplace for others. In a recent online survey conducted by irishhealth.com, it was reported that nearly half of the general public (47%) do not support the exemptions listed above.70
ASH Scotland believes that exemptions should only be introduced in exceptional cases, and in such instances employers and service providers should provide all reasonable means for employers and other service users to avoid exposure to second-hand smoke.
Any possible exemption should be justified in terms of the acceptability of exposing members of the workforce to a preventable Class A carcinogen.

Economic Impacts
The Scottish Licensed Trade Association has estimated that “the capital cost of compliance with the Bill will be in the region of £85million, suggesting that “costs may be well in excess of that, depending on the views of the local regulatory authorities on matters such as the provision of fire escapes and facilities for the disabled”.71 They have also reported that smoke-free legislation will force more than 140 pubs to close, and lead to the loss of 2,300 jobs, and £59 million in tax revenue.72

However, there is a wealth of international evidence to demonstrate that smoke-free public places don’t have a negative impact on business. In addition to the evidence we have already submitted to the Scottish Executive in response to their public places consultation, a number of positive economic impacts have recently been reported.

A recently published international review models the likely impacts of moving from the current voluntary code to comprehensive legislation on smoking in public places in Scotland. Modelling procedures utilise existing evidence on the economic impacts that have been measured in other countries with comprehensive smoke-free legislation. The report concludes that conservative estimates of savings in the workplace exceed the ‘worst case scenarios’ for losses in the hospitality industry. The effect on the hotel, restaurant and bar sectors in Scotland is centrally estimated at +£110 million (range –£63million to +£281million). The study also suggests that the most sizeable economic impact is a net gain for society in resource terms, which are centrally estimated at £115 million five years post legislation.73

The level of turnover in Scotland should also be borne in mind when interpreting any future claims of economic loss; there are around 5,000 openings and closures of businesses over a 3-year period, without attributable effects to policy changes.69 Predictions of a downturn in business are encountered in every country where legislation has been, or is currently being, introduced. For example, in Ireland, the The Licensed Vintners Association (LVA) recently published research concluding that the economic impact of smoke-free legislation is unfavourable for the licensed trade in the Republic of Ireland.74 However, a number of factors should be taken into account when interpreting this conclusion. The LVA’s study was based on subjective interviews with over 270 publicans around Dublin. They were asked to describe how they viewed the impact of legislation, to estimate the effects the legislation has had, and to predict the economic future of their business. This material is entirely unreliable as a proper economic assessment as it is not based on hard financial or economic data.

It is interesting to note that the publicans’ estimates of their sales figures are significantly different to the hard data available, such as the drink sale figures produced by the Central Statistics Office (CSO) as well as the drinks manufacturers themselves. According to the latest figures from the

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70 http://www.irishhealth.com/poll.html?pollid=174 (Accessed 07/01/05)
71 SLTA response to Stewart Maxwell Bill, page 3, para. 1
72 ‘Smoking ban will cost 2,300 jobs and 140 pubs, report claims.’ Press article in the Scotsman, 05 February 2005, available online at: http://news.scotsman.com/scotland.cfm?id=141022005 (Accessed 08/02/05)
Health Committee, 6th Report, 2005 (Session 2) – ANNEX C

CSO, bar sales are reported to have picked up sharply, with sales figures rising by 2.3% between September and November 2004. ⁷⁵ This rise marks a turnaround after two months of declining volumes. Whilst bar sales continued to be down on 2003, falling by around 5.1%, this is dramatically less than the 29% fall in volumes claimed by the LVA, whose figures do not take account of seasonal changes to drinking purchases. ⁷⁶

Smoke-free legislation in the Republic of Ireland was introduced in what was already a shrinking bar sales market. Sales reportedly hit their peak in May 2001, and since then, the volume of drink sold in Irish bars has fallen by approximately 15%. ⁷¹ Many factors have contributed to this climate, including changing demographics, the price of drink, increased price competition from supermarkets and off-licences, increased excise duty on alcohol, and changing working patterns and lifestyles. ⁷⁷ Yet the LVA report attributes all of the alleged downturn in the trade to smoke-free legislation. This is simply not credible, and claims to this effect don’t stand up to scrutiny.

The LVA has also claimed that the introduction of smoke-free legislation in the Republic of Ireland has led directly to the loss of 2,000 jobs in Dublin. ⁷⁰ However, these figures are dubious, as they too are based on subjective interviews with bar managers or owners and not on objective economic information. Mandate Trade Union, the third largest union in the Republic of Ireland, represents almost two thousand bar workers, mainly based in Dublin. The union’s records indicate that job losses in the greater Dublin area have been in the order of a couple of hundred, not the thousands claimed. ⁷⁶

In the United States, many hospitality groups have claimed that their business has been detrimentally affected by smoke-free legislation. For example, in Beverly Hills, California, the Restaurant Association said that their businesses had suffered a 30% decline in revenues during the five months after smoke-free regulations were in effect. ⁷⁹ As a direct result of such opposition, organised by the tobacco industry, Beverly Hills repealed their smoke-free restaurant ordinance. Studies have since shown that, contrary to tobacco industry claims, there was no detectable drop in restaurant sales during the time the ordinances were in effect, nor was the an increase in restaurant sales following reversal of the 100% smoke-free ordinances. In fact, sales increased slightly during the period the smoke-free regulations were first in place. ⁸⁰ Anecdotal reports, polls or interviews with business owners concerning economic impacts of smoke-free legislation should be treated with great scepticism. Smoke-free legislation has been passed in every conceivable type of community, from small towns and rural areas to a number of states, and economists have studied the impacts on communities across the spectrum. No objective, peer reviewed study ever conducted has found a significant negative economic impact associated with smoke-free legislation. ⁸¹ The reliable evidence, that measures hard numbers from independent sources, remains clear. Legislation on smoke-free enclosed public places will not harm the economy, and will improve Scotland’s appalling rates of cancer, heart and lung disease, both by cutting smoking rates and by reducing people’s exposure to unwanted smoke.

Public Opinion

UK public opinion continues to demonstrate that it is time to put an end to smoking in enclosed public places. Results from key questions in the recent Scottish Executive consultation document demonstrate that 82% of respondents believe that further action needs to be taken to reduce

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⁷⁵ ‘Retail sales rise of 2.8% marks turnaround – CSO.’ Press article in the Irish Times, 22nd January 2005.
people’s exposure to second-hand smoke.\textsuperscript{82} Eighty percent of respondent support a law to make enclosed public places smoke-free. Fifty six percent of respondents felt there should not be any exemptions to the law, with only 35% stating they would like to see some form of exemption.

Populus have recently published findings of a survey they claim to be independent, conducted on public attitudes to smoking with 10,000 British respondents (1,000 of whom were Scottish). On the contrary to the findings outlined above, Populus results demonstrate that 72\% of Scottish respondents want separate smoking and non-smoking areas in pubs, clubs and bars. Only 22\% of Scottish respondents state that they support the notion of completely smoke-free public places.\textsuperscript{83} These and other such findings from this poll have been widely quoted by the hospitality trade in their attempts to rebut legislation. However, only 46\% of respondents in this survey have never smoked. A further 23\% used to smoke, 8\% class themselves as occasional smokers, and 24\%, nearly one in four, smoke every day.\textsuperscript{79} No information is provided concerning the number of individuals in Scotland within each of these four groups. This sample simply does not provide a representative picture of the opinion of the Scottish population, and renders extrapolations to the wider Scottish population meaningless. It would be possible to use statistical procedures that take combined account of nationality and smoking status in order to give true percentages, but Populus does not appear to have done this.

In addition, the Populus poll asks respondents how smoking should be handled specifically in pubs, bars and clubs, rather than phrasing the question to ask about enclosed public places. Research has demonstrated that smoking restrictions in pubs and bars have lower levels of public support than other enclosed public places.\textsuperscript{84} However, findings of a poll commissioned by the Office for Tobacco Control demonstrate that public support for smoke-free bars and restaurants in the Republic of Ireland increased once plans for legislation were announced. In June 2003, 67\% of the Irish public supported the proposed law for smoke-free bars and restaurants, compared to 59\% in favour before legislation was announced in February 2003.\textsuperscript{85} A recent survey conducted by Amarach Consulting found that 89\% of respondents agreed that the legislation was a great success, and nearly 90\% of smokers believed that the smoke-free law was working.\textsuperscript{86}

The Populus question is a loaded question, and a useful reminder that opinion polls can be conducted to provide any ‘evidence’ required by those who commission the survey, so long as questions are phrased carefully. Andrew Cooper, Director of Populus, recently stated that the ‘right’ question to ask re: public attitudes to smoking should be “What do the British and Scottish people think is the best approach to the issue of smoking in public places?”\textsuperscript{79} Why then, was this not the question asked, and the results reported accordingly? Perhaps the answer in part lies with those who commissioned the research, in this case FOREST, a front group funded by the tobacco industry.\textsuperscript{87}

The Tobacco Industry’s Attempts to Rebuke Science

The tobacco industry is renowned for its extensive attempts to fight second-hand smoke issues across Europe. There are now a number of published reports that document tobacco industry projects to recruit scientists in developed countries around the world who would criticise the science on second-hand smoke, cast doubt on whether SHS harms people and “prolong the

\textsuperscript{82} Smoking in Public Places A Consultation on Reducing Exposure to Second Hand Smoke. Key Findings of Responses to a Public Consultation. Available online at: http://www.scotland.gov.uk/library5/health/smipp02-02.asp (Accessed 13/01/05)


\textsuperscript{85} OTC/MRBI survey shows more than two-thirds of public support proposed ban on smoking in pubs and restaurants. Office of Tobacco Control Press Release, 16\textsuperscript{th} June 2003. Available online at: www.otc.ie/article.asp?article=45 (Accessed 10/02/05).


controversy” about the effects of health effects of SHS. Indeed, documents made public demonstrate Philip Morris’s intention to create a foundation that would “become THE scientific authority on a wide range of human concerns, thus putting itself above WHO, FAO and other organisations who restrict themselves to narrower fields”.91

There are also published reports that document attempts by the Philip Morris tobacco company to conceal important research that could and should influence government policy. The scientists involved in research that is associated with tobacco manufacturers appear to publish only a small amount of their research, and what is published appears to differ considerably from what is not. In particular, unpublished reports have provided evidence that suggests SHS is more harmful than mainstream smoke,92 which is most interesting concerning the industry’s continuing denial of the harmful health effects of SHS.

Dr Steven Stotesbury, a scientist from Imperial Tobacco Limited, recently challenged the science on second-hand smoke, in particular questioning the statistical techniques and methodologies that have been used in the body of research on the health hazards of SHS. He claims that even in studies that have claimed associations between SHS and disease, the relative risk is generally low, i.e. between 1.0 and 2.0, and would not normally be regarded as sufficient to prove a causal effect. To support this statement, he uses the following quote from Baroness Jay of Paddington, Health Minister (1998): “A stronger association – of greater than 2 – is more likely to reflect causation than is a weaker association – of less than 2 – as this is more likely to result from methodological biases or reflect indirect associations that are not causal.93 On this basis, Stotesbury concludes that the levels of relative risk that are used to substantiate the case of SHS to justify public smoking measures have been officially described as ‘too low to prove a causal effect’.94

The National Research Council (2002) states that there is no biological reason for the use of 2.0 standard as opposed to any other standard. They continue “the use of such a hard standard obscures the fact that any risk means that some people could be harmed by the agent in question. For example, the relative risk of passive smoking – is reliably shown to be about 1.2, i.e. the risk of developing lung cancer is elevated about 20% by passive smoking”.95

It is generally accepted that in assessing the evidence for a link between a risk factor and a disease, a range of factors need to be taken into account. These factors have been included in lists such as the Austin Bradford-Hill criteria96, proposed more than 35 years ago for attributing disease causation to environmental factors. The general principles behind this approach are widely accepted and utilised by epidemiologists, clinical researchers, pharmaco-epidemiologists, and by UK Government Advisory Bodies and Committees in order to establish the robustness, the clinical importance, and the public health significance of possible risk factors for disease.

The Bradford-Hill criteria emphasise that evidence that a risk factor causes a disease should not be based on only one factor, such as the strength of the association. The criteria emphasise the need to examine a range of factors, including the following: strength of the association (i.e. as measured by level of relative risk); consistency of the association (similar results emerging from several studies done in different populations); specificity of the association; temporality (i.e. the cause must 88 Barnes, D. and Bero, L.A. (1988). Industry-funded research and conflict of interest: An analysis of research sponsored by the tobacco industry through the Center for Indoor Air Research. Journal of Health, Policy and Law, 21, 515-540.
90 http://tobaccodocuments.org/profiles/whitecoat.html
93 House of Lords Hansard written answer. 31st March 1998, columns 31-32.
precede the effect); biological gradient (i.e. increasing dose must lead to increasing disease frequency); plausibility (i.e. the biological plausibility of the observed association); coherence (the knowledge that the association does not conflict with current knowledge about the disease, such as its natural history and biology); experimental evidence; and analogy.

According to advice that ASH Scotland has received from a leading and respected national statistician, it is therefore not reasonable to assess causality solely on the basis of meeting an arbitrary cut-off for relative risk. The argument for the harmful effect of SHS rests not only on the strength of the association with disease but also on the consistency of the evidence, temporality, biological gradient and other factors as outlined above. Dr Stotesbury states: “the case for a smoking ban has often been argued on an emotive and subjective basis”. On the contrary, there has now been 50 years worth of research into tobacco, which demonstrates conclusively the damage it does to human health. Nevertheless, the licensed trade and the tobacco industry continues to try and cast doubt on the link between SHS and lung cancer, heart disease, respiratory disease and tobacco.

Scientists representing the tobacco industry have also raised doubts as to the robustness of using meta-analysis as a statistical means of inferring conclusions regarding the science of SHS and disease. Stotesbury, for example, states: “risk estimates that are based on a mathematical combination of different studies, many of which are weak or inconclusive, are extrapolated into the headline claims about specific numbers of deaths due to passive smoking. In other words, the science and statistics have been exaggerated to fit the anti-smoking case”. 

SIGN (Scottish Intercollegiate Guidelines Network) give guidance to the Scottish NHS on effective treatment and are widely accepted and internationally recognised. In general their conclusions do not differ in any important way from other reviews about effective treatments. SIGN rate meta-analysis as the highest level of evidence available about the effectiveness of treatments. If critics believe that meta-analysis is not a legitimate technique, then they should be prepared to say whether they believe meta-analysis when used to assess treatment. For example, SIGN guidelines recommend the use of clot-busting drugs to treat acute myocardial infarction. This recommendation is made on the basis of a meta-analysis of 12 trials. Similarly, SIGN guidelines recommend chemotherapy as a treatment for breast cancer, also on the basis of a meta-analysis. In fact, meta-analyses are used in almost every SIGN guideline currently published. Would the tobacco industry reject such recommendations on the basis that they are based on meta-analyses?

As Sir Austin Bradford Hill stated, “All scientific research is by its very nature incomplete, whether it is observational or experimental. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have or postpone the action that it appears to demand at a give time”. Scientific research does have limitations; it produces likely explanations rather than certainty; and when taken out of context it can be misinterpreted. Meta-analysis has an important role to play in causal assessments, although like all science meta-analysis contributes to the weight of evidence rather than offering proof. Meta-analysis provides more precise estimates of the magnitude of the effect than can be obtained from individual studies, but causal inference requires a range of kinds of evidence to be taken into account. Making causal claims on the basis of one or two aspects of either method (i.e. on the basis of relative risk values and/or, confidence intervals) clearly does not equate with objective, scientific interpretation of the evidence.

Opponents of smoke-free legislation often cite a study conducted by Enstrom and Kabat, published in the British Medical Journal in May 2003, which concludes that exposure to SHS does not lead to an increased risk of illness. The publication of this article caused widespread debate

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and controversy, with more than 140 BMJ readers responding to the paper and associated editorial.

Enstrom and Kabat undertook a follow-up examination of a subset of the American Cancer Society Cancer Prevention study cohort (CPSI), comprising 35,651 never smokers who had a spouse who smoked. The cohort, and information on their smoking status, was established in 1959. Additional smoking status information was gathered by the American Cancer Society in 1961, 1963, 1965 and 1972. Extended follow-up research was then carried out until 1997, by Enstrom and Kabat, which included gathering updated information on smoking status. This extended follow-up phase was conducted with initial support from the Tobacco-Related Disease Research Program (TRDRP), a Californian Research program funded by the Proposition 99 cigarette surtax. After continuing support from the TRDRP was denied, follow up through 1999 and data analysis were conducted at the University of California at Los Angeles with support from the Centre for Indoor Air Research, an organisation that received funding primarily from US tobacco companies.

The results of this follow-up study suggested no significant causal relation between SHS and related mortality, although Enstrom and Kabat didn’t rule out a small effect. Results also suggested that the association between coronary heart disease and lung cancer may be somewhat weaker than generally believed.

The Chief Executive of the Vintners Federation of Ireland, Tadg O’Sullivan, recently spoke out about this paper, stating that “the BMJ would not risk its reputation in publishing this research unless it were absolutely sure of its validity.” It is noteworthy that, in the editorial in the BMJ regarding this paper, a number of points were made regarding interpretation of findings, including the potential for socio-economic confounding to affect results, and the potential key role for misclassification of exposure status in studies of passive smoking.

O’Sullivan also stated that “the American Cancer Society decided that they would not publish (the study) when they discovered what the results were going to be”. However, the American Cancer Society were not directly involved in the Enstrom and Kabat follow up, they merely provided the initial data. The ACS did in fact publish, to coincide with the Enstrom and Kabat publication, concerns regarding a number of flaws in the use of such a small subset (10%) of the CPS-1 database and the potential for misclassification of exposure status when undertaking research with this particular dataset. The ACS also noted that an association between exposure to SHS and lung cancer was demonstrated in studies using the Cancer Prevention Study 11 dataset, which contained substantially more patients than in the Enstrom and Kabat study.

O’Sullivan continues that the Enstrom and Kabat study “simply rubbishes the claims of the pro-ban lobby”. Following publication of the study, the UK Government Advisory Committee on Carcinogenicity of Chemicals (COC) were asked to undertake a review of the evidence presented in this paper. The Committee concluded that no definitive conclusions could be drawn from the Enstrom and Kabat study. They also stated that there was no reason to change the conclusion they had reached in 1997, following a request from the Scientific Committee on Tobacco and Health (SCOTH) to review the evidence regarding exposure to SHS and lung cancer, namely:

“Taking all the supportive data into consideration we conclude that passive smoking in non-smokers exposed over a substantial part of their life is associated with a 10-30% increase in the risk of lung cancer which could account for several hundred lung cancer deaths per annum in the UK.”

O’Sullivan refers to a second study to back up his argument of there being “a vast array of evidence to prove that the issue (of the association between passive smoking and ill health) is grossly exaggerated”.\(^9\) The study in question, conducted by researchers at the Oakridge National Laboratory of Tennessee, suggested that exposures to SHS may be lower than previously indicated for bartenders, waiters and waitresses.\(^10\)

Oakridge National Laboratory of Tennessee and its researchers, although part of the U.S Department of Energy’s often highly-classified research establishment, are also for rent to private companies. Roger Jenkins, the lead author of this study, has conducted several other pieces of research commissioned by the tobacco industry, that typically attempt to show that exposure to SHS is not a health hazard. Jenkin’s findings, and Jenkins himself, frequently appear in hearings to oppose local smoke-free measures. As an expert witness for the defence in a lawsuit bought by flight attendants against the tobacco industry over the lung cancer and other diseases they contracted at work, Jenkin’s evidence was excluded by the judge because of his pro-tobacco industry bias.\(^10\)

Without exception, the ‘evidence’ presented by hospitality groups and the tobacco industry suggest no associations between SHS and ill-health is flawed, weak, and lacking in scientific credibility. The WHO International Agency for Research on Cancer’s (IARC) classification of SHS as a human carcinogen is based on the full scope of evidence; observational studies, carcinogenic components of SHS, experimental models, and biomarker studies. The issue of whether exposure to SHS causes ill-health has been resolved scientifically. It is only hospitality groups and the tobacco industry that cynically continue the “debate”.

SHS kills up to 1,000 people every year in the UK\(^1\)\(^2\), with some studies suggesting the figure is even higher than this.\(^2\) Ventilation does not protect employees and customers from the harmful effects of SHS\(^2\)\(^6\)\(^9\), and any assertions otherwise are based on flawed science. The Scottish Executive has made their decision regarding legislation on a wealth of robust scientific and medical evidence. The new laws will benefit everyone, and the publication of this Bill will dramatically improve Scotland’s health. A comprehensive law to end smoking in enclosed public places is the only way in which to protect the people of Scotland from the health hazards associated with SHS.

Appendix 1: ASH Scotland Mapping of Figures 7 and 18 from Dr Geen’s unpublished paper, ‘Can ventilation clear ETS?’

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\(^10\) Roger Jenkins and Oak Ridge National Laboratory. Available online at: http://www.tobaccoscam.ucsf.edu/vent/vent_hq_internal_4.cfm (Accessed 21/01/05)
SUBMISSION BY AMICUS

Background

Amicus as the UK’s largest private sector union represents a diverse range of interests from our members in the Health sector to those in Food, Drink and Tobacco and those in the Heating and Ventilation industry.

We have smoking and non-smoking members of the union and as such we believe that the interests of all people should be considered.

Sections of the Bill covered by this submission

Whilst this submission relates only to the proposals contained in Part 1 of the Bill (Prohibition of smoking in certain wholly enclosed spaces) it should not be construed that this implies Amicus endorsement or otherwise of the other Sections of this Bill.

Overview of Part 1 of the Bill

The Amicus Food, Drink and Tobacco National Industrial Conference has already declared its opposition to a total ban on smoking in public places believing that solutions can be found by looking at the introduction of greater restrictions rather than total prohibition.

We are more inclined to support the proposition from Dr John Reid, UK Health Secretary suggesting that an outright ban is not the way forward.

Employment Issues

It is our view that, whilst health matters are important, equal consideration should be given to the employment implications of any legislation that may be enacted by the Scottish Parliament.
Evidence from the Central Statistics Office Ireland indicates that employment in the Hospitality sector in Ireland has been severely affected since the advent of the smoking ban that was introduced in 2004.

The latest available figures indicate that between Quarter 3, 2003 and the same Quarter in 2004 employment in this sector fell by 6.1%. This equates to a loss of some 7,600 jobs lost to this particular Sector in a 12-month period.

There is nothing to suggest that the introduction of a total ban in Scotland would produce a different set of results.

In fact if the 2003 figure of 150,000 employed in the Scottish hospitality industry, which is contained in the Bill supporting paperwork, were taken as a guide then extrapolation of the Irish statistics would give an indication of some 9,000 jobs being lost in that Sector.

No doubt the hospitality industry will make its own views known to the Parliament on this particular issue.

Amicus in Scotland has members employed in the food and drinks industries as well as with the tobacco company sales forces and the vending companies whose machines are commonplace in pubs, clubs and restaurants throughout Scotland.

It is our belief that the employment of our members in these sectors could equally be threatened in the event of the introduction of a total ban on smoking in ‘enclosed’ areas.

Alternatives to a Total Ban

To date it would appear to us that the Scottish Executive has dismissed out of hand any propositions suggesting that there are alternatives to a total ban.

Public opinion indicates that there is widespread support for greater restrictions on smoking in public places and an extension of no smoking areas.

However the majority do not support the proposition of total prohibition.

In workplaces partial or total bans on smoking have in the main been introduced as a result of consultation and co-operation between the employer and the representatives of the workforce. As a result enforcement does not appear to be an issue.

Amicus would encourage the voluntary approach suggested by the Hospitality industry which includes:

- the provision of more non-smoking areas
- the banning of smoking at bar counters
- the banning of smoking in areas where hot food is served
- the open displaying of a smoking policy at the entrances to premises.

In addition to the above we would also advocate improved ventilation systems.

Ventilation/Filtration Systems

The Scottish Executive dismisses the idea that adequate ventilation and filtration systems can provide any kind of solution.

Via the Executive web site it is possible to access a site www.smokefreescotland.com/facts/second-hand-smoke) which asserts that ‘research suggests that the air-flows possible with current ventilation systems are not sufficient to eliminate the health risk associated with second-hand smoke.’

There is no indication as to the source (or sources) of that research.
However it appears to be taken as fact by the Executive.

We would refute the sentiments of that statement.

However, there is evidence to suggest that there are adequate ventilation systems available – including research currently being undertaken by the University of Glamorgan.

Additionally we would suggest that organisations such as the Heating and Ventilation Industry and Government Departments such as the Ministry of Defence could be helpful in this area.

We believe that the option of utilising adequate ventilation systems can provide a base for job creation in that industrial sector.

Economic Issues

The Bill, and the supporting paperwork, seeks to outline some of the financial implications in the event of a total ban being introduced.

These tend to concentrate on the projected savings to the Scottish Health Service by highlighting 2 main areas namely:

a) Reduction in the smoking population
b) Reduction in exposure to ETS.

We would acknowledge that the introduction of any restrictions [either in full or in part] on smoking in enclosed spaces is likely to give rise to a reduction in consumption either as a result of individuals cutting down or giving up smoking completely.

However it would seem to us to be imprudent if the only financial impact to be taken into consideration is in relation to savings that may be made in one area namely the cost of health care provision.

We believe that consideration should also be given (and taken into the overall view of the financial impact) to the areas which have the possibility of creating a negative financial impact.

These areas would include the loss of revenue to the Exchequer and the increase cost of benefits such those arising from unemployment.

It is estimated that there are 1.275 million smokers in Scotland.

Revenue (to the Exchequer from Scotland) from tobacco products is estimated to be in the region of £1.04 billion.

Accepting for a moment the figure of 4% reduction in smokers, which comes from the Wanless Report, it would be logical to assume a similar reduction in revenue.

This would equate to a reduction of £41.6 million to the Exchequer.

It is also some £26 million greater than the estimated savings of £15.7 million that would be saved by the health service.

In addition to loss of taxation revenue consideration should also be given to the likely additional cost of State benefits to those who may find themselves made unemployed as a result of the introduction of the proposals contained in Part 1 of the Bill.

This of course may be difficult to quantify in full. However if we take the figure of 9,000 who may loose their jobs in the hospitality industry and assume that 50% of that number may be long term unemployed we can make an estimate of what that cost may be.
That would make 4,500 people claiming Job Seekers Allowance (JSA) for 26 weeks.

Taking an average figure for the weekly level of JSA for persons over the age of 18 years that would mean 4,500 claiming £50/week – a total of £225,000 per week or £5.85 million over a 26 week period.

This figure of £5.85 million when added to the loss of Revenue figure of £41.6 million gives a total [negative] figure of £47.45 million.

When the projected savings to the NHS of £15.7 million are then put in to the equation this would give a net negative impact of £31.75 million as a result of the implementation of this part of the Bill.

[The Bill and its associated paperwork refuses to address what mechanism would be employed to redress this loss of Revenue – would this be through increasing taxes, cutting services or what?] This figure does not take into consideration any other related benefits to which individuals may be entitled.

The associated paperwork also quantifies to an extent the likely additional costs to the Local Authorities in ‘policing’ the enforcement of Part 1 of the Bill.

It does however attempt to look at the additional financial impact on Local Authorities of potential loss of revenue in respect of Council Tax or ‘rates’ revenue lost in the event of the closure of premises in the hospitality industry as a result of these measures. [Loss of revenue in this direction would be likely to result in further increases in the Council Tax to compensate for these losses.]

Conclusion

We would urge that co-operation rather than coercion and compulsion should be the way forward.

Both sides of this debate have rights, which should be respected, and that the right to choose should be made available to both smokers and non-smokers alike.

We should not forget that tobacco products are still legal substances in this country and as such should be treated no less favourably than other such products which the adult population is free to purchase and consume.

Amicus

SUBMISSION BY STUC

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

If yes, why?

We do agree with the objective behind banning smoking in public places, namely to reduce the risk to the health of those who work in and visit public places.

However, we remain concerned that a number of issues need to be more closely examined if this objective is to be met.

We are of the view that for this piece of legislation needs to be introduced but have reservations at the timescales laid down by the Executive. Our main concern at this time is that, while it is desirable to protect workers in the hospitality industry from environmental tobacco smoke, little research appears to be available or carried out by the Executive as to the numbers of workers in
the industry that have direct exposure to the harmful effects of tobacco through smoking themselves. Anecdotal evidence we have received suggests this could be as high as 70%.

The STUC General Council took the view, outlined in our response to the Scottish Executive, that in order to protect jobs in the short term that a longer lead in time, perhaps three years, was required.

This would have allowed the Scottish Executive to work with the hospitality trade to ensure support was available to those who work in the industry to stop smoking. If the Executive had been willing to work with employers in the hospitality industry there could have been opportunities to investigate innovative approaches to delivering smoking cessation advice at the front line as the ban approached.

Additionally, a more realistic timescale could have allowed employers to put in place transitional arrangements to ensure the lead in period had minimal impact on profitability and possibly, in turn jobs.

It may be that by insisting on implementation in 2006 the opportunity to work with the employers to reach a vast number of smokers assist them to stop smoking and improve their health has been lost.

If not, why not?

Are there any other comments you would like to make?

The STUC although supporting the ban on health grounds is concerned at the effect that this move will have on employment in the hospitality industry throughout the country. The figures that we have seen indicate uncertainty with regard to the accuracy of the financial impact this will have. The detrimental effect that unemployment has on health also needs to be taken into consideration.

It should also be remembered that many individuals work in the hospitality industry not through choice but necessity. This includes students, young parents and those who need to take additional jobs to supplement low pay in their main employment.

The STUC would reiterate that we support the principal of the ban on health grounds but we would have preferred the Executive to have been more cautious in their approach and used the time to ensure all stakeholders bought into, and supported, the ban and worked together to ensure the main objective of improving Scotland’s health is achieved.

We are also concerned in relation to the enforcement of such a ban. There is concern that Local Authority Environmental Health departments are not resourced to take on this extra work. We would also be cautious in relation to positive comments about the ban being self regulating as a result of potential financial sanctions. Scotland, through reserved legislation enjoys some of the best health and safety regulation in Europe. However, many employers still risk the health and lives of their workers despite the threat of financial penalties.

**SUBMISSION BY UNISON SCOTLAND**

**Introduction**

UNISON Scotland welcomes the opportunity to respond to the call for evidence from the Scottish Parliament’s Health Committee regarding the above Bill. While welcoming some of the general principles and aims of the Bill, UNISON Scotland would like to comment on some particular issues highlighted in the call for evidence.

**Part of Bill: Part 1**

Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? Yes

UNISON Scotland support a ban on smoking in enclosed public spaces not just in terms of the general health benefits to non-smokers but also with regard to the implications on worker health and safety. With this in mind UNISON Scotland believes that there should be further guidelines for staff who have to work in service users’ homes (home carers and others) regarding their health and safety at work from ETS.

UNISON Scotland believes that under health and safety legislation employers must protect the health of employees and provide a healthy and safe working environment. With today’s level of awareness on passive smoking it would be difficult for any employer to argue that they are not in breach of these duties by not prohibiting smoking at work in all areas except for specifically designated places where non-smokers have no reason to enter.

UNISON Scotland is also concerned about the role of Environmental Health Officers as the enforcement authority for the Bill. There are concerns over the safety of these officers in enforcing this bill and assurances should be given that the legislation provides adequate protection for such officers in the enforcement of their duties.
Smoking, Health and Social Care (Scotland) Bill: Stage 1

14:03

The Deputy Convener: The convener has now arrived, so I will vacate the chair.

The Convener (Roseanna Cunningham): Thanks very much. I am sorry that I am late. Children from a local primary school are visiting the Parliament this afternoon, so I needed at least to go and say hello to them.

We now move on to our evidence-taking sessions on the Smoking, Health and Social Care (Scotland) Bill. The committee papers include submissions from a number of the organisations that are to give evidence this afternoon. Members also have a copy of the draft Smoking, Health and Social Care (Scotland) Bill (Prohibition of Smoking in Certain Premises) Regulations 2005, which the Executive has prepared for us, and a copy of the Scottish Parliament information centre briefing on part 1 of the bill. In addition, we have a note on the committee’s recent fact-finding visit to Ireland.

I welcome the members of our first panel: Paul Waterson, chief executive of the Scottish Licensed Trade Association; Stuart Ross, chief executive of the Belhaven Brewery Company, who also represents the Scottish Licensed Trade Association; Christopher Ogden, director of trade and industry affairs, Tobacco Manufacturers Association; and Steven Stotesbury, senior scientist with Imperial Tobacco, who also represents the Tobacco Manufacturers Association. I ask the panel for two brief introductory statements—one from the Scottish Licensed Trade Association and one from the Tobacco Manufacturers Association—after which we will move on to questions from the committee.

Paul Waterson (Scottish Licensed Trade Association): Thank you for inviting us to the committee today. Our association is totally committed to improving the health, safety and welfare not only of our members, who are the licensees of Scotland, but of our staff and customers. The matter on which our thoughts diverge from those of the Scottish Executive is on the most efficient way of doing that. A total ban will cause our members to lose their livelihoods and our staff to lose their jobs; there would be a significant impact on health if that were to happen.

Managing smoking efficiently has been the aim of the SLTA for a long time. We are one of the founding partners of the Scottish voluntary charter group, which has worked with the Scottish Executive since 1999 to encourage licensed premises to introduce smoke-free areas and so on. Although the group had exceeded all the Executive’s charter targets, except one that related to paperwork, we realised that voluntary action had served its purpose. In May 2004, we asked the Executive to introduce legislation that would have three key elements: a smoking ban at the bar counter in all pubs in Scotland; a smoking ban wherever and whenever hot food is served; and, within three years, a commitment that 50 per cent of the total floor space in all pubs in Scotland should be given over to non-smoking areas. We further suggested that a review be conducted at the end of the third year and appropriate further steps taken.

The proposals are fair and enforceable; they reflect public opinion which, from Executive research, we know favours smoking restrictions. The proposals echo to some extent the thoughts of the committee’s colleagues at Westminster and are in tune with the European Union, which also wants restrictions to be put in place to protect our trade and give choice to our customers.

Good health messages, like good laws, are easily understood, easily enforceable and backed by public opinion. A total ban is none of those things. Evidence from Ireland shows that jobs have been lost and business is down, especially in rural areas. Some research shows, as it does for Norway, that smoking cessation rates are down since the ban. There has also been an increase in drinking and smoking in the home, which does not reduce or eliminate environmental tobacco smoke risks but accentuates them.

Our view is fully supported by Dr John Reid, who gave evidence recently to the Health Committee at the House of Commons. He said that “A complete ban on smoking in public places is not a good thing on health grounds ... because you get a displacement of smoking from some public areas to the home ... a percentage of people who previously went to the pub to smoke will now get a carry-out and take it home. I think that the figure in Ireland is about 15 per cent.”

Dr Reid went on to say that “80 per cent of people ... did not want a complete ban” on smoking in pubs. He gave a second reason for the adoption of the route that Westminster appears to be taking, which is the recognition that ultimately, in a “free society”, men and women have a right within the law to choose their own lifestyle.

We submit that the dictatorial approach of the Scottish Executive has resulted in the presentation of a bill that is predicated on incomplete and, to a great extent, irrelevant research. We also submit that the health outcome of the bill will exacerbate rather than reduce the problems that Scots experience from passive smoking.
Christopher Ogden (Tobacco Manufacturers Association): Thank you for inviting me to speak on behalf of the Tobacco Manufacturers Association. I am accompanied by Dr Steven Stotesbury, who is a scientist from Imperial Tobacco. Steven will be able to address any questions of a scientific, technical nature, for which I am grateful. We have submitted six documents for the committee’s consideration and we are here to answer any questions that might arise from those submissions. We will also deal with any additional points that are raised.

The TMA represents British American Tobacco, Gallaher and Imperial Tobacco, which together create a £12 billion a year industry in the United Kingdom. Of that total, some 80 per cent goes to the Treasury in duty and VAT receipts. Tobacco is a legal product, and we take the view that smoking is a matter of informed adult choice. We acknowledge the fact that there are health risks associated with smoking, and it is quite right that public health authorities promote risk awareness programmes. We cannot possibly object to that. What we do object to, however, is the distortion of science to further an anti-tobacco agenda. It is one thing to tell smokers that they are harming themselves, but it is quite another to say that, by smoking, they are harming others. That is the premise on which section 1 of the Smoking, Health and Social Care (Scotland) Bill is based.

The whole issue of environmental tobacco smoke—ETS—is being driven by a strident, determined anti-smoking lobby whose ultimate objective is a tobacco-free world; ETS is a means to that end. Our view is that the scientific evidence—and it is important to understand that the evidence that exists is epidemiological, not medical—does not prove causation between exposure to ETS and death or disease. Nevertheless, that is being posited as a given by the anti-smoking lobby, which is assiduous in extrapolating dubious relative risk figures into absolute numbers of deaths. We are not alone in our view. In 2003, Richard Smith, formerly the editor of the British Medical Journal, said:

“We must be interested in whether passive smoking kills, and the question has not been definitively answered. It’s a hard question, and our methods are inadequate.”

So the medical profession thinks along similar lines.

We are not in denial of ETS to the extent that we do not acknowledge the fact that other people’s smoke can be annoying and, indeed, irritating to non-smokers. Of course, it can be; however, in the interests of common sense, freedom of choice and natural social justice, alternatives to an outright ban on smoking in public places should be considered. It is perfectly possible to create designated smoking areas with proper ventilation in a range of public places, which can accommodate the preferences of both smokers and non-smokers. Opinion polls indicate that that is what the public want, and among the population at large there is a greater degree of tolerance and a greater sense of fair play than those who are implacably opposed to tobacco might wish us to believe.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I am interested to hear the evidence from the Tobacco Manufacturers Association. In your written submission, you acknowledge the fact that tobacco smoke can be irritating to non-smokers, and you just confirmed that you refute the fact that passive smoking kills people. You will be aware that the committee has received other medical evidence—for instance, from Action on Smoking and Health Scotland.

ASH Scotland cites the findings of the International Agency for Research on Cancer’s working group

“of 29 experts from 12 countries convened by the World Health Organisation.”

It states:

“This working group have now published the long-awaited 1,500 page review of all published evidence related to passive tobacco smoking and cancer, concluding that secondhand smoke is carcinogenic to humans.”

Do you still refute that evidence?

Christopher Ogden: My colleague will deal with the specific scientific details in a moment. However, in response to your question, I have to say that we refute that evidence. The relative risk figures in some ETS studies do not warrant the claims that have been made about its effect on health. For example, many are spousal smoking studies that rely on recall of exposure to smoke over many years. Indeed, of the five largest studies into ETS, three determined that, statistically, there was no increased risk to health; one determined that there was a slightly increased risk; and one determined that the risk was slightly decreased. That, in a microcosm, exposes the degree of contradiction and discrepancy in the various studies.

Mike Rumbles: So you refute the evidence of 29 World Health Organisation experts from 12
countries.

Although the SLTA does not go as far as the Tobacco Manufacturers Association, its submission says:

“We find the claims of hundreds of deaths a year of non-smoking bar workers as a result of ETS … to be incredible from our own observations.”

Does the SLTA accept that ETS is carcinogenic? If you do not accept that ETS causes hundreds of deaths a year, how many deaths do you think there are and how many of them are acceptable?

Paul Waterson: We see the same risk factors as everyone else, and do not think that they are large at all. Indeed, we think that the claims have been grossly exaggerated. For example, we hear that a bar worker dies every week from the effects of passive smoking. I have been in the trade for 30 years and have to say that neither I nor any of my colleagues know of any bar worker who has died in that way. When we asked about these figures, we were told that one bar worker a week died in Scotland, then that one a week died in the UK, then that it was not really one a week. It goes on and on. Where are these figures coming from?

Mike Rumbles: That is exactly what I want to get at. Are you refuting the medical evidence that ETS is carcinogenic? Are you saying that you do not believe that these deaths are happening?

Paul Waterson: As far as smoking is concerned, a comparison of relative risk factors shows that someone who uses a mobile phone has more chance of getting a blood clot in his eardrum.

Mike Rumbles: But how many people have to die from ETS before you think that it is unacceptable?

Stuart Ross (Scottish Licensed Trade Association): We have read the research that was undertaken for the Scottish Executive by the University of Aberdeen, which concluded that of the 865 people who die each year from passive smoking, 120 experienced second-hand smoke in all types of public places. No one knows how many people experience second-hand smoke in licensed premises, because there has been no research into that matter.

The licensed trade gets frustrated by statements such as the one that the First Minister made to Parliament on 10 November when he presented the bill. He said that 1,000 people in Scotland die each year from the impact of second-hand smoke. However, the Executive’s own research mentions 865, more than 700 of whom experience the problem at home. Our argument is predicated on the fact that the Scottish Executive has carried out no research whatever into the question whether an outright ban will solve or shift a health problem. In fact, as Paul Waterson said in his introductory remarks, Dr John Reid made exactly the same point to the House of Commons Health Committee on 25 February 2005.

Mike Rumbles: I understand the Tobacco Manufacturers Association’s position, because it has made it absolutely clear.

Steven Stotesbury (Tobacco Manufacturers Association): Can I come in here?

Mike Rumbles: I want to pursue this question first.

The TMA has said that people do not die from ETS. However, the SLTA has not said that; instead, by refuting the figures, you are playing a numbers game. You are still not answering my question, which is: how many people have to die from passive smoking before you think that it is a problem that we need to solve?

Stuart Ross: We want fewer people to die from it. We have read a lot of research on the subject and we listened to Dr John Reid at Westminster saying that more people will be harmed by an outright ban on smoking than would be harmed by his proposals. There are obviously different views. You must appreciate that we are business people running bars and trying to do our best within our own domain. We are not health experts, but there is clearly a division of opinion on the matter. We cannot answer the question, but we listen to a lot of people.

The crucial point that we want to make to the Health Committee, and the point that we have been making all along in our various submissions, is that the research has been conducted by the University of Aberdeen, and upon which the bill is predicated, is incomplete and, to a large extent, irrelevant. That is made quite clear in the document that we submitted, which was prepared by the well-respected Moffat centre at Glasgow Caledonian University. It peer-reviewed the University of Aberdeen work and came to the conclusion that it was based on studies of smoking restrictions in countries round the world, not of smoking bans in any countries. Indeed, there has been only one outright ban of smoking, in Ireland, which came into place in April 2004, as members will all know from their trip to Ireland. The Irish ban has not even had a year to run, and there has obviously been no complete research into its health or financial consequences.

Steven Stotesbury: I would like to make a point, because I am afraid that if we go on our position may not be understood. Our position is not to say categorically that no one can die, or has ever died, from exposure to environmental tobacco smoke. Our position is that the science is inconclusive and that the risk factor cited is extremely small. Unfortunately, for both sides in
the debate, the issue remains uncertain. I wish that I could tell you otherwise, but I cannot. Neither can anyone who follows argue legitimately that the risks are proven on scientific grounds; they are not. Therefore, there is uncertainty, and within that uncertainty I believe that there is the space and opportunity for us to find proportionate solutions that will, while minimising involuntary exposure to smoke, enable smokers to enjoy a legal product in a social setting.

Helen Eadie (Dunfermline East) (Lab): I want to ask about the economic impact of a ban. First, how much duty is generated through taxation for the UK Government from tobacco revenue?

Christopher Ogden: Last year, it was in the region of £9.6 billion.

Helen Eadie: How much money is spent by the national health service in Scotland on treating smoking-related disease?

Christopher Ogden: That question is best answered by the health authorities, but I understand that the cost, for the United Kingdom as a whole, of treating what are described as smoking-related diseases is £1.5 billion.

Helen Eadie: It is £200 million in Scotland, according to the Scottish Executive. Do you know the cost of the payment of welfare benefits to those unable to work due to smoking-related illnesses?

Christopher Ogden: No, I do not.

Helen Eadie: You may be interested to know that it is £40 million. What is the loss of total productivity through smoking-related time off work in Scotland?

Christopher Ogden: Again, those are figures that are no doubt familiar to the public health authorities, but I am not in a position to comment on them.

Helen Eadie: You are arguing that there will be a loss of money to the Exchequer, and I am highlighting the fact that there is also a cost to the Exchequer. If your argument is to be persuasive, I want you to be able to quote to me precisely what the pluses and minuses are. I am asking you about the total loss of productivity through smoking-related time off work in Scotland.

Christopher Ogden: I shall answer that by saying that the tobacco industry has always been at pains not to trade figures in that way. We think that it is irrelevant to the argument, which is to do with the consumption of a legally manufactured, legally sold product that is bought by those who wish to purchase and consume it.

Helen Eadie: The premise of your argument is that it would cost the Exchequer more to ban tobacco smoke than it would not to ban it. I am saying that it would cost the Exchequer more if we allow you to continue to cause smoking-related illnesses. The answer that I was looking for is £450 million.

What is the estimated cost of sickness absence that is related to exposure to environmental tobacco smoke, for those with asthma and chronic bronchitis?

Christopher Ogden: To clarify, in mentioning the size of the United Kingdom tobacco market, my intention was not to juxtapose those figures with the figure with which you have presented us. We have not approached the economic argument about health costs.

Helen Eadie: You will agree that it is important for any Executive in arriving at a policy conclusion to know what the costs and benefits of the policy are. Your argument has been about costs and benefits, but you cannot provide any persuasive thinking on the issue.

Christopher Ogden: I can do that, but by concentrating on the issue that is at stake, which is not active smoking, but second-hand or environmental tobacco smoke. Our argument on that issue is completely different. Our view is based on the fact that the case is simply not proven that exposure to other people’s smoke causes death or disease.

Helen Eadie: Are you really saying that all the World Health Organisation reports on the subject and the various other reports from a variety of universities and experts are not telling the truth?

Christopher Ogden: I would not put it quite like that—I am saying that those reports do not give a definitive position. I should add that organisations such as the WHO, the BMA and the Royal College of Physicians have as an ultimate objective a tobacco-free world; for health reasons, they do not wish people to smoke.

Helen Eadie: When did you read the 1998 report of the UK Scientific Committee on Tobacco and Health?

Christopher Ogden: Recently. There is a more recent SCOTH report, which is a meta-analysis of existing studies, but which adds nothing to the 1998 report.

Helen Eadie: What were the conclusions of the report?

Christopher Ogden: It gave a relative risk factor of 1.24 for lung cancer that is related to environmental tobacco smoke.

Helen Eadie: So the increased risk of lung cancer from environmental tobacco smoke is about 20 to 30 per cent.

Christopher Ogden: The use of percentage
terms—

Helen Eadie: Was that what the report said?

Christopher Ogden: With all due respect to the committee, I will explain what that means.

Helen Eadie: The report talked about the risk of exposure to environmental tobacco smoke.

The Convener: Let the witness answer.

Christopher Ogden: The medical community accepts the figure that, among those who do not smoke and who are not exposed to smoke, 10 in 100,000 people per annum die from lung cancer—the norm is 10 in 100,000 people per year. A relative risk of 1.24 that is arrived at as a result of an ETS study means that 12.4 in 100,000 people would contract lung cancer, the extra 2.4 people being those who are exposed to ETS. That translates into a 24 per cent increase. That sort of percentage increase tends to be headlined in the media, but it gives a misleading impression. A man off the street could go into a pub and think, “Oh my goodness, people are smoking in here—I’ve got a 24 per cent chance of contracting lung cancer.” Of course, that is completely wrong.

Helen Eadie: Are you saying that it is acceptable for society to allow that percentage of people to die from exposure to smoke?

Christopher Ogden: I am saying that we take a different view on the percentages that have been arrived at. More than 60 ETS studies have been conducted, which, as a whole, are insufficient to warrant those figures.

14:30

Steven Stotesbury: I have a follow up point on the SCOTH report. The TMA made an oral submission to SCOTH, which is acknowledged in the report, in which we debated and challenged SCOTH’s conclusions. We had an expert who calculated the figures for meta-analysis and who came up with an alternative range of figures that suggested that, perhaps, the risk was not significant. The point was argued and was acknowledged in the report but, unfortunately, that is where the matter stands. SCOTH did not take those conclusions on board and the report did not state what its view of that alternative was; it simply acknowledges the fact that the TMA came to SCOTH, gave a presentation and left. That is unfortunate.

Helen Eadie: What do you say about the World Health Organisation report?

Steven Stotesbury: It takes a selective view of the research that has been done. There are between 60 and 70 different reports on lung cancer. The vast majority of those conclude that the risk is inconclusive, and a minority come to the view that there is a small, significant increase in risk. The WHO and the IARC, which is an agency of the WHO, seem to have cherry picked some of the studies that fit their case.

Helen Eadie: What would you say is a small, insignificant amount of people at risk? The SCOTH report puts the figure at 24 per cent.

Steven Stotesbury: What I mean by—

Helen Eadie: Do you believe that, if 24 per cent of people are at risk, that is a small, insignificant number?

Steven Stotesbury: That is not what I mean by—

Helen Eadie: That is what the report says.

Steven Stotesbury: Can I define what I mean by “significant”? No report that has ever been published comes up with a figure like 24 per cent.

Helen Eadie: Are you aware that the SCOTH report is an overview of 37 other studies?

Steven Stotesbury: It is an overview of 37 studies, whereas nearly 70 have been published. By definition, SCOTH has been selective in its approach to the studies that it has chosen to focus on.

Helen Eadie: Do you agree with the paragraph in the SCOTH report that says:

“The increased risk to non-smokers of lung cancer from secondhand smoke (SHS) was estimated at 24% in the overview of 37 studies and 4626 cases commissioned by SCOTH”?

Steven Stotesbury: I am aware of that conclusion.

Helen Eadie: Do you deny that that figure of 24 per cent is significant?

Steven Stotesbury: Can I explain what I mean by “significant”? I think that we are talking at cross-purposes.

The Convener: Are you using the word “significant” in a specific statistical sense as opposed to its normal use? That might be where some of the difficulty arises.

Steven Stotesbury: Yes, I am using it in a specific sense. In every study—including the IARC study—the headline figure is an average. However, the result is quoted in terms of a range from a lower figure to a higher figure.

In every study, those who conduct the study are comparing populations. In the usual case, they compare a population of non-smokers who are not exposed to smoke with a population of non-smokers who are exposed to smoke either in the workplace or in the home and examine the outcome in terms of health.

By definition, if there is no difference between
those two groups, the result is quoted as 1. If, within that limit of confidence—which is another statistical term—the result of a study is quoted as 1, that study is defined as being non-significant. That is the particular and precise meaning of "significant" that I am using. I apologise for the fact that we are talking at cross-purposes.

**Helen Eadie:** Thank you for that clarification.

The SCOTH report also says that "new studies on SHS exposure and the risk of heart disease have strengthened the findings of the 1998 SCOTH overview which estimated that the excess risk in non smokers exposed to SHS compared to those not exposed was 23%".

What do you say about the fact that such evidence and statistics are being produced for us?

**Steven Stotesbury:** It is right to say that evidence continues to be produced. You will find that people who have an anti-tobacco agenda will pick up on the studies that show something sensational. However, the many studies that suggest that there is no increased risk tend to get left out of their reports and consideration. To return to something that Christopher Ogden said, because we are considering an increase in risk that is incredibly small statistically, it is best to focus on the studies that have included the greatest number of cases. If we consider the largest studies that have been conducted, we get a consistent pattern. Of the top 10 such studies, the top seven are inconclusive in that they include the possibility that there is no difference between the risk to an exposed group and to a non-exposed group. Two of the studies conclude that there is a significant increase in the risk and one concludes that there is a significant decrease in the risk. By any analysis, that is uncertain and inconclusive. I would not call it conclusive proof that there is risk; there is a measure of uncertainty.

**Shona Robison** *(Dundee East) (SNP):* One of the problems with the debate is that many statistics are produced by both sides and it is important that both sides produce statistics responsibly. I turn to the section in the SLTA's evidence on the reduction in smoking incidence. You cite statistics from Norway and argue that "In 2003-4, the incidence of smokers aged 16-24 actually increased by 0.9%".

You do not mention the fact that the incidence of smoking among the same age group increased in the years 1996-97 to 2002-03. You just take the figure from 2003-04 and say that "From these data you could conclude that the smoking ban markedly decreased or reversed the decline in smoking incidence that was being achieved previously."

How can you come to that conclusion on the basis of one year's figures, given that previous years' figures from before the smoking ban show that there was a rising incidence of smoking in the 16-24 age group?

**Paul Waterson:** Of course, it has taken 12 years to introduce the total ban on smoking in Norway, so there was a cycle there that we will not have.

**Shona Robison:** With all due respect, that is not the point.

**Paul Waterson:** The figures also show that although smoking was being reduced by 3.1 per cent among the whole population before the ban, the rate is now down to 0.3 per cent. There is definitely room for debate about the figures. The figures do not tell us that if we introduce a ban we will stop people smoking totally. That is what we in the licensed trade are saying about the introduction of a ban. The figures exist and we can argue about them, but it is surprising that all we hear all the time is, "Introduce the ban—it'll be the best thing that ever happened. Everybody's going to stop smoking. The percentages will go up." That is not happening in Norway.

**Stuart Ross:** At the Scottish Executive's conference on smoking last September we heard speakers representing different countries that have adopted a phased approach to banning smoking talk about the success of their reductions in incidence of smoking. Our argument is predicated on considering whether an outright ban or a phased approach is better. The evidence that we heard at the Edinburgh international conference centre in September suggests that the phased approach works.

**Shona Robison:** I am suggesting to you that you undermine the credibility of your evidence by pulling out one year's statistics when all the previous years' statistics show that there had been an increase in smoking rates among young people, which is a trend across Europe. What you did distorts the picture and is selective. Further on, you say of the statistics:

"This suggests that whilst smoking bans may help
the light and very light social smokers to give up, and probably reduce the tobacco consumption of heavier users, it does little if anything to cause regular users to stop."

Even if that were true, would you not say that it was a success to reduce tobacco consumption among heavier users and to get

"light and very light social smokers" to stop smoking? Would not that in itself be a success?

**Paul Waterson:** We are not saying that we should not do something to stop people smoking; we are saying that we do not need a ban to achieve cessation rates.
Shona Robison: You said in your written evidence that a smoking ban achieved cessation; I am asking whether it would be an achievement in itself if a smoking ban achieved that.

Paul Waterson: Yes—but we do not need a ban to achieve cessation.

Shona Robison: But you said that a smoking ban had achieved it.

Paul Waterson: Yes. We do not want nothing to happen. We appreciate all that you say, but we are saying that we do not need an overall ban to achieve cessation. Other countries are achieving cessation through restrictions, so why do we need a ban—especially a ban that will be introduced overnight? It has taken Norway 12 years or thereabouts to reach that point.

Stuart Ross: In Australia, there was a ban on smoking in restaurants, which was later extended to bars. That has been an exemplary success in raising the cessation rate. Our argument is not based on health grounds; it is about what will improve health best and what will do least financial damage to business interests. Those are the two fundamental arguments that we would like to put forward—and have been putting forward—to the Finance Committee and the Health Committee.

Shona Robison: Your evidence suggests that the result of a smoking ban such as I have just outlined would not be an achievement in itself. Your evidence says that a smoking ban achieving that would not be an achievement. I suggest that it surely would be an achievement.

Finally I want to ask about the Irish situation. You say that there is no evidence from Ireland, but you cite the experience in Ireland in your written submission. Either there is evidence from Ireland or there is not. You say that in Ireland there has been a shift towards people smoking and drinking at home. I would not dispute that. However, do you accept that many other factors could be behind that? When we were in Ireland, we found that as well as the smoking ban's being enforced, a number of other changes were taking place; for example, the drink-driving laws were being toughened up. You might screw your nose up at that, but members of the licensed trade in Ireland said that that was having a major impact on whether people drink in rural pubs. There was also a general trend towards people drinking at home because cheap booze is available in supermarkets. That was also acknowledged by the members of the licensed trade, who accepted that it was not just the smoking ban that was having an impact on people coming through their doors. Do you accept that those are other factors that might contribute to more people smoking and drinking at home?

Stuart Ross: You asked quite a lot of questions at once. I will try to answer them in order. First, you asked whether or not there is evidence from Ireland. Ireland is the only country that has imposed an outright ban in a sudden—or dictatorial—manner, as the Executive is proposing. When we were asked to give our views on the proposals from Holyrood, we had to get research done. All that was available to us at that time was the four or five-month period of the Irish ban. We commissioned the Centre for Economic and Business Research—a well-respected firm in London that has no axe to grind—to examine the Irish situation and to find out what the percentage of displacement was from on-trade or pub trade to take-home trade. That research was carried out independently and was not influenced by our views. Shona Robison would believe that anything we say is tainted by commercial interests. It was independently concluded that, if the Irish position was replicated in Scotland, there would be a loss of revenue of more than £100 million, a loss of profit of £90 million, a negative shift in jobs of 6 per cent; and a decrease of £56 million in the revenue take from the licensed trade.

Not being economists, we asked the CEBR to carry out research, but we accept that people must decide whether or not to accept the CEBR's view. As I said earlier, the ban in Ireland has been in place for less than a year, so we do not know the true position in Ireland. However, when Diageo announced its results two weeks ago, its chief executive made great play of the fact that Guinness sales were up in the take-home trade but well down in the pub trade; all the evidence points to a shift. We need to remember that there is always a reason for commercial movements, whether that be the weather, the economy or pricing.

Although the health lobby quotes statistics that are claimed to show a reduction in the use of tobacco as a result of anti-smoking legislation such as outright bans and restrictions, people never mention the fact that the number of smokers is decreasing anyway. People who have a commercial axe to grind always put the best slant on their figures. I am sure that politicians also do that at times.

Shona Robison: To be clear for the record, are you saying that the licensed trade accepts that other factors have been at play in Ireland? Do you accept that factors such as drink-driving laws and the lower price of drink in the burgeoning number of supermarket outlets have been a major factor in Ireland's increased take-home trade?

Stuart Ross: Whether or not I accept that is irrelevant. We asked the CEBR to conduct independent research. We submitted the research
to the committee, although Shona Robison may not have had a chance to read it. The research concluded that assigning the Irish situation to Scotland would result in the statistics that I have just quoted.

Shona Robison: Did the study take account of the other factors?

Stuart Ross: Yes. The study’s conclusion, if you read it—

Shona Robison: How did the researchers know how much of the change was due to other factors and how much was due to the smoking ban?

Stuart Ross: You would need to ask that question of the researchers. I am not here to speak on their behalf.

Shona Robison: Are you in touch with the trade association in Ireland?

Stuart Ross: Yes.

Shona Robison: In that case I have no doubt that the Irish licensed trade association will have given you the same information as it gave us. It told us that the other factors at work are just as important, if not more important, in putting pressure on the industry. Do you accept that?

Paul Waterson: The smoking ban “greatly accelerated”—those were the words that the Irish used—the downturn in the Irish licensed trade.

We need to remember that the Scottish licensed trade does not have the same stability as the Irish trade. We are talking about two entirely different types of business. Because of the way in which Irish licences are granted, licensed trade businesses in Ireland tend to be handed down from generation to generation and are asset rich. As such, they are far more able than our industry to handle a downturn in business. Most businesses in Scotland are relatively young, with large loans and rented properties. We are in a much more difficult position, because the trade in this country will not be able to withstand a downturn in business such as the Irish trade has handled.

The smoking ban in Ireland has certainly greatly accelerated the move away from the pub to off-sales drinking. As I am sure members will know, all jurisdictions that have big off-sales drinking populations have problems with alcohol abuse. The health problems that are associated with such abuse are exacerbated and get much worse when drink is taken out of the controlled environment.

Stuart Ross: Surely the relevant point is whether or not anti-smoking legislation will improve the nation’s overall health. That brings us back to the question whether more people will smoke and drink at home as a result of a ban and the impact that such a development would have on children. ASH Scotland’s written submission points out that children who are exposed to ETS in their early years are three times more likely to contract lung cancer or smoking-related diseases in later life than are children who are not exposed. If the trend towards take-home drinking is exacerbated by legislation, that is not necessarily good news for health promotion. That is surely a crucial issue that needs to be taken into account, but no research is being done on it. In our view, if the bill is the most important bill that has been introduced in the Scottish Parliament—as the First Minister has claimed—the proposals should be properly and fully researched in respect of relevant like situations.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I will turn to another matter that we will probably never resolve, even though we have spent hours and hours on it. We will have one more attempt. Is smoking a health hazard? Can we agree on that?

Christopher Ogden: As I said in my opening statement, we do not disagree that health risks are associated with smoking.

Mr McNeil: A yes or no answer would be fine, because there are other people to get in.

Christopher Ogden: That was a yes.

Mr McNeil: We have just heard ASH being quoted as saying that exposure to passive smoking increases the risk and health hazard. I accept that. Do you agree?

Christopher Ogden: No.

Mr McNeil: So—a person who is not exposed to passive smoking is at the same risk as someone who is exposed to it seven days a week, eight hours a day.

Steven Stotesbury: That is too close to call.

Mr McNeil: That is a difficulty. If you are not prepared to concede that, it is difficult for the committee to take seriously your evidence and your claim that you accept fully your duty of care to your staff. If you are not prepared to go from agreeing that smoking poses a health risk to agreeing that passive smoking also poses a risk—

Stuart Ross: I think—

Mr McNeil: I am coming to my question. I should not have made that comment, but my line of questioning is about—

The Convener: It would be fair to let the witnesses respond.

Stuart Ross: You cannot lump together the four of us who are on this one panel. Paul Waterson and I represent the Scottish Licensed Trade Association and have no links with the Tobacco
Manufacturers Association. Of course we accept the risk. Our argument is predicated on that, and our submission to Tom McCabe last May was about how we would handle it. We put to him a five-point plan, the main elements of which Paul Waterson outlined. Since 1999, we have been working with the Scottish Executive—through the Scottish voluntary charter on smoking in public places—to encourage more smoke-free areas. Our objective is to restrict the use of tobacco in licensed premises without fundamentally damaging business interests while still providing freedom of choice for the individual, as supported at Westminster by John Reid, whom Paul Waterson quoted.

Mr McNeil: You said that earlier. Does the SLTA accept that smoking is a health hazard and that increased exposure to passive smoking is also a health hazard?

Stuart Ross: Yes, but the relative risk of passive smoking has to be taken into account.

Mr McNeil: Yes or no will be fine.

Stuart Ross: We are saying that the relative risk has to be taken into account, as does the relative risk of shift.

Mr McNeil: That is useful, particularly as far as you attitude to your staff is concerned. On page 2 of your submission, you claim that there is a “low level of staff exposure”.

How have you measured that? What risk assessment has been carried out? What air pollution tests has your industry carried out to establish the bald statement that there is a “low level of staff exposure”?

Paul Waterson: There are building control rules and regulations to which all licence holders must adhere, so the atmosphere must be kept within certain limits. However, we have the problem that we are told that ventilation does not work. We have done research—we are back to the problem of whether you agree with the research that we commissioned—that showed categorically that relatively inexpensive ventilation systems work, but we are told that we need a hurricane blowing through our premises to make the air clean enough. We have a problem with that. Licence holders are under a duty of care under building control regulations and other legislation. That looks after the staff side.

Mr McNeil: So you are not aware of any risk assessment that has been carried out throughout the establishments that you represent to establish whether you can make the claim that there is a “low level of staff exposure”.

Stuart Ross: Although I have worked in the industry for 30 years and have been the boss of Belhaven for 20 years, not once has a member of staff complained to me about passive smoking in the work environment.

Mr McNeil: You came to us today saying that you are responsible employers. Have you carried out a risk assessment in any of, or throughout, the establishments that you represent to allow you to submit that there is a “low level of staff exposure”? How are you able to make that statement without measuring exposure?

Stuart Ross: The Scottish Executive’s own research shows that health problems because of passive smoking are mainly experienced in domestic environments. You need only read the University of Aberdeen research to draw that conclusion. Six sevenths of ETS problems come from domestic sources, not from public places. Licensed premises are only one small part of a vast array of public places, so you can draw the conclusion from that report that the incidence of staff experiencing passive smoking problems in licensed premises is tiny.

Mr McNeil: You have no scientific basis on which to say that. You have not even carried out a risk assessment, as you would be required to do.

Stuart Ross: Could you tell me how to carry out a risk assessment?

Mr McNeil: Yes.

Stuart Ross: How would you do it?

Mr McNeil: You would speak to the Health and Safety Executive and get its chemists to perform air pollution tests in and around bar areas, which you claim—

Stuart Ross: We have done that with ventilation. That is exactly what Paul Waterson said.

Mr McNeil: Not every bar that I go into has ventilation.

Stuart Ross: That is exactly the point. You are right that ventilation has been adopted by Italy as the solution to the health problems. It is just about to be adopted by Germany. It has been adopted by the European Parliament, in which 544 out of 600-odd members of the European Parliament voted in favour of ventilation as a solution to ETS problems. You say that we have not considered ventilation, but we have considered it, and we have encouraged our members to use it. Indeed, in Belhaven, we put ventilation into every unit that we upgrade.

Mr McNeil: You mention the Health and Safety Executive in your submission in defence of some of your claims, but you have not involved the HSE
in carrying out a risk assessment. There is a well-established hierarchy in measuring risk. The first point is that you eliminate the risk, not that you ventilate the cause of the risk and then remove it only subsequently.

Stuart Ross: If you read the University of Glamorgan report you would see that it concluded that a pub in Glasgow that had ventilation systems and in which smoking was allowed had fewer contaminants in the air than a no-smoking pub in the centre of the city that did not have—

Mr McNeil: If you have not—

Stuart Ross: You are not listening.

Mr McNeil: If you have not evaluated the hazard and the risk, how can you evaluate what type of ventilation to use?

Stuart Ross: We are not scientists. We are businessmen.

Mr McNeil: You have not done anything in that regard to protect your staff.

Stuart Ross: That is nonsense—of course we have.

Mr McNeil: Your staff are exposed to passive smoking seven days a week and eight hours a day.

Paul Waterson: So, do you not agree that ventilation does any good at all—you think that it does absolutely no good?

Mr McNeil: Ventilation has to be introduced alongside a proper assessment of the hazards and risk to your employees. You have confirmed today that you have not taken that seriously.

Paul Waterson: That is not the case. Guidelines on clean air have been laid down and we are within those guidelines.

The Convener: Where do the guidelines come from?

Paul Waterson: They are health and safety guidelines.

The Convener: Do you comply with them currently?

Paul Waterson: Research shows that we are well within the guidelines; in fact, the non-smoking pub had more problems than the smoking pub. That is one of the reasons why we have said that we know that it can be uncomfortable for bar staff and that we will ban smoking in bar areas. We have said that openly. To do so is fair and consistent with what you are saying.

Mr McNeil: You mention “substantial control methods” on page 3 of your submission. What scientific basis do you have for using the word “substantial”? Who has validated them? Has the HSE validated them, and how can it do that throughout the pubs that you represent?

Paul Waterson: The methods are “substantial” within the limits that are laid down.

Mrs Nanette Milne (North East Scotland) (Con): I confess that I am beginning to be blinded by science. Do you have any further comments on Professor Hole’s report that was commissioned by the Scottish Executive and NHS Scotland, and on the University of Aberdeen review? Do you have any points to raise that have not been covered? I am slightly unclear as to your concerns with both.

Steven Stotesbury: I want to make two comments. First, I do not want to say too much about Professor Hole’s report, but I feel that it is unfortunate that in presenting his evidence he has taken the position that there is a certain level of risk and has extrapolated figures from that. It is disappointing that he did not begin by examining the balance of evidence in various studies and considering the variability or uncertainty of that risk estimate.

15:00

Mrs Milne: Are you saying that he has plucked the initial figure out of the air?

Steven Stotesbury: No.

Mrs Milne: Then how did he arrive at it?

Steven Stotesbury: He has based the figure on a particular report without verifying it or testing its variability. For instance, using the SCOTH report’s relative risk figure of 1.24 would in all fairness require an examination of SCOTH’s assessment of the uncertainty of that figure and the whole range of variability.

Mrs Milne: And what about the University of Aberdeen review?

Steven Stotesbury: I am not familiar with it, so I will not comment on it.

Mrs Milne: Does the SLTA wish to comment on that review?

Paul Waterson: That review covered areas where smoking was restricted, rather than banned outright. For example, it considered one study on the effects of smoking in Californian hotels and restaurants, but not in pubs. We do not think that is the right foundation for decision making.

Stuart Ross: I should point out that those researchers had nothing to look at—when the research was commissioned, an outright ban had not been imposed anywhere in the world apart from Ireland, where it had been in place for only a couple of months.

Mrs Milne: So those researchers were not
comparing like with like.

**Paul Waterson:** Definitely not.

**Mrs Milne:** We have already been told that ventilation can remove the obvious effects of smoke—that is, the smoky atmosphere—but that unless it creates a tornado it cannot remove carcinogens from the atmosphere. Do you have any scientific comments to make on that claim?

**Steven Stotesbury:** Yes. First, I should make two comments, because the previous argument that we had on ventilation leads me to think that the committee might be under the false impression that, on the one hand, there is fresh air and, on the other, there is air that is contaminated with ETS. In fact, the air around us and in most indoor environments is full of chemicals. If members want it, I can quote chapter and verse from reports. Suffice it to say that many of the chemicals in environmental tobacco smoke are already around us and come from a variety of sources, such as varnish on wood, and from paint, carpets and the aftershave that we put on in the morning. A chemical examination of that air would show that it was a soup. I am sorry to say that, but that is the reality of the situation.

Measuring the chemical effect of smoking in such a venue would show that its impact on the number of chemicals present would be very minimal. For example, there might be a very small increase in carbon monoxide. There would also be a sudden peak in nicotine, which is a major product of ETS. However, many of those chemicals, which are accepted as carcinogens, are present no matter whether there is ETS. As a result, ventilation is a very good solution; it deals with carcinogens. I do not know where that argument came from, but it is not a scientific argument. I am keeping an eye on the time and I ask members to make their questions questions, rather than speeches.

**Mrs Milne:** Are all solid particles removed by ventilation?

**Steven Stotesbury:** Solid particles behave differently. It can be easier to remove them, because they can be filtered out. They do not behave like pure gases, but they float in the air and can be removed in approximately the same way.

**Mrs Milne:** Are the carcinogenic substances mainly gases or solids?

**Steven Stotesbury:** There will be carcinogenic substances in both phases. Some substances will be apportioned between them, but we do not want to go into that level of complexity.

**The Convener:** I am keeping an eye on the time and I ask members to make their questions questions, rather than speeches.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** We accept that cigarettes are an addiction and all packets carry a message indicating that they kill. You accept that there is a decline in smoking in the population and that probably 70 per cent of people do not smoke. You are catering for the 30 per cent who still smoke. Do you accept that in this country the number of people who smoke is decreasing, but that in other countries, especially in the east, it is increasing? We are selling more cigarettes abroad.

**The Convener:** What is your question?

**Dr Turner:** I have asked a question. We can run through things quickly. We accept that cigarettes kill—that is stated on every packet.

**The Convener:** That is not a question—it is a statement. Ask a question.

**Dr Turner:** I am asking whether the witnesses accept that cigarettes kill, as is stated on the packets. The answer should be a quick yes.

**Stuart Ross:** We have already answered the question.

**Dr Turner:** Are you not catering for the 30 per cent of people in this country who still smoke?

**Stuart Ross:** All the research shows that 60 per cent of people who go to Scottish pubs smoke. We do not cater for smokers; we cater for people who want to eat and drink. Some of them happen to smoke. We do not make a living out of selling tobacco.

**Dr Turner:** Exactly. You will have a business plan for the future if a ban is introduced. You have probably looked into the benefits of a ban, some of which have been mentioned. Cleaning bills, fire risk and so on would go down.

**Stuart Ross:** Your point is absolutely valid. There is an opportunity for all public houses to get more business from people who do not like to go into smoke-filled environments. However, 60 per cent of people who currently go to pubs smoke, so there is a big risk that those people will transfer their drinking habits from the on-trade to the take-home trade. My crystal ball is no better than yours. We can examine only the research that is available. We have commissioned research from the CEBR—the research has been presented to
the committee—that shows the evidence from Ireland in the period for which it is available. That is not a guess; it is assigning known information from Ireland to Scotland.

Dr Turner: Public houses in Ireland accepted the situation and changed their business trends. I suppose that you would do the same.

Let me be more scientific and talk about the duty of care. In New York, a decision was made to carry out blood tests. I would like to hear your scientific take on those tests, which measured the levels of cotinine in the blood of staff, rather than particles and carbon monoxide. The tests found that in pubs and restaurants in which there was a ban on smoking, those levels were reduced markedly. What do you have to say about that?

Steven Stotesbury: I am not familiar with the study, but cotinine is a well-known biological marker.

Dr Turner: Do you think that it was sensible to carry out the tests in New York?

Steven Stotesbury: It was a reasonable thing to do. I will be precise—you cannot infer a direct quantitative relationship between levels of cotinine and exposure to tobacco smoke. However, qualitatively you can tell the difference between an exposed and a non-exposed group. Some people try to extrapolate amazing things from cotinine levels—

Dr Turner: Do you accept that that is better than doing nothing? If you had figures from before, during and after exposure, they might be statistically significant over time.

Steven Stotesbury: They would give an indication of exposure or non-exposure.

Dr Turner: If you wanted to look after the people in establishments, you would not look to carry out air tests, because you think that the air is okay. However, we have heard evidence that sometimes people do not turn on the ventilation, because it is too expensive. Would it be a good idea to carry out blood tests?

Steven Stotesbury: Because I am interested in air-quality measures—I hope that I have already made a case for their being a better route to go down—I am more in favour of measuring air quality and air-quality indicators than in an intrusive practice such as taking blood samples from staff.

Dr Turner: Staff might agree to the procedure if they thought that you had their interests at heart.

It has been said that the proposals will result in more smoking at home, but the experience in Australia seems to show that a reduction in smoking in the workplace results in less exposure to smoke for children at home. Do you disagree with that?

Stuart Ross: I agree that the route that Australia took was successful. The tobacco restrictions there were introduced gradually, over a period of time, which meant that people had a chance to get used to the restrictions and so did not switch from going out to socialise to socialising at home.

Dr Turner: We have been aware for more than 35 years—probably 40 years—that cigarettes are not good for us and that even to inhale the smoke of cigarettes may not be good for us. Given that Scotland has the worst health record in the UK, and perhaps in Europe, it is not a surprise that we are trying to do something about cigarette smoking.

Paul Waterson: Yes, but the issue is what we should do about it and what will work. In comparing the Australian licensed trade with ours, we should bear in mind the climate and the other variables. We must consider what will work and have a significant impact here—nobody questions that. We do not believe that a ban on smoking in licensed premises will have the impact that you perhaps think it will have. The point that we are trying to make is that a ban would simply shift the problem somewhere else.

Dr Turner: Do you accept that cigarettes and alcohol go together and that people drink more when they smoke? There might be a cost benefit for you in encouraging people to smoke.

Paul Waterson: As I had the first no-smoking pub in Scotland, I can say that there are different markets. That was in the mid-1980s, so perhaps it was a bit ahead of its time. I know the arguments, but the point is that, at present, people have a choice. Customers should continue to have the choice about where to go. We should increase ventilation levels and ensure that the trade adheres to our proposals, which is why we want legislation on the issue. That is the way in which we should start the process, rather than going straight for a ban that we do not believe will work and that will affect business, as we have heard.

Stuart Ross: That is our view—you might have a contrary view, to which you are entitled, but the fact is that the most important piece of proposed legislation that the Scottish Parliament has introduced is not based on research. There has been no research into whether the proposals will solve, shift or even exacerbate the health problem. You may argue that I say that for reasons of commercial advantage, but it is a fact.

Dr Turner: Given that you agree that environmental tobacco smoke is a health hazard and that you would like a gradual implementation of measures, when do you believe that a ban could be introduced in Scotland?
Stuart Ross: Under the proposals that we put to Tom McCabe, there would be no smoking in any premises where food is served and no smoking at the bar counter in any premises. Smoking would be allowed in pubs where no food was served, but that would be restricted to 70 per cent of the airspace, which would be reduced to 60 per cent and then 50 per cent. After three years, the measures would be reviewed, taking account of public opinion shifts and the health of the nation. We put that proposal to Mr McCabe in May last year, but there has been no engagement with us on them. Sure, we had a public consultation, during which we stood on the same platforms as ASH and other pro-health and anti-tobacco lobbies, but at no stage in the consultation process did the Scottish Executive sit down with us to discuss how our proposals would work. As Scottish businessmen with a vested interest in our concerns and in promoting health in Scotland, we are naturally frustrated by that.

Dr Turner: The measures would last for only three years, according to your evidence.

Stuart Ross: We said that we would review them after three years. I dare say that, if the proposals were not regarded as robust enough, everything would be open to negotiation.

Janis Hughes (Glasgow Rutherglen) (Lab): You mentioned a number of things that you could have done, such as increasing the amount of ventilation. Why did those things not happen during the period of the voluntary charter?

Stuart Ross: They did.

Janis Hughes: Did they happen on a scale that any of us would have noticed?

Paul Waterson: We achieved all the targets that were set by the Scottish Executive—they were not our targets—except one, which was on paperwork. The voluntary charter was successful. We approached it from a standing start and not many resources were put into it, so the fact that we achieved what we achieved showed great commitment from the trade. Furthermore, in our new proposals we said that we agreed that there should be legislation. We said that, at first, the legislation should be based on the elements of the voluntary charter so that we could drive the measures forward quicker. In any trade, there are always people who lag behind others. There are responsible operators in every business, but sometimes there are irresponsible operators. We asked for legislation and we moved on to our new proposals to drive things forward. We were aware that, although we had achieved the targets that were set, things were perhaps not moving quickly enough. We say that openly. That is why we wanted legislation.

Janis Hughes: How many pubs implemented the voluntary charter and had an area that was designated as smoke free?

Paul Waterson: I do not have the figures in front of me.

Janis Hughes: Roughly.

Paul Waterson: We certainly achieved the targets that were set.

Stuart Ross: I would say that at the moment about 15 to 20 per cent of Scottish pubs have an area that is designated as smoke free.

Paul Waterson: We want that to increase to all pubs.

Janis Hughes: That is perhaps the problem. The changes did not happen quickly enough.

Stuart Ross: Your point is valid. The Scottish licensed trade is definitely not perfect in relation to air quality. One of the problems is that the more responsible operators will invest to improve air quality, whereas others, who are not members of trade associations or are not committed to the issues in the way that we are, will do nothing. That is why we need a level playing field through legislation. However, you must admit that, because of the investment in Scottish pubs in the past 20 years, the condition of air in them is much better than it was. Progress was being made, although it could be made faster. One of our arguments is that such improvements should be made mandatory.

Janis Hughes: You mentioned the need for a level playing field and you say in your evidence: “it was unlikely that … accelerated uptake could be achieved by voluntary measures, as there were widely perceived commercial disadvantages to those operators restricting or banning smoking”.

In evidence on Stewart Maxwell’s member’s bill, we heard—perhaps from you—that his proposals would not give you a level playing field because they would displace people who wished to smoke from places where food was served; smoking would be banned in such places, so people would move elsewhere. Is the Executive’s proposal a level playing field, in relation to your commercial concerns?

Stuart Ross: The Scottish Executive’s proposals obviously represent a level playing field, but our argument is that the bill is not necessarily the best way of achieving the health results that you are looking for, because of the displacement issue. Moreover, the imposition of an outright ban dictatorially against the wishes of 82 per cent of the Scottish public will have a big impact on our businesses and we are naturally concerned about that. Those are our two fundamental concerns.
Janis Hughes: You mentioned earlier that no specific research has been done on the effects of passive smoking in the home, but you claim—

Stuart Ross: I said that no research has been done into whether an outright ban or the phased introduction of tobacco restrictions would result in displacement of the ETS problems from public places to—

Janis Hughes: I may have picked you up incorrectly, but in your submission you say: “85% of health problems caused by Environmental Tobacco Smoke are derived from domestic situations”.

Where does that figure come from?

Stuart Ross: The Scottish Executive’s research, which was conducted by the University of Aberdeen, concluded that 865 people die from passive smoking in Scotland each year but that only 120 of them experienced the problem in public places—not just licensed premises, but all public places.

The Convener: We are just about at the end of this session. Could you just clarify one thing? Your submission says that the SLTA “represents the interests of over 1800 self-employed licensees.”

Your evidence also says that those people mainly work in pubs. Do you have a rough figure for how many pubs are not in the SLTA?

Stuart Ross: There are 5,000 public house licences in Scotland. The SLTA is also a member of the against an outright ban group, which has been promoting the phased approach. The SLTA is only one constituent part of the AOB group, which represents 3,500 Scottish public house licences.

The Convener: The SLTA submitted a petition to the Public Petitions Committee and we have just been notified that that petition is being referred to the Health Committee. It will be incorporated into our stage 1 evidence. I thank you for that and I thank you all for coming. The session has been fairly gruelling, but I do not suppose that you expected anything else.

I welcome our second panel of witnesses, which includes Paddy Crerar, the chairman of the British Hospitality Association Scottish committee, Ian McAlpine, who is from the Coal Industry Social Welfare Organisation and the Committee of Registered Clubs Associations, and George Ross, who is from the Royal British Legion clubs and the Committee of Registered Clubs Associations. Will the British Hospitality Association give the committee a brief introductory statement, followed by CORCA?

Paddy Crerar (British Hospitality Association Scottish Committee): Although I represent the BHA in Scotland, I am also an independent hotelier with a hotel chain in Scotland. If a ban were to be imposed, the BHA would support it for the reasons that are set out in our submission to the Scottish Executive. However, we require further work to be done on the exemption of hotel bedrooms.

The Convener: May we now hear from CORCA? Mr Ross?

George Ross (Royal British Legion Scotland): I should point out that my organisation is not an executive member or a body of CORCA. I represent the Royal British Legion Scotland.

Ian McAlpine (Coal Industry Social Welfare Organisation): Perhaps I can assist. CORCA is an umbrella body. It is made up of various bodies including the Royal British Legion Scotland, CISWO, the Working Men’s Club and Institute Union, and Conservative and Labour clubs. George Ross and I are here primarily on behalf of our own organisations, but we are also wearing the general CORCA hat.

The Convener: Thank you. We will go straight to questions.

Shona Robison: I have a question of clarification for the British Hospitality Association. What sort of relationship do you have with the Scottish Licensed Trade Association? Do you work closely together?

Paddy Crerar: I believe that we have a very good relationship. We work closely together on most subjects.

Shona Robison: Do you have dual membership?

Paddy Crerar: I personally do not.

Shona Robison: I am sorry; I meant to ask whether your members can also be members of the SLTA.

Paddy Crerar: Yes, they can.

Shona Robison: Okay. Has the fact that the two organisations are taking very different positions on the issue led to a rigorous debate behind the scenes?

Paddy Crerar: The positions that we are taking are not really that different. Our position is that, if a ban were to come into place, we would support it in the form that is proposed. The BHA has accepted, perhaps wrongly, that the ban is a fait accompli and that we should therefore try to ensure that the bill contains proposals that best suit our members.

Shona Robison: That is helpful. My next question is whether your concern about hotel rooms relates to the fact that no mention is made
of them on the face of the bill. I understand that the Executive’s intention is that the bill will not apply to hotel rooms. Is that also your understanding? If so, do you want the exemption to be made explicit in the bill?

Paddy Crerar: That intention is not clear in the bill. My understanding is that hotel rooms could be covered, but we think that they should be entirely exempt.

Shona Robison: My understanding is that they would not be covered. Obviously, we will have to pursue the point with the Executive. Your clear position is that the exemption should be on the face of the bill. You think that there should be no ambiguity. Is that correct?

Paddy Crerar: Yes.

Shona Robison: Thank you.

Dr Turner: I, too, have a question of clarification about hotel rooms. I am sure that I read somewhere that, although hotel premises are covered by the bill, it may be possible to designate smoking and non-smoking rooms.

Paddy Crerar: We would not wish to support that.

Dr Turner: So you would rather that all hotel rooms were smoking rooms.

Paddy Crerar: Yes. We would rather have them all as smoking rooms. We think that designating certain rooms as smoking rooms and others as non-smoking rooms would be unworkable.

Dr Turner: We are talking only about bedrooms.

Paddy Crerar: Yes.

Dr Turner: Are you happy about the provisions as they relate to the downstairs bars and restaurant areas?

Paddy Crerar: “Happy” is too strong a word. If the Parliament decides to go ahead with a ban, our submission sets out how we would support it.

Dr Turner: You would accept the ban for downstairs but not for the bedrooms, which you would like to be within your jurisdiction. Your proposal has cost implications, however. The bedside rugs and carpets in many hotel bedrooms have cigarette burns. What is the annual cost of repairs and redecoration that result from smoking damage?

Paddy Crerar: I am more concerned about the potential loss of business. We have a number of clients from Spain and we are growing business with Poland and Russia—the sort of places that were mentioned earlier where a high percentage of the population smokes. If smoking is not allowed in the bedrooms, those customers would have nowhere to smoke on our premises. The potential loss of business far outweighs the cost of repair and replacement.

Dr Turner: That is clear. Thank you. You are also concerned about recruitment. In your submission, you say:

“As currently drafted section 7 appears to suggest that owners or head landlords may be proceeded against even in circumstances where they are not in day to day control of the business. This is not compatible with natural justice and should be addressed.”

Paddy Crerar: Under the bill, if someone persists in smoking on our premises despite the fact that we have done all that we can to prevent them from smoking, short of physically throwing them out, I understand that the owner of the business, who may not be the manager of the business, could be acted against in a court of law. The BHA thinks that that is unfair.

Dr Turner: On recruitment, do you not think that people would want to work in premises where there was no smoking? Allowing smoking might be a factor in their not wanting to work there.

15:30

Paddy Crerar: The truthful answer is that I think that there are probably as many people who would be happy working in a smoking environment as there are those who would be happy working in a non-smoking environment. That is the nature of the trade. A lot of our staff—about 70 per cent in our company—smoke, so I cannot see that there would be a positive or negative effect on recruitment.

Dr Turner: Do you think that factors other than a cigarette ban would cause trouble in recruitment?

Paddy Crerar: Yes.

The Convener: I would like to clarify something. In the past few days, we have received the draft regulations. There is a clear indication in the guidelines that the regulations have been drafted in such a way as to include hotels, guesthouses and bed-and-breakfast accommodation within the scope of the law, but to allow proprietors, if they wish, to designate bedrooms in which smoking may be permitted. Are you saying that you would prefer bedrooms to be clearly excluded from the guidelines?

Paddy Crerar: If the guidelines say that the rooms can be designated by the owner, that is effectively the same thing.

The Convener: So you would be happy with that.

Paddy Crerar: Yes.

The Convener: Will you ensure that you make that position clear in the consultation on the
guidelines, just in case there is any dubiety about

I would like to ask a question of the two witnesses from the Committee of Registered Clubs Associations. I understand that you each represent a different group within CORCA—one the Royal British Legion clubs, with which all of us will be familiar, and the other the miners welfare clubs, which, for geographical reasons, will not be so familiar to all committee members. I would like each of you to tell us the views of your individual organisations about the ban.

Ian McAlpine: I represent the Coal Industry Social Welfare Organisation Scotland, which is an umbrella body for miners welfare schemes. As you will appreciate, with 53 independent clubs and approximately 50,000 members, there are widely varying views about the bill and its impact, both positive and negative, on registered clubs.

My organisation’s view is that we wholeheartedly support the prohibition in enclosed public places. Our stance is based solely and specifically on the fact that it is a health and safety issue. Any employer has a duty of care to employees, and that duty of care must extend to the membership, user groups and volunteers who are using the facilities.

We are a mining charity and our whole ethos is to promote quality of life, so it would be wholly inappropriate to support a pro-smoking lobby. However, we acknowledge that there are wide and differing views, and there are individual management committees and individual members who would prefer CISWO not to support the bill but to lobby the Parliament to make amendments to align the bill with the more diluted proposals south of the border. There are individuals who are genuinely concerned about the impact of the bill on their way of life. There is also genuine concern about the impact of the bill on the income generation of certain community clubs and the worry is that those borderline clubs might close if income dropped to such an extent that they were no longer viable, because of a perception that smokers would stop using the facilities. There are also individuals who just completely ignore the health risks, who will quite happily ignore the fact that smoking is potentially addictive and harmful and who will happily support the pro-smoking lobby.

In the CISWO miners welfare network there are already management committees that are partnering health professionals and agencies that provide practical support in their premises to their membership and the wider community. With encouragement, they are organising support groups and smoking cessation courses that link in with nicotine replacement initiatives. They are helping deliver the Government’s ambitions in relation to peer education and a healthy lifestyle. Given that the majority of the population are non-smokers and that the bill will allow them to socialise in a smoke-free environment, there is a strong argument that it might ensure a more secure future for many facilities in the medium to long term. However, careful management and support of what will be a radical change will be needed in the short term for obvious reasons. Some people are clearly up for the challenge, but some might never be.

On some of the other agencies that come under the CORCA banner, the general secretary of the Club and Institute Union has intimated to me that there is a general consensus that its members would much prefer to have an arrangement whereby clubs provide smoking areas and separate non-smoking areas; in their view, that would be adequate. I have not had any direct dialogue with either the Conservative or the Labour clubs. I imagine that there is quite a cross-section of opinion there. Perhaps George Ross can pick up on that.

The Convener: Before we hear from George Ross, how did you go about ascertaining the views of the miners welfare clubs? What was the internal process that has enabled you to represent the views of that set of clubs?

Ian McAlpine: In my line of work I support the miners welfare scheme management committees on a variety of initiatives and give advice on best practice. In recent years I have been involved proactively in coalfields community regeneration and assisting in setting up projects to develop facilities and their usage.

The Convener: I appreciate that, but how did you ascertain the views of clubs specifically on the proposed ban?

Ian McAlpine: I have not spoken to all management committees on the ban specifically. That is why I intimated earlier that there was a wide and varying set of views on the subject. I can speak for CISWO and I can highlight to you the differing views on the ban.

George Ross: I am the legal affairs officer of the Royal British Legion Scotland. Although I have responsibility, I have no authority over any of our branches or branch clubs; they are completely separate units. We have 214 branches in Scotland, 87 of which have clubs. Clubs are brought about by members producing a viable plan and presenting it to their branch; if the plan is accepted, a club will be born. In our 214 branches and clubs we have approximately 59,000 members. I have no authority over the branch clubs, but I carried out a small exercise in Edinburgh and the Lothians and in Glasgow and the western counties. I found that the minority—
approximately 20 per cent—were looking for a complete ban. Of the other 80 per cent, 65 per cent did not want a ban and 15 per cent said, “Okay you can have a ban, but please exempt our clubs.” They took the view that a lot of smoking occurred in domestic areas, such as households.

If the ban were to come into being—and it looks as if it will—many of our clubs will have difficulty staying alive. Many of the Royal British Legion clubs, which serve the ex-service community and those who believe in the aims and objectives of the Royal British Legion, will close. They provide the only means within our organisation for members to socialise and enjoy comradeship.

An important historical fact is that in the first and second world wars, cigarettes were issued to soldiers, sailors and airmen by the Government. Following my 23 years in the Army, I moved to the Royal British Legion Scotland, where I became a war pensions appeal officer and presented cases at tribunals. Many of the people whose cases I presented had chest problems due to smoking-related diseases such as heart disease. Their defence was that they caught the diseases from which they suffered through smoking and that the Government had issued them with cigarettes to smoke during the wars. The Government’s response, which was relayed through the Veterans Agency and Department of Social Security representatives, was that an individual’s decision to smoke was a matter of freedom of choice and that, therefore, the sufferers had brought their conditions on themselves.

Now, however, we are looking at a complete turnaround. The Government, which issued cigarettes to the servicemen at that time, is introducing a complete ban that will mean that the ex-servicemen will have nowhere to go. The Royal British Legion feels that the Government should accept some of the blame.

Let us consider the issue of drugs. Nowadays, the Government issues needles and so on to drug addicts—those who inject drugs, smoke cannabis and take magic mushrooms—in order to help them. I heard that nicotine patches are being issued to younger smokers. If that is the case, I believe that the Government should issue nicotine patches free of charge in every chemist’s throughout Scotland. That would help to educate those who smoke that smoking can cause fatal diseases.

I feel strongly that the Government has a responsibility in this area.

The Convener: That is a fair point. It is not germane to what we are doing with the bill, but I am sure that every member of the committee will have taken on board what you have said.

Mike Rumbles: I am a member of the Royal British Legion and served in the Army for 15 years. I remember saying to the soldiers, “Let’s have a smoke break now.” The phrase rattled off the tongue; it was the accepted parlance and it was accepted that people would smoke. However, time has moved on and we are all aware of the medical evidence on smoking and so on.

Mr Ross, you said that some of the clubs would close. I accept that there will be an economic impact and that the evidence from Ireland suggests that a certain number of people would not come to the club or the pub. However, what evidence do you have for your claim that some of the clubs would close?

George Ross: Some of our clubs are so small that they survive only due to the money that is put into a particular gambling machine. That is the only income that they have from which to pay the employees who run the bar. If a smoking ban is brought in, our membership will be reduced in more than one way. Under sections 107 and 108 of the Licensing (Scotland) Act 1976, our membership has to be clearly identified and the ordinary member must be the main member. Associate members cannot rise above that level; if they did, we would be breaking the Licensing (Scotland) Act 1976. Under a smoking ban, our low membership—of both ordinary members and associate members—would deplete further and the club would close.

Mike Rumbles: You accept the fact that there is a public health argument. We are talking about saving lives, but we are also talking about some of your smaller clubs closing. I know that you are here to protect the interests of your members, but how do you balance the economic argument and the public health argument? You have just told us that you are involved with claims for your members against the Government on public health grounds.

15:45

George Ross: For your information, I am a non-smoker, but I understand that it is about the freedom of the individual to smoke or not to smoke. That is what the Government said, regarding our pensions appeal tribunals. It is the individual’s choice whether to smoke or not to smoke. Those individuals who smoke need not go to clubs; I am sure that they can go somewhere else to find what they are after, but if they cannot, that is discrimination against the smoker.

More important—I referred to hard drugs being taken—smoking is taking a drug. The Government and the law are moving in and closing the ring on the suppliers. The newsagents and shops, including Tesco, that are supplying cigarettes are supplying drugs. It is exactly the same—there is
no getting away from it. Smoking is taking a drug.

The Convener: One or two members have indicated that they want to ask questions. This always happens: for 15 minutes, nobody wants to ask a question and then everybody wants to ask questions at once.

Mrs Milne: The last time I was in a British Legion club, the atmosphere was extremely smoky and I was not aware of there being ventilation. Do you know how many of your clubs have ventilation, either efficient or otherwise? If, as is proposed in England, ventilation were to become compulsory, how would that impact on your clubs? You have said that a ban would result in some of them closing. What would be the impact on your clubs of their having to provide adequate ventilation?

George Ross: Several clubs in Edinburgh and the Lothians, including the one in Broughton Street, have ventilation systems. The one in Bridge of Weir, near Glasgow, has a ventilation system. Those clubs are successful. You must remember that the club is brought about by the primary unit, or branch. Moneys that are raised from trading for profit within the club are transferred over and go into the branch funds. Our branch is charitable, and we cannot spend that charitable money on the upkeep of the premises of our branch club. The money that is raised becomes charitable money and we can use it only for charitable purposes. It is as simple as that.

Recently, I spoke to the Office of the Scottish Charity Regulator, the new body that has taken over from the Inland Revenue regarding charities. We talked about installing ventilation and a disabled toilet. We discussed the issue with OSCR and the Inland Revenue. It may be that, within the premises, we can install ventilation for the health and safety of employees and those members of the ex-service community who use the premises for benevolent and welfare purposes. That is the only way that we can get round the rules. However, some of our small branches and branch clubs may close because they have insufficient funds. With all the good will in the world, they are transferring the money from the branch club to the branch, and it can be used only for charitable purposes. They cannot spend it on their premises.

Mr McNeil: You have mentioned your experience of challenging employers—the Ministry of Defence or whatever—about their duty of care to service personnel. How seriously do you take your duty of care to your employees who work in the clubs? What choice have they got about working in that hazardous environment?

George Ross: The majority of employees of Royal British Legion Scotland branch clubs will likely be smokers. Obviously, a time may come when clubs—although I do not know which ones—might have employees who do not smoke.

I am not really in a position to answer your question. However, before any employer takes on any employee, they must surely ask, “Do you smoke or not?”

The Convener: It is probably worth remembering that the bill is not being brought in under health and safety or staffing rules.

George Ross: I understand.

The Convener: It was a valid question, but I do not want us to go too far down that road.

Mr McNeil: You mentioned a straw poll that you took the time to carry out, and you said that you had no figures. Did you carry out a straw poll to establish how many of the people working in the clubs smoke? Did you carry out a straw poll to establish what percentage of your members smoke?

George Ross: All I can say is that we are trying to modernise the Royal British Legion Scotland and bring it into the 21st century. You have to realise that the clubs and branches came about after two world wars and that most of our members are of the older generation. We have very few members of the younger generation, but we are seeking to modernise our clubs.

When I say “modernise our clubs”, I mean that I would rather have 10 first-class buildings with all the necessary community facilities—such as crèches, computer networks and pool tables—than have 80 stinking clubs that are full of sawdust and dirty water. We want to take out the old dirty water, throw out the old accordion, and bring in Bacardi Breezers and karaoke. That is modernising. That is moving into the 21st century. However, it takes time to do that. I cannot give you figures, sir, but it takes time. We are in the process of modernising. The legion is a very big beast. It is slow moving and we have to keep kicking it until it moves. It will move, but until then we have to educate it.

I do not think that I have answered your question, but I am asking you to give us time—we are trying to modernise. However, I feel that bringing in a complete ban, all at once, is provocative and is against my members.

Helen Eadie: You have told us about your total membership and you have told us that you held a small consultation exercise. Did you circulate a questionnaire?

George Ross: Yes, it was a formal survey. I kept it to our Edinburgh and Lothians and Glasgow and western counties areas. However, I intend to expand the survey nationally. We have just completed a survey of our declining membership
and a survey of our clubs with disabled access and facilities.

We are being hit. Licensing legislation is being changed, health and safety considerations are coming in, and now we have legislation on smoking. Those will all lead to big objectives. Reaching those objectives will not come about by itself—we will have to generate money, and that money is not available.

Helen Eadie: You are saying that you sent out a questionnaire on a range of issues. Is that right?

George Ross: Yes.

Helen Eadie: So it was not only on smoking.

George Ross: No.

Helen Eadie: But questions on smoking were included among other questions.

George Ross: Yes.

Helen Eadie: Could you give the committee clerk a copy of your questionnaire?

George Ross: Certainly.

The Convener: We would be grateful if you could send that to us.

Helen Eadie: How many copies of the questionnaire did you circulate?

George Ross: We circulated it with the Scottish Legion News to approximately 60,000 members.

Helen Eadie: What was the percentage rate of return?

George Ross: In the two areas where we carried out the survey, the percentage of people looking for a complete ban was 20 per cent.

Helen Eadie: But how many people returned the questionnaire?

George Ross: I think that 54 per cent of people returned it.

Helen Eadie: How many members do you have in the Edinburgh and Lothians area?

George Ross: I am sorry, I do not have the figures in front of me.

The Convener: Thank you for your attendance and for the evidence that you have given to us. Feel free to provide us in writing with the information that we have requested and other points that occur to you and that you wish you had made. We still have a couple of weeks in which to produce a draft report on the bill.

I suspend the meeting until 4 o’clock, to allow members a brief break before we hear from the third panel of witnesses.
ACPOS is broadly supportive of the bill’s aims, but we are interested in enforcement and the work that might fall the way of the police in Scotland.

The Convener: In this section of our evidence taking we are, of course, concerned principally with enforcement issues.

Helen Eadie: The written submission from the Royal Environmental Health Institute of Scotland states:

“should smoking on public transport become an offence the issues surrounding compliance on cross border ... public transport will require to be addressed.”

Will you enlarge on that issue?

Keith McNamara: We understand that the proposed ban in England will not take effect until 2006, whereas the bill will come into force before that. That time lag means that there will be an issue with cross-border travel.

We are also unclear whether the proposed ban in England and Wales will extend to public transport. We could have a scenario in which people can smoke on a bus while it is in England but it is illegal for them to do so as soon as the bus crosses the border. That is the type of issue to which we are referring.

Helen Eadie: Do you propose any solutions to address that issue?

Keith McNamara: We would need to work with the travel organisations. As the bus crossed the border, people would need to be told to stub out their cigarettes. That might be the best solution that we can offer.

Helen Eadie: Finally, your written submission states:

“The Institute believes that clear and unequivocal definitions must be provided”.

Will you expand on your concerns about the definitional issues?

Keith McNamara: Yes. Since we made our submission, the draft regulations that define which premises would be included in the ban and which would not have been issued. Those regulations, which came out last week, have gone a considerable way towards resolving that issue. As enforcement officers, we need to know which premises would be covered by the ban and which would not. In many respects, time has solved that problem for us.

Helen Eadie: What sharing of knowledge about definitions have you had with colleagues from Ireland?

Keith McNamara: One of the speakers at last year’s annual conference was an officer who enforces the ban in Ireland. We have regular contact with my counterpart in Ireland, who is the chairman of the Environmental Health Institute of Scotland. In fact, I spoke to her on the phone before I came to the Parliament; our contact is frequent.

Helen Eadie: Have your colleagues in Ireland given you any pointers about the definitions that have caused difficulties over there? We heard about such difficulties during our evidence gathering. Have you been alerted to them?

Keith McNamara: They have raised several matters with us, but they have not identified definitions as being a problem.

Helen Eadie: Will you tell us about some of the issues that have been raised with you?

Keith McNamara: Our colleagues in Ireland have stressed the need for us to get in our promotion before we introduce the ban. Believe it or not, the ban in Ireland seems to have been widely accepted. That is largely thanks to a major promotional campaign by central Government and because local people who work on the ground visited premises to provide information and an opportunity to ask questions on a one-to-one basis.

One issue that was raised was having to deal with noise disturbance outside premises, but our Irish colleagues said that that was not too much of a problem. There had been a concern that people who went outside for a fly smoke could create a disturbance, but apparently that has not been a problem. Businesses have tried to overcome the ban, for example by setting up beer gardens with open sides. When people congregate in such an environment, it can cause a noise disturbance. Litter has also been mentioned. If more people stand outside premises, there will be more cigarette-related litter. In Ireland, that was not picked up on. Our Irish colleagues feel that that is one lesson to be learned. They would advise anyone else to take that issue into account.

Mr McNeil: Much of the evidence tells us that 70 per cent of people do not smoke. What are the challenges for enforcement? It is estimated that Shona Robison has 21,000 smokers in her constituency. How can we deal with that? How do we get the nearly 40 per cent of people who smoke to comply?

Gordon Greenhill: We start from the premise that most Scots are law abiding and that, if a law is introduced, they will comply with the terms of the act. That has been the experience with other new legislation that the Scottish Executive has brought in, such as that relating to the issuing of fixed-penalty notices for littering. About 90 per cent of the fixed-penalty fines that are imposed are paid, because people accept that they have done something wrong. From the Irish experience and from our experience of serving fixed-penalty
notices, we assume that if someone is asked to put out their cigarette or is issued with a fixed-penalty notice, they will accept that. The fact that someone is smoking does not make them a hardened criminal; they will be breaking the law but, once people in this country know what the law is, the majority of them will comply with it.

Alan McKeown: It is important to remember that we are not banning smoking; we are just banning smoking in public places.

Mr McNeil: It is estimated that there are 21,000 smokers in Shona Robison’s constituency, so we are talking about a significant problem. Many of those people will want to smoke in public places.

I will take my point a bit further by considering the estimated cost of the ban. In the Dundee City Council area, which covers both Dundee constituencies, it is estimated that there are 40,000 smokers. The council there estimates that the ban will cost £95,000. The number of smokers in Inverclyde, which is a much smaller area, is estimated to be 17,000, but Inverclyde Council says that the ban will cost £140,000. How seriously can we take the information that we have about preparations for the anticipated implementation of the ban when so much of it is questionable?

Alan McKeown: A number of councils went through their information quite rigorously. There was not a set template; we wrote to councils based on the papers that we had. We heavily qualified our evidence to the Finance Committee by saying that we would go back and re-examine the information once we had the draft regulations. We now have them, so we will go back and re-examine the information. We might consider defining some headings under which every council will do similar things. There is no question about the need to tighten up the costs, and we have not tried to hide from that. We have worked out a cost of £6 million for this year and next year to make—

Mr McNeil: Did you submit that evidence on the basis that we should take it seriously?

Alan McKeown: Yes, indeed.

Mr McNeil: Are you now saying that we should not take it seriously?

Alan McKeown: No, we are saying that the evidence was submitted on the basis of the information that was available to us at the time, which was incomplete because the draft regulations did not exist. We now have the draft regulations, so we will go back to our members and clarify the costs.

Gordon Greenhill: There will be two elements to enforcement of the bill. In Edinburgh, the City of Edinburgh Council enforces health and safety legislation in 17,000 premises, so we will go into those premises, say “This is a no-smoking area. You have to have signs up here,” and give advice to the owner of the premises. The bill will give us responsibility for another 3,000 premises that the Health and Safety Executive currently regulates, so visits to those premises will be an additional burden.

The second element is officers enforcing the law where breaches are taking place. We will need a small number of officers to do the in-your-face enforcement and a small number to get round premises to ensure that they comply with the legislation.

Mr McNeil: How many visits can an establishment that you regulate expect in a year or two years?

Gordon Greenhill: We visit all the 17,000 premises in a five-year cycle, but it is not as simple as all 17,000 premises being visited once every five years; there is a different inspection rate for different types of premises. There are different categories of risk, so we visit the high-risk premises every year and the medium-risk premises every two years, but we would visit a corner shop only once every five years. We are probably talking about 25,000 inspections being done in a five-year period.

Mr McNeil: So enforcing the bill would be a significant challenge for you.

Gordon Greenhill: No. We would not be doing full health and safety inspections; we would visit only to check that the no-smoking provisions were in place, so the inspections would be quick.

Mr McNeil: Would you just be checking that the premises had signs up?

Gordon Greenhill: It would be more than a matter of signs. We would check that there was no evidence of smoking paraphernalia.

Mr McNeil: No ashtrays.

Gordon Greenhill: Aye—no ashtrays, cigarette burns or other stuff like that.

Mr McNeil: So you do not plan on going into premises at weekends to do spot checks.

Gordon Greenhill: Yes, we do. Most councils have plans to cover the evening and early hours of the morning. It would be naive to say that we would have any impact on smoking in pubs if enforcement were to take place only during the daytime.

The Convener: We went to Ireland for three days to speak to, among others, representatives of the Health Service Executive, western area, who talked about the need for clear overtime allocations and which activities resulted in real
on overtime spending. They also talked about there being a concomitant 20 per cent decrease in their food control activities as a result of the increased activity that they were having to undertake because of the introduction of the ban. Have you considered that aspect of the bill’s impact on your work?

Gordon Greenhill: That is a good question, and the answer to it is yes. The last thing that we want is for the bill to have a negative impact on food safety in Scotland, because we have a large number of tourists and a large number of people who go out to wine and dine. There will be no impact on food inspection regimes throughout Scotland if the bill is properly funded when it becomes an act.

The Convener: There will be no impact if the resources are in place.

Gordon Greenhill: Absolutely.

The Convener: So you would try to avoid replicating the situation in Galway, where food control activities have decreased by 20 per cent.

Gordon Greenhill: Absolutely. Implementation of the bill’s provisions on smoking will have no effect on the food hygiene inspections in Scotland if the funding is available.

Dr Turner: I address my questions to Deputy Chief Constable Mellor. There has been a hint that, because people will be forced out of pubs and on to the streets, the police might be busier on the streets. Will you comment on that? It seems from your evidence that you do not expect to be much involved in enforcing the bill, because others will do that. Do you expect problems?

16:15

David Mellor: The law of unintended consequences could apply. Certainly there would be concern about the safety of women and others who fall into more vulnerable categories when they are smoking outside pubs and clubs. Given that we want to prevent crime, there would be concern if people were more exposed to crime and vulnerability by being outside public houses and clubs late at night in circumstances in which there might be a reasonable fear of violence or attack. We will have to keep an eye on that and log it, and make it part of our patrol strategy, to ensure that we address the fact that people are more vulnerable if they are outside premises smoking.

On your second point, we expect our involvement in enforcement to be fairly insignificant. Over the years, we have worked closely with environmental health officers on a range of issues. Clearly, we would be entirely prepared to support environmental health staff, because one can imagine that public order situations might arise. I read with interest about the mass non-compliance campaign at Fibber Magee’s pub in Galway. It would not be surprising for the police to take an interest in such issues.

We are interested to hear what the environmental health staff’s enforcement strategy will be. If it is based on gathering evidence via observation, then going back and confronting people at a later time, that would be less likely to create friction and public order situations, and so it would be less likely that the police would be involved. We support that particular enforcement strategy.

The Convener: I have a follow-up question. I do not know whether this was suggested to other MSPs, but I was invited to hold local surgeries on the smoking ban in licensed premises, and I dutifully did so. A concern that was raised is that, in areas where there is a problem with drugs, it will be much harder for those who run licensed premises to keep an eye on what is happening, because there will constantly be people hanging around outside, so they will not be able to control what happens outside, for example if transactions are taking place. Has that registered on your radar?

David Mellor: It has not. It is an interesting theory. You are saying that people will be coming and going and hanging around outside, which will provide cover for those who are involved in illicit drug dealing and supply. That has not registered with us, but it is an interesting point. Our drugs enforcement staff would take that into account, but we tend to operate on the basis of accumulating evidence carefully by observation or through the use of closed-circuit television and so on. It would be possible to use that evidence to negate someone’s defence if they said, “I was not supplying drugs. I was just outside having a quick smoke.” It is an interesting point, to which we need to pay attention.

The Convener: Does any committee member want to come in specifically on the evidence from the police?

Janis Hughes: I have a question not on the police evidence, but on the displacement of people outside premises. In Ireland, we learned about a large increase in applications to councils for tables and chairs outside licensed premises, particularly in pedestrianised, city-centre areas. Does COSLA expect a rise in such applications? People will want to smoke all year round, so we will experience that situation all year long, not just in the summer, as we do now.

Gordon Greenhill: There is no medical evidence on passive smoking in the open air, so we would welcome that situation. On the issue of applications for licences for beer gardens and so
on, there will probably be a lot of joiners running about putting up gazebos at the back of licensed premises, which is fine, as long as it is done in a properly controlled manner. The many beer gardens that exist in built-up areas do not give cause for concern, as long as they are managed properly.

Janis Hughes: I was thinking more about the issues for councils, who will have to deal with the rise in the number of applications for licences for beer gardens. We heard evidence that people who want to go into business in Ireland should start selling outdoor heaters, which are in high demand. You mentioned gazebos, which might be another idea. In city-centre areas, many premises will probably apply for a licence to have tables and chairs outside, which people will use all year round until fairly late at night. How will that affect those areas?

The Convener: Before the witnesses answer, I refer to our experience in Ireland, where there was evidence that pubs, particularly city-centre pubs, that had no space at the back were renting pavement space at the front from councils, even for just a couple of tables. Will councils take a similar approach here?

Alan McKeown: We must discuss that in the various political groupings in COSLA. The issue is being considered by our health improvement committee and environment committee. We need to take the issue to the planning committee, now that we know exactly what is to be done. Because the measures will cut across all those functions, we must ensure that we take a strategic approach to applications, rather than deal with them one by one. We will take a report to the council leaders as the bill goes through Parliament and our views become more sophisticated. However, we will take a strategic approach rather than a piecemeal one.

Mike Rumbles: The Royal Environmental Health Institute of Scotland’s written submission raises the issue of officers “serving Fixed Penalty Notices in potentially dangerous situations.”

The committee’s experience of enforcement of the ban in Ireland was interesting. We were constantly told that the success of enforcement was linked to the non-confrontational approach and that the ban was largely self-policing. As part 1 of the bill does, the ban in Ireland focuses on the offence of permitting others to smoke in no-smoking premises. Basically, we will focus on the landlord or manager of the premises. To give some anecdotal evidence, when we were doing our research in Galway, someone started to light up and was put out of the pub by the manager like lintie—we hardly noticed it. The focus is on management ensuring that the law is obeyed.

Surely you do not envisage environmental health officers and police officers going round the pubs issuing fixed-penalty notices to anybody they spot smoking. Surely, as in Ireland, the focus will be on a self-policing approach and on enforcing the ban through the managers of premises.

Keith McNamara: You are absolutely spot on. We flagged up the issue because people might see the fixed-penalty notice as the first means of taking action against individuals, whereas there will be a basket of measures that can be applied appropriately. You are right that we need to focus on managers and to deal with issues proactively to target resources in the most effective way. If we went to premises and took action against an individual smoker on one night and then the next night went back and dealt with another individual smoker, that would not be an effective use of resources. Taking action via the management is in line with the general principle that we apply in environmental health, which is that we take action against the person who has the premises and who controls the risks. The same is true of licensing law—the person who has control of the premises has the major responsibility.

We have spoken to our colleagues in Ireland about the issue, who say that they would take action against an individual who was being deliberately obstructive or obstreperous. We need to have enforcement powers against individuals, but we hope that they will be used rarely. The proactive enforcement in Ireland and the fact that enforcement has been taken up by the trade there are examples of good practice.

Alan McKeown: We take a slightly different view. The law is the law and if its integrity is to be protected, it must be enforced. We accept that a mature and sensible approach should be taken throughout, but if the law is to be successful, it has to be implemented.

The Convener: Will you clarify that you will go after individual smokers as opposed to licensees?

Gordon Greenhill: There are two elements. The licensee must take every possible step: they must have signs up, there must be no ashtrays and they must explain the new law to their clientele. The Royal Environmental Health Institute of Scotland is absolutely right; initially, we as an enforcing body would ensure that all those elements were in place. I assume that this august body will do an extensive education and publicity campaign, so that people know what is what.

However, because of the way in which the bill is written, there is no option. If someone is smoking at premises after that education has been done and the implementation date has passed, the only option will be to issue an immediate fixed-penalty notice, which is an effective measure. The Scottish Executive has gradually introduced fixed penalties
and decriminalised things. People are not criminals if they smoke or drop litter, although they are not in keeping with the rest of society. You have introduced those pieces of legislation, and that is what this law before us says. It says—

The Convener: To clarify, we have not introduced this piece of legislation. We are in the process of gathering evidence on it to establish whether there are things in it on which we wish to comment. If there is a slight difference on the issue, it is important that we know about that.

Gordon Greenhill: What you have put out for consultation will be good legislation because it is clear. There is no vagueness and there are no grey areas. If the person who is in charge of the public house, licensed club, shopping mall or something has put in place the proper management procedures, the problem will come down to the individual who is contravening the legislation.

David Mellor: Although we do not expect to play anything other than a peripheral role in enforcement, one thing that police officers learn early on is the importance of discretion. The law does not have to be enforced there and then in all cases; it is possible to enforce it by taking action after the event. One has to balance a whole range of issues, including the danger to public order and the risk of making the situation worse. We need a degree of common sense and discretion, although when I heard the comments that were made earlier, I was quite interested in the idea of posting officers on the border to capture people as they come over on buses.

Mrs Milne: Mr McNamara, you say in your written evidence that the Scientific Committee on Tobacco and Health’s report

"concluded that ETS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to”.

I assume that you accept that there are risks associated with ETS. Do you also accept that children and infants are not likely to be harmed in pubs but that if ETS goes into the home because people smoke there instead of going to pubs, infants and children will be at greater risk as a result of the bill?

Keith McNamara: It is a matter of individual discretion and choice. If I take my child out to a restaurant for a meal, I do not want her to be subjected to ETS. If people choose to smoke in front of their children at home, that is their individual choice.

Mrs Milne: Your submission says that a "high profile media campaign" should precede the introduction of any legislation. The people in Ireland also made that point to us. Given that the provisions in the bill are supposed to come into effect in a year’s time, is there enough time for such a campaign to be run?

Keith McNamara: I would say so, but we need to start planning it now. Gordon Greenhill and I have had discussions about various aspects of the bill, but COSLA, the Society of Chief Officers of Environmental Health in Scotland and the Royal Environmental Health Institute of Scotland need to work closely to assist with the promotional campaign.

Mrs Milne: My impression is that there was a longer run-in period in Ireland.

The Irish said that the definition of closed or non-enclosed spaces caused them problems with enforcing the ban. For example, people constructed shelters that were all but enclosed. Do you have any views on that?

16:30

Keith McNamara: Yes. As I understand it, in Ireland, a space was not enclosed if less than 50 per cent of the enclosure was within walls. However, in Scotland, the recently issued draft regulations stipulate that a space is enclosed if the only openable elements are the doors and windows. It does not matter whether the Irish system or the system that is outlined in the draft regulations is introduced; businesses will still try to get round it by erecting marquees, tents, gazebos, beer gardens and so on.

Mrs Milne: I am sure that they will find ingenious ways of getting round the regulations.

My last question is for Gordon Greenhill. Would you have to recruit additional environmental health officers to enforce the legislation? If so, would that be a problem? I understand that it is quite difficult to recruit qualified EHOs. Indeed, one source of recruitment has been Ireland; I wonder whether that source is likely to dry up now that the Irish are enforcing their legislation.

Gordon Greenhill: Six Irish EHOs are working for me in Edinburgh, and they are very good.

There are problems with recruiting and retaining EHOs in Scotland. We are actively discussing with the Executive and the society ways in which we can speed up training, but we will not overcome those problems in the time span that we are talking about. It takes four years for someone to qualify as an EHO, after which they must undertake a year’s practical training and sit their chartered exams. The situation will not be cured overnight.

I do not think that the sort of enforcement that we are talking about will require an environmental health officer. We will be able to use what is called an enforcement officer. Many people meet that standard of qualification; for example, 12 ex-police
officers work in my department and they are very effective at enforcement.

The Convener: I suppose that they have a bit of experience in that respect.

Shona Robison: I am sorry to go back a step, but I think that we are beginning to uncover something quite important. I simply want to be clear in my own mind.

The panel members appear to disagree about enforcement. Earlier, when David Mellor said that it would be better to carry out enforcement post-event, Gordon Greenhill shook his head; I see that he is doing it again now. I want to explore the difference of opinion on this matter and on the question whether we need a lighter touch and more self-policing. The witnesses seem to have different interpretations of what the bill will mean, and we need to clear up any misunderstandings or have some clarity that will allow us to put those differences of opinion to the Executive. Will you help us by identifying where the difference of interpretation lies?

Keith McNamara: I am not sure that there is any disagreement. We do not have any problems with issuing fixed penalty notices. However, as a line manager, I could not ask two officers—who, at that stage, would have no police support—to put themselves in danger by issuing a notice some Saturday night in a pub full of people with a few drinks in them. I should say that, in my career, we have always had the best of police support in tense situations. I need to make that differentiation from the perspective of my staff's health and safety. That said, I do not object to the principle of issuing fixed penalty notices to individuals.

Shona Robison: Do you disagree with that, Mr Greenhill?

Gordon Greenhill: Yes. I would expect my staff to issue fixed penalty notices. They do so already—what else can they do if a Rottweiler fouls in the middle of a public park? More than 3,000 fixed penalty notices have been issued in Edinburgh, all of which have been paid. No one has given Donald Duck as their name and, when a situation has arisen, the police have been fantastic.

The Convener: I suggest that issuing fixed penalty notices to individuals on a Friday or Saturday night in a busy pub is a very different matter. Have you thought through the implications of what you are saying?

Gordon Greenhill: Absolutely. I agree with you entirely. All our officers are trained to use a hefty dose of common sense. They would walk away from a situation of the sort that has been described or call the requisite back-up. However, if people in a public house persist in lighting up after the ban has been in place for six months and we have spoken to the licensee and the clientele a number of times, should we walk away?

Shona Robison: Surely in such a situation action would be taken against the managers of the premises for permitting smoking to take place there. Would you not threaten them with action if they continued to allow smoking? That is the approach that has been successful in Ireland. However, you seem to want to tackle the problem more from the point of view of individuals. I am not sure why that is the case.

Gordon Greenhill: Our approach is based on our experience of the existing fixed penalties. As I have said, the public are law abiding. I do not disagree that, if the managers have done everything that they can, we would expect them to enforce the ban. However, the bill as drafted makes smoking in enclosed public places an absolute offence. You need to revisit that phraseology.

Mike Rumbles: I do not think that we need to revisit the terminology, which is absolutely clear. Section 1 is entitled “Offence of permitting others to smoke in no-smoking premises”. That is the focus of the bill. It also creates an offence of smoking in banned premises. The bill is quite clear. The committee's experience is that the ban in Ireland has been successful because the emphasis of enforcement has been on management allowing people to smoke. If you pursued an individual in the way that you seem to be outlining, would you not end up with what David Mellor suggested—a greater issue of public safety and disturbance? I may be reading the bill wrongly, but surely it is written in such a way as to ensure that management is tackled first and foremost. Is that not the issue on which we must focus?

Gordon Greenhill: I agree. You are saying that the emphasis is on the owner, licensee or shopping mall contractor to have in place management systems to ensure that people do not smoke. That is fundamental. However, ultimately there is an offence if people persistently flout the law.

Mike Rumbles: Yes, but the approach that is taken in Ireland is to issue a penalty notice to the licensee on the following day or to threaten action if he persists in allowing people to smoke on his premises. Action is not necessarily taken against the individual smoker. That is the right way of dealing with the problem. I believe that our bill is framed in the same terms. If I have misunderstood it, we need to sort that out.

Alan McKeown: Whenever we discussed the framing of the legislation, there was a debate about whether the onus should be solely on the
licensee or whether it should be on individuals, too. We are debating how far we should go down the road of placing responsibility on individuals. We would expect the licensee to exercise due diligence. Indeed, the licensing committee should put management systems in place to ensure that licensees put up signage and that their door staff give information to clients as they come in, go round the bar to remind people of the ban and catch them before they start smoking. If all that is done and is seen to be done, but there is a persistent offender, the only way of dealing with their behaviour under the legislation is to fine them.

We take your point about the need to deal with inflammatory situations outwith the immediate environment, so that there is no threat to the environmental health officer and the rest of the clientele in the bar. As Gordon Greenhill said, that is where a hefty dose of common sense comes in. We need to find a mechanism for dealing with such situations without creating conflict in the bar.

Mike Rumbles: I would like to have one more shot at this issue. I do not want sets of officers, uniformed or not, to go round pubs and clubs in Scotland issuing fixed penalty notices to people who are smoking. That is not the right way in which to approach the bill.

Gordon Greenhill: I agree; that is not the concept that I am trying to get across. We have always worked well with the licensed trade and publicans. Let us be honest: the nub of the problem will be in pubs and clubs. If the bill is to be implemented properly, we will ultimately have to tackle what we call the refuseniks. We will probably do that jointly with the police. A hard-core element of people will flout the law and we will have to issue those people with fixed penalty notices.

The Convener: You can understand our concern.

Mr McNeil: Surely the appropriate response of the licensee or publican to someone who insisted on lighting up would be to ask them to leave the premises.


Mr McNeil: If a licensee did not ask the person to leave, or did not eject them from the premises, the focus would be on that licensee.

Alan McKeown: Yes. That would have to be considered. We do not dispute that.

David Mellor: From a policing point of view, we do not agree with the “in-your-face enforcement” strategy that Gordon Greenhill talked about. We are talking about how we solve a problem and the bill offers one way of doing that. Another way is through publicity campaigns, for example. When we try to solve a problem, it is helpful to have the back-up of positive legislation, which we should use judiciously when we need to do so. I will give a parochial example: if we were in consultation with environmental health officers in Fife about a strategy for enforcing the bill, we would have to take a problem-solving rather than a confrontational approach.

The Convener: If no members have further specific questions, I will release the witnesses. You are probably sitting there thinking, “Please release us”. You are free to go.

I welcome the witnesses from ASH Scotland: Dr Rachel Harrison is senior policy and research officer; and Sheila Duffy is head of information and communications. I invite one of the witnesses to give a brief introductory statement.

Sheila Duffy (ASH Scotland): We thank the committee for inviting us to give evidence. ASH Scotland welcomes the bill and the opportunity that it represents to address a known health hazard in Scotland.

We take issue with the statement that was made earlier that the evidence on second-hand smoke is largely epidemiological. There is good medical evidence that second-hand smoke, as a known carcinogen, increases the risk of lung cancer, heart disease and complications during pregnancy and poses particular health risks to children and infants.

Since the committee last took evidence on the health impacts of second-hand smoke—

16:45

The Convener: Ms Duffy, you must speak into the microphone. We are having difficulty hearing you at this end of the room.

Sheila Duffy: My apologies.

I was emphasising that the debate is about health. Second-hand smoke is a toxic substance that threatens the health of smokers and non-smokers, and it is preventable.

Ventilation is not a solution to the problem of second-hand smoke, as it cannot effectively clean the air of toxic gases and particles. We believe that people have misrepresented the research by Dr Geens, which compared a pub with ventilation in which smoking was allowed with a smoke-free pub. His research showed that, even with ventilation, particulate levels in the smoking pub were three to 10 times higher, but the measurements were presented in a graph in which the axes differed by a factor of 10 to make it look as if they were the same. There is no known safe level of exposure to second-hand smoke.

Voluntary approaches have been tried in
Scotland but, in line with experience elsewhere, they have failed to increase protection. The Scottish Licensed Trade Association’s proposed five-point plan lacks an evidence base. Such partial policies are costly and, by delaying effective protection, they lead to increases in health inequalities. Comprehensive legislation, such as the proposal in the bill, is the fairest and most effective way forward. Ending smoking in enclosed public places and communicating effectively why such a step is being taken will not only reduce the burden of health and economic inequalities that tobacco places on our most vulnerable communities, but create positive environments for our children and support the majority of smokers who want to stop smoking. We believe that the majority of Scots will welcome the measure.

The Convener: In our evidence taking on a previous bill, we heard evidence that covered most of the public health arguments in respect of environmental tobacco smoke. In this part of the meeting, we will concentrate on any new health evidence that has emerged subsequently rather than go over the same evidence. The SLTA said that there was new evidence, so we want to give ASH Scotland the opportunity to respond to that.

Shona Robison: There is so much information and so many statistics and different interpretations of the same studies that the subject can, in some respects, become almost impenetrable. Both the SLTA and the Tobacco Manufacturers Association said robustly that there was no evidence to suggest that ventilation did not work. They questioned the source of research that made such a suggestion. For our benefit, will you clarify whether such research is independent, where it comes from and when it was produced?

Dr Rachel Harrison (ASH Scotland): A whole host of independent research on ventilation has been conducted. The SLTA likes to respond to the research that was conducted by Dr Geens of the University of Glamorgan, but we know that that was not an independent study. Our submission refers to research by ventilation experts such as Professor Repace, who is based in the States. He refers to research by ventilation experts such as University of Glamorgan, but we know that that has been conducted. The SLTA likes to respond to the host of independent research on ventilation has produced a huge amount of valuable and robust evidence that show s that ventilation simply does not work because it does not remove the carcinogenic aspects from the air. Ventilation is not a suitable outcome measure for reducing the health hazards that are associated with exposure to second-hand smoke.

Shona Robison: Are the five references in your written submission all to independent research?

Dr Harrison: Yes.

Mike Rumbles: I wanted to put this question to the Tobacco Manufacturers Association, but we ran out of time. The association took exactly the opposite view from ASH, although it appeared to be in denial of the scientific evidence.

In what year did the Tobacco Manufacturers Association—or its predecessors.recognise that smoking, as opposed to environmental tobacco smoke, causes deaths? The association opposed the scientific evidence for many years, but I understand that it had to accept it eventually. It strikes me that it is now in the same position in opposing the scientific evidence on environmental tobacco smoke. Do you know when it eventually accepted the scientific evidence on smoking? An answer to that question might be helpful. Sheila Duffy: I do not know whether there is full acceptance in the tobacco industry of the fact that there is a link between active smoking and lung cancer. Even nowadays, Imperial Tobacco gives evidence in court casting doubt on such a link.

Mike Rumbles: The new evidence that the University of Glasgow published in November suggests that up to 2,000 deaths per year in Scotland are related to the ETS exposure of non-smokers—that is, lifelong non-smokers or quitters. As far as you are aware, is that research robust?

Dr Harrison: As far as we are aware, it is. It might be useful to draw the committee’s attention to a newer study, which has been published since we submitted our evidence. The study, which was published recently in the British Medical Journal, says that exposure to second-hand smoke kills more than 11,000 people a year in the United Kingdom. That figure is much higher than it was previously thought to be. The first available figure for people who die as a result of exposure to second-hand smoke in the workplace is given as 600 a year. That figure is very much in line with recent research that was conducted by David Hole, which suggests that approximately 1,000 Scots die every year as a result of second-hand smoke.

Mr McNeil: Does that figure relate to smoking in public places?

Dr Harrison: There are specific figures for exposure to second-hand smoke—

Mr McNeil: On the 1,000 deaths and second-hand smoking in public places, is there a direct—

Dr Harrison: The study does not specifically talk about enclosed public places.

Mr McNeil: Then why is it relevant?

Dr Harrison: It gives a comparison point that is useful to have when one is working with estimates.

Mr McNeil: For the purposes of the argument, we criticised the tobacco lobby earlier for misusing or selectively using statistics. Have you, too, not just done that?
Dr Harrison: I would not go as far as to say that I have. It is useful to consider estimates and studies that are based on estimates in the context of other research that has been conducted, including large-scale research studies such as those that have been done by the World Health Organisation, the International Agency for Research on cancer and the Scientific Committee on Tobacco and Health. When such things are considered in the context of wider research evidence, it is clear that second-hand smoke kills.

Mr McNeil: But what you say is related to the level of exposure to second-hand smoke.

Dr Harrison: Yes.

Dr Turner: Earlier, I tried to point out that blood test studies in New York have proved that breakdown products of nicotine are diminishing in the bloodstream of people who work in premises in which there has been a smoking ban and that such products were proving to be a good indicator. Do you agree?

Sheila Duffy: Yes. There was a huge drop in the cotinine levels of non-smoking bar staff in New York—I think that the figure was 85 per cent.

Dr Turner: Are such studies worth while, or are there other indicators that are easier to measure?

Sheila Duffy: Cotinine is a good indicator of exposure to tobacco smoke.

Dr Turner: Is it a better indicator than carbon monoxide?

Sheila Duffy: Measuring carbon monoxide can work for short-term exposure.

Dr Turner: Did you clarify whether the Geens study proved that the pub that had a ban had better air than the pub that did not have a ban, if like was compared with like on the correct graphs? Forgive me if you have clarified that matter.

Sheila Duffy: It did, despite being located in the city centre next to Queen Street station and major roads.

Dr Turner: It is good to have that clarified.

Mrs Milne: I have a question about enforcement and implementation. You have referred to high compliance rates in Ireland. When we were in Ireland, people were at pains to say that there was a very long run-in to the legislation. Public opinion was carried along with the promotional campaign, so that by the time the legislation was implemented, the public were ready for the legislation and it was timely. People also said that they had been able to get unions and other organisations on board because the ban was introduced in Ireland as a health and safety at work measure. Obviously, we cannot do that here, because health and safety is a reserved matter. Given that the bill is due to come into force next year, is there enough time for the Scottish public to be brought on board to the same level as the Irish public were, so that by the time the legislation is enforced people are ready for it and therefore the compliance rate will be high? Do you have any comments on that? I know that I am asking you to speculate.

Sheila Duffy: We might benefit from the validated results that are emerging from the experience of other countries that have introduced legislation, therefore we may not require such a long lead time to reach the same level in Scotland. However, I agree that we have a busy job ahead to communicate why the bill is being considered and, we hope, implemented.

Mrs Milne: But is it possible to do that in a year?

Sheila Duffy: Yes.

Dr Harrison: Public opinion that some action should be taken has been increasing steadily since about 1996, so although some polls suggest otherwise, a large proportion of the public are behind measures being taken.

Mrs Milne: Does “some action” equate to a complete ban with few exceptions, except on humanitarian grounds?

Dr Harrison: I will answer that question with regard to the Scottish Executive’s opinion poll by Market Research UK, which I know has come under scrutiny by the likes of the SLTA, because it demonstrated that there were lower levels of support for legislation that covered pubs than for legislation that covered other places. There are important points to note, the first of which is that the public’s support for a ban in pubs is generally lower than that for a ban in other places, such as restaurants. However, in places where legislation has been introduced, public regard for the legislation has generally continued to grow.

Mrs Milne: Your submission quotes the UK Government advisory committee—the Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment:

“Taking all the supportive data into consideration we conclude that passive smoking in non-smokers exposed over a substantial part of their life is associated with a 10-30% increase in the risk of lung cancer”.

Can you define “a substantial part of their life”?

Dr Harrison: No, because it was not defined in the paper that we looked at to gain that evidence.

Helen Eadie: What do you know about the tobacco company Philip Morris’s attempt to conceal important research that could and should influence Government policy?

Sheila Duffy: We know from documents that have been disclosed in litigation in various places
that the tobacco industry has sought to delay, alter and deny evidence, and to run concerted campaigns to prevent the health evidence from having the obvious effect.

**The Convener:** May I enter a note of caution? I am being reminded that we should be careful where this leads to in terms of privilege.

**Helen Eadie:** I understand that, but I want to ask about litigation in various places.

**The Convener:** Everybody be careful. We do not want to end up in litigation.

**Sheila Duffy:** We have seen evidence in tobacco industry documents of the industry’s own commissioned research being altered following legal advice to remove evidence of harm from smoking.

**Helen Eadie:** Where is litigation taking place or where has it taken place?

**Sheila Duffy:** There has been litigation in America. We can come back to you with further details on that.

**Helen Eadie:** Will you provide details of all the litigation cases of which you are aware?

**Sheila Duffy:** Yes.

**Helen Eadie:** Can you comment on the assertion in your report that second-hand smoke “is more harmful than mainstream smoke”?

**Dr Harrison:** We can provide you with further details on that if you wish.

**Shona Robison:** The SLTA argued that a displacement effect may lead to increased smoking and drinking in the home. Whether or not you accept that, given the trend towards more home drinking because of the availability of cheap alcohol in supermarkets, it is likely that people will drink more at home and therefore there is a danger that people will smoke more at home. Is ASH concerned about that problem and, if so, what measures are required to deal with it?

17:00

**Sheila Duffy:** We have worked for several years with people on low incomes, particularly in areas of deprivation. We are concerned about increased smoking at home because it has obvious impacts through sudden infant death syndrome and respiratory infections among children. It is important that we communicate clearly to people the reason why the bill is under consideration, because people who understand why smoking has ended in enclosed public places in Scotland are unlikely to expose their children to smoke at home.

**Shona Robison:** Must that issue be taken into account in the publicity campaigns that come with the ban?

**Sheila Duffy:** That will be vital. It would also be helpful if some of the disinformation on the issue was robustly refuted in campaigns.

**The Convener:** Do you anticipate that the ban will result in a decline in smoking in the home?

**Sheila Duffy:** The evidence from Australia is that voluntary restrictions increased after legislation on smoking came into place.

**The Convener:** So you anticipate—

**Sheila Duffy:** We anticipate that exposure of children to tobacco smoke at home will decrease if the pattern here follows that in other countries.

**The Convener:** That is what I asked you. Basically, you anticipate a decline in smoking at home.

**Sheila Duffy:** Yes.

**The Convener:** Do you intend to measure that?

**Sheila Duffy:** I believe that the Scottish Executive is considering ways of measuring a baseline.

**Mike Rumbles:** When the committee went to Ireland, we met Sean Power, a minister of state at the Department of Health and Children, who informed us that in 2004 cigarette sales in Ireland decreased by 17 per cent, which led to a decrease of more than €100 million in revenue for the equivalent of the Inland Revenue in Ireland. The evidence is clear that the ban in Ireland has led to a decrease in smoking. It is assumed from the evidence that smoking is decreasing everywhere, but we cannot tell that. To follow up the convener’s question, how can we measure the impact of the ban here? We have heard about the SLTA’s fear that the ban will simply displace smoking, but the evidence from Ireland is that smoking will decrease. The key is how we measure the effects of the ban. Do you have any suggestions as to how the Executive or other organisations can do that?

**Sheila Duffy:** The early indications are encouraging. The number of calls to the smokeline from people expressing an interest in stopping smoking has increased since the discussion about the proposed legislation started. It should be possible to measure the success of smoking cessation services and the number of people who take advantage of the opportunity to stop. Most smokers say that they would like to stop. Beyond that, there is an on-going discussion about measures of the bill’s success, to which we would be happy to contribute.

**Mr McNeil:** Have you done, or do you have available, any research on illegal supply and smuggling of cigarettes and its impact on deprived
communities?

Sheila Duffy: We have done some work on that, which is available on our website. The issue is a big one for certain communities. For tobacco control to work, effective action is required on a number of fronts.

Mr McNeil: Do you have evidence that illegal supply of cigarettes in Ireland has increased? The news today is that the Irish Republican Army has made that a business for itself. Could that be related in any way to the decrease in cigarettes that are sold legally?

Sheila Duffy: There are concerns about large-scale smuggling because it tends to go with other criminal activity. Action has been taken to hold tobacco companies accountable so that they do not collude with large-scale smuggling activity.

Mr McNeil: I am trying to establish that the 15 per cent reduction in sales of tobacco—

Mike Rumbles: It is 17 per cent.

Mr McNeil: Mike Rumbles reminds me that it is a 17 per cent reduction in legal sales of tobacco. Could that be partly due to smuggling of cigarettes?

Sheila Duffy: I am not aware of evidence to that effect.

Dr Harrison: Neither am I.

Mr McNeil: Could the reduction in legal sales not possibly be because of smuggling? Is the reduction caused only by people stopping smoking?

Dr Harrison: We do not have evidence on that.

The Convener: If there was evidence of large-scale black market trading in cigarettes that is not reflected in official figures, would you accept that that would displace over-the-counter trade?

Dr Harrison: Do you mean evidence from Ireland?

The Convener: I mean any evidence. If there was evidence here of a substantial black market in cigarettes it would not register in the figures for the over-the-counter trade.

Sheila Duffy: That is right.

The Convener: There are no further questions, so you are free to go. Thank you very much for coming in to give evidence.

The next witnesses are from the trade union side. I ask the representatives from Unison, the Scottish Trades Union Congress and Amicus to come to the table. Please check that the nameplates in front of you are the right ones—if they are not we will all get confused.

I welcome you to the meeting. Andy Matson is the regional officer from Amicus, Ian Tasker is assistant secretary of the STUC and Dave Watson is head of policy and information at Unison Scotland.

I ask Ian Tasker from the STUC to make a very brief introductory statement—perhaps he can hold the jackets thereafter.

Ian Tasker (Scottish Trades Union Congress): The STUC represents approximately 630,000 members. The proposed legislation on smoking has been discussed at some length within the trade union movement. If the committee had hoped to hear of consensus among the trade unions, I can tell members that that will not happen today. The STUC’s position is that although we broadly support a ban on the basis of the impact on the health of Scottish citizens and workers in general, we have problems with the timescale for implementation.

The Convener: Thank you.

Janis Hughes: I declare an interest as a member of Unison.

I will ask Dave Watson about the evidence that Unison submitted on the role of environmental health officers in enforcement. You probably heard the previous witnesses’ evidence—there was some disagreement about the role of environmental health officers and the role that the police may play in enforcement. Can you comment on the remarks that were made by Mr Greenhill about how he sees environmental health officers working to enforce the legislation?

Dave Watson (Unison Scotland): It is important to say that we represent environmental health staff, so our perspective is probably not a high-level policy one but one that reflects discussions with colleagues who work on the ground. It is important to understand that environmental health staff already enforce fixed penalty tickets in a number of areas including littering, dog fouling, emissions and—soon—domestic noise. The key element for a member of staff who seeks to enforce a fixed penalty on an individual is that they need the name and address of the person. In some cases they also need the date of birth, but in essence the name and address is the key information. The view of our members is that there will be difficulties in enforcement—some of them put it more colourfully than that—and we are not hiding from that.

I will comment on what the committee heard from the witness from the City of Edinburgh Council. Edinburgh has a particularly high enforcement rate for fixed penalty tickets, but that is not the experience throughout Scotland. I do not have the precise figure for the enforcement rate in Glasgow, but I understand that it is significantly lower than the 95 per cent rate—I think that is the
assessments and appropriate mechanisms. We would not allow our members to be placed in high-risk situations and our advice to workers is always that they should back off from such situations. We must acknowledge that there are safety considerations for staff.

I have given a long answer, but there are many enforcement issues in relation to environmental health. We have concerns, although I emphasise that we support the bill and the approach to enforcement.

**The Convener:** You talked about the City of Edinburgh Council’s experience of having policemen available on call. Unison represents members throughout Scotland, including members in areas in which it is well known to everyone that an environmental health officer would be lucky if a policeman arrived within 45 minutes or an hour. Do you agree that in different parts of the country different issues might arise?

**Dave Watson:** Yes. However, colleagues in Edinburgh tell me that when people are simply told, “I will have to call a police officer to come and enforce the fixed penalty”, they tend to provide their names and addresses. We need to acknowledge that there will be a hard core of people who will cause difficulties, but in general, enforcement of fixed penalties has not been a problem.

**The Convener:** Are enforcement officers empowered to detain a person while they wait for a police officer to arrive?

**Dave Watson:** No, but that has not been a problem. People give their names and addresses when the consequences of not doing so are brought to their attention.

**The Convener:** I am still interested in what happens if a person knows that the policeman will not arrive for an hour. In such circumstances must staff wait with the person? There are issues about that.

**Mr McNeil:** We have received evidence from the Republic of Ireland that shows that, on average, 94 per cent of premises that were inspected comply with the law. Compliance levels are reported at 94 per cent in hotels, 99 per cent in restaurants and 91 per cent in licensed premises. Do not those figures demonstrate that anti-smoking legislation is largely self-enforceable?

**Dave Watson:** That is probably the case in respect of the history of other fixed penalties, but it would be foolish to say that there are no costs associated with enforcement.

There has been great emphasis on pubs and
similar premises, but we also represent staff who work in other enclosed premises where alcohol is present such as places of entertainment, local authority premises, community centres and so on. Often, the staff who work in—or, more important, who manage—those premises are community based and there is concern that they may be put under pressure in enforcing their managerial control over premises. There may be hostility towards them from some people in the community. Their job is not quite the same as that of the manager of a city centre pub, who can go home at night and be well away from the place. A community worker is much more a member of the community, which must be taken into account. There are safety issues relating to that, which local authorities will have to take into account, and there will be training and cost implications.

The Convener: The previous panel of witnesses expressed differences of opinion about the kind of enforcement that we might anticipate. Would you be more supportive of the police approach than of the other approach?

Dave Watson: In all things, a pragmatic approach must be taken to enforcement. I understand where my colleagues from the Royal Environmental Health Institute of Scotland and the City of Edinburgh Council are coming from. There is no hierarchy of offences in the bill. I accept the fact that section 1 focuses on managerial responsibilities and that the other sections deal with stand-alone offences, but if someone has responsibility for enforcement, they must take that responsibility.

Shona Robison: I have questions on Amicus's written submission. To give us some background, can you tell us how many of your members work in the food and drink industry, for tobacco companies and for vending machine companies? What percentage of your members in the food and drink industry work behind bars, where environmental tobacco smoke is a direct issue?

Andy Matson (Amicus): I will deal with the last question first. Not many of our members work behind bars; they tend to work in other sectors of the industry, but that does not mean that we do not have members who do such work part time. Members of other organisations will put in a couple of shifts at a pub or hotel to augment their income, and I am sure that Unison members and members of other unions fall into that category. The bulk of our members in the drinks industry are involved in manufacture, whether of soft drinks such as Coca-Cola, or alcoholic drinks, which are produced by companies such as Diageo. Our members are also involved in food manufacture.

As far as the tobacco industry is concerned, the split between vending and manufacturing is heavily weighted towards those who are employed in manufacture of tobacco products. The industry, like many others, has been in decline, but we reckon that about 4,500 to 5,500 people are employed in the tobacco industry in the UK. That is nothing like the number of people who were employed in the industry in its heyday, primarily because of advances in technology and so forth. Within the tobacco industry, the workforce is split between those who are involved in production, those who are involved in administration and those who are involved in selling. The vast majority are involved in manufacture.

There are no more than 700 vending machine operatives employed in the UK who service and fill the vending machines in pubs, clubs and restaurants. The numbers in tobacco company sales forces in the UK are similar to the numbers of vending engineers.

Shona Robison: Just to be clear, is the biggest proportion of your members in food and drink manufacture, compared with tobacco manufacture and vending? I ask because when you talk about economic impact, you talk about a reduction in alcohol sales, rather than in tobacco sales, impacting economically on your membership through loss of jobs.

Andy Matson: I do not necessarily accept the logic that if a ban were introduced, it would lead to a reduction in either consumption or production of alcohol. If one considers the Irish experience and talks to the licensed trade in Ireland, people will say that, on the one hand, there has been a significant downturn in sales of draught beers—beer that is sold over the counter in pubs—while the sale of canned and bottled beers has increased. The Irish licensed trade has suggested that there has been a shift away from drinking in pubs, clubs and hotels to drinking at home, therefore it is not unnatural that there would be a reduction in sales of draught beer as sales of cans and bottles increase. It would be reasonable to extrapolate that situation to Scotland should similar circumstances exist.

Shona Robison: What I am trying to get at is where you foresee economic impacts on your membership and where they work. It will not be on the bar staff who might lose their jobs because of the proposed legislation. You are saying that it will not impact on manufacture of drinks because there will be an increase in off-sales, so where does Amicus's concern lie in respect of its membership and the potential loss of jobs?

Andy Matson: There are two areas. First is where we foresee our members being directly affected, but secondly we believe as a union that should any Parliament—Holyrood, Westminster or Cardiff—enact legislation, the economic impact on the community has to be considered. What we have said and included in our written submission is clear.
The convener will recall that when we gave evidence to the committee on Stewart Maxwell’s bill, I said that we felt then that it would be difficult to quantify the number of jobs that could be put at risk in the tobacco and food and drink industries. We can draw some analogies with the vending of tobacco products in Ireland. Our information is that the vending machine companies in the Republic of Ireland have shed between 25 per cent and 35 per cent of their labour, depending on the area in which they operate and the nature and size of the company. Any ban in the UK would also have an impact on throughput of products through vending machines. That has been the experience in Ireland. As far as the other areas are concerned, it would be irresponsible for any Parliament to consider legislation in isolation from the grand position as far as employment is concerned.

We believe that it is fair and reasonable to extrapolate from the Irish experience, given that Scotland and Ireland are similar in their rural and urban make-up, although their populations may differ. Extrapolating from the official Irish Government statistics, which are referred to in our written submission, should allow Parliament and the committee at least to consider the position of the hospitality industry, which we believe will be hardest hit by the ban. We need to take things from there. If the impact on the hospitality industry is similar in Scotland to what it was in Ireland, questions must be asked and people must be given assurances about safeguards and retraining. We need to ask where the money that is lost will come from.

Shona Robison: Is it fair to say that your concerns are more about the wider impact on the economy than about the impact on your members?

Andy Matson: Yes.

Shona Robison: I will turn to that issue. Your written evidence focuses on the estimated £41.6 million reduction in revenue for the Exchequer that might result from fewer people smoking. With all due respect, if you were to take that argument to its logical conclusion—I wonder whether you would—you would argue against all smoking cessation policies across the board. Restrictions on tobacco advertising, health warnings on cigarette packets to warn about the dangers of smoking and bans on smoking in public places are all measures that will potentially reduce tobacco revenue to the Exchequer. Surely Amicus would not argue that smoking cessation policies are a bad thing. Are attempts to improve the health of our nation not a more important objective? Where does Amicus stand on that? Do you agree with anti-smoking policies, which try to reduce levels of smoking even though they might have an adverse impact on the amount of money that the Treasury receives?

Andy Matson: Our written submission states clearly that the union’s food, drink and tobacco sector’s national conference has declared our opposition to an all-out ban on smoking in public places. The union’s position accepts the requirement for greater restrictions and controls on smoking and for consideration to be given to alternatives, including ventilation and filtration systems. We have been consistent on that.

I should say that the mathematics in our written submission are not based on figures that we have pulled from the sky. For example, the bill’s accompanying documents mention the Wanless report’s estimate that a reduction in smoking of something in the region of 4 per cent would emanate from the introduction of a ban. Using that figure and other figures that have been produced by Parliament, our submission puts some reasoned and logical economic argument before the committee. We believe that it is important that the proposed ban be considered not narrowly but in the round. We believe that the electorate are entitled to be told what the bill will or will not mean. If it will mean a shortfall either in revenue for Scotland or in resources for local authorities, the electorate are entitled to know where that money will come from.

Shona Robison: Would a 4 per cent reduction in smoking not be a good thing?

Andy Matson: I am not saying that it would be a good thing or a bad thing. In our submission, we say clearly that we intend to concentrate on the economic and employment side of the debate, which we believe has been somewhat swept under the carpet. For example, the financial memorandum that is attached to the bill tends to consider primarily areas in which estimated savings to the health service can be quantified.

The estimated costs to local authorities of implementation and enforcement are slightly underestimated in the financial memorandum, according to COSLA’s written submission, which says that the cost will be about £6 million in the first two years. That money has to be found by the local authorities, and we should be clear that COSLA is saying that its support for the bill is dependent on local authorities’ getting funding for implementation. It is reasonable to ask where that funding will come from.

17:30

Mike Rumbles: On that point, I understand entirely that you are focusing on the economic and employment side, but we have to focus on everything in the round. In your written submission, you say:

“It is our view that … health matters”
You equate a possible downturn in business with the deaths of 1,000 to 2,000 people in Scotland every year through passive smoking—that is based on the scientific information that we have received. Are you seriously suggesting to us that the economic argument that you propound should outweigh that?

Andy Matson: Not necessarily, but from the economics, which we outline in our paper, it appears to us that to save about £15.5 million we will lose in the region of £50 million. We are not economists, but simple sums suggest to us that that is the case. That seems to me to be the economics of lunacy.

As a trade union, we have always supported and argued for health and safety. We believe that health and safety in the workplace is paramount. The industries in which we have operated over the years are primarily those in which there have been health and safety risks from fumes of one type or another, but those risks have been resolved in industry with the use of improved ventilation systems. There have been problems with fumes from chemicals that are used in certain processes in the electronics industry, but ventilation and filtration systems have been used to resolve some of those issues. In heavy engineering industries such as shipbuilding there have been difficulties with fumes from welding rods and so on, but improved ventilation systems have gone some way towards resolving those problems.

Evidence is available to suggest that ventilation and filtration systems can provide health and safety support to workers in the hospitality trade, but we are concerned with the wider public debate over the past few months has prevented us from taking that opportunity for the trade union movement to work with the hospitality trade, but we are concerned that the wider public debate over the past few months has prevented us from taking that opportunity.

Helen Eadie: When we visited Ireland, we heard about the new investment opportunities, which have been mentioned by the deputy convener, such as the manufacture of gazebos and patio heaters. A whole range of construction-related jobs has been created, which it is felt must offset the number of jobs that have been lost in the hospitality sector.

Ian Tasker: I am not aware of any figures relating to what those new industries are doing to offset the overall economic cost. We support the view of Amicus that job losses are an important consideration. People who work in the hospitality industry often do not choose to do so; they do it to see themselves through college or as a second job. If jobs in that industry disappear—although we are not wholly convinced that the forecast loss of jobs will materialise—that may lead to increased social exclusion for many people who are already on low wages.

Helen Eadie: What is your comment on the potential impact of the ban on those who suffer from smoke-related diseases, especially asthma and chronic bronchitis? Can you even up the balance sheet from what Andy Matson has said and acknowledge that there is a cost to Scotland of £83 million for sickness absence related to exposure to environmental tobacco smoke?
overall health improvement. We therefore support the health arguments, but we believe that some smoking cessation initiatives must be provided for the hospitality trade, as various estimates say that between 50 and 70 per cent of the people who work in that industry smoke.

Helen Eadie: What is your comment on the cost of the loss of productivity to Scotland through smoking-related diseases causing time off work? That cost is estimated at £450 million.

Ian Tasker: If people are suffering from lung cancer or any lung disease, there will be a loss of productivity. However, there is also a loss of productivity through drink-related illnesses. We have to look at the whole picture. Smoking is one issue, but there are a lot of occupational health illnesses.

Helen Eadie: We will move on to the subject of alcohol later. Do you know what the cost is of the payment of welfare benefits to those who are unable to work due to smoking-related illnesses? Do you accept—again, evening up the balance sheet with what Andy Matson has said—that that cost is £40 million? That brings the total cost to around four times the amount that Andy Matson has suggested in his submission to the Scottish Parliament.

Ian Tasker: I think that Andy Matson would be better placed to comment on those figures. We are looking at the situation and considering what the health benefits will mean, but what is important is how we use the cost savings relating to health to mitigate the situation in relation to job losses and the arguments that Andy Matson has put forward. The trade union movement exists to protect jobs and to protect members’ health and safety, so we are caught between the devil and the deep blue sea.

Helen Eadie: Do you accept that all the savings that we have talked about this afternoon—more than £600 million by now—could be channelled into the public sector works that we so desperately need across Scotland? The trade union movement is always bemoaning the fact that there is never enough money to go round to create jobs in the public sector. Could not that money be redirected from the savings back into the health service, which unions represent?

The Convener: I should point out that all that we are asking for is a general opinion. It is not really for the individual unions to answer that question. Unfortunately, it will not be a matter for them.

Helen Eadie: Okay. I have a specific question. How much money is spent by the national health service in Scotland, and do you agree that that money—£200 million—would generate more jobs?

The Convener: I think that we understand the point that Helen Eadie is making. There are two sides to the equation. Money may be lost on one side, but it may be gained on the other. That is the point that needs to be addressed.

Andy Matson: It is unfair to become selective about which work-related illnesses one wants to quantify. We might want to extend that to include work-related stress, which is a big issue these days, although I do not know whether anyone has tried to quantify how much it is costing. As far as our submission is concerned, we have certainly not tried to draw anything out of the air. We have looked at papers that have been produced on behalf of the Parliament in supporting the bill. We have not sought to go beyond that to any documentation that is not among the official papers for the committee. If such papers had been appended, each and every one of us would probably have had a tome to read, but we have tried to make a reasonable submission in the light of the official paperwork that was sent out to interested parties when the Parliament issued invitations to comment.

Dr Turner: I have a quick question about the heating and ventilation industry. I take it that you will not be expecting to lose many people from that industry, because I understand that there is heating and ventilation in premises anyway. Would you expect to lose anybody in that area?

Andy Matson: No. Our view is that, if the Parliament were to consider a voluntary ban, rather than a total ban, and to tie it in with requirements for improved ventilation systems, there would be an opportunity for expanding employment in the heating and ventilating industry, not only in installing upgraded equipment but in on-going maintenance to ensure that the systems work efficiently. That is certainly not an area in which we envisage a downturn in employment.

Dr Turner: A large number of people do not accept that ventilation works and there is quite a range of expensive ventilation systems. If we were to go down that pathway to an eventual ban, would we be leading people into expense and eventually putting the ventilation suppliers out of business, not to mention people in other businesses, because they would have spent and borrowed so much money to install useless equipment—or equipment that you may not think is useless but that many people believe is useless?

Andy Matson: I accept that some people believe that, no matter how super-efficient the ventilation and filtration system that could be installed, it is irrelevant to the argument. Equally, some people—including us—contend that adequate ventilation and filtration systems can be developed and installed to provide the necessary...
safeguards that the committee and the Executive through the bill seek to put in public places.

17:45
The Convener: Do members have any final, small points?
Mr McNeil: When will we finish?
The Convener: We will finish when we finish. There is time for you to ask more questions.
Mr McNeil: I will follow up Helen Eadie’s questions. There is a big divergence in view from that of the Irish trade unions, which were clearly partners for the greater good of a large group of workers in the hospitality industry. The STUC submission refers to choice in the round and says:

“individuals work in the hospitality industry not through choice but necessity. This includes students, young parents and those who need to take additional jobs to supplement low pay in their main employment.”

Where else would the trade union movement argue that protection that workers deserve should be deferred until others catch up? As trade unionists, when we meet a health hazard, the first principle is to ask whether that hazard can be eliminated. Smoking is a hazard that can be eliminated in the workplace. Only when we cannot eliminate a hazard do we seek to enclose it or replace it with safer materials. We have a hazard that can be eliminated and we should not defer the support that workers in the hospitality industry deserve. I appreciate that that was more of a statement than a question.

The Convener: Indeed.
Ian Tasker: Duncan McNeil has summed up our position. After much debate, we are supporting a ban. We believe that smoking is a hazard and should be treated as a workplace hazard. It is unusual for the Scottish Parliament to consider legislation that will impact on the workplace.

The STUC youth committee discussed the matter and also favours a ban, but we have not had the chance to work in partnership on the matter. That is what we want to achieve, but we will not do that by April next year. We must promote partnership to engage with the anti-smoking lobbies and the SLTA and we must move partnership to achieve the overall ambition of a ban on smoking in public places.

Dave Watson: I agree with Andy Matson that the Parliament should always consider the economic impact of legislation. When that is clearly measured, just transition arrangements should be put in place to deal with it. However, Unison has discussed the matter with Impact, our sister union in Ireland, and we take the same approach. As always in health and safety, the risks and the economic impact must be balanced. Given the number of deaths that smoking causes, the impact of second-hand environmental tobacco smoke and the fact that 70 per cent of adults do not smoke, the balance is in favour of the ban.

The voluntary arrangements have not worked. Equally, for many of the reasons that Duncan McNeil gave, the ventilation approach is not right. When we can get rid of a risk, the proper health and safety approach is to get rid of it. It is not as though alternatives do not exist. People do not have to smoke in pubs or other buildings. If an employer said that we had to keep that approach in place, we would say, “On yer bike. We’re not having ventilation. Get rid of the risk.” On the balance of health and safety, that is what we would argue.

I say bluntly that we approach the issue from a public health perspective. We represent staff in the health service and social care sector who see the damage that tobacco smoke does daily. If you have had to nurse someone with lung cancer, you tend to take a fairly firm view on the dangers of smoking. We put the bill in the context of the Executive’s wider programmes to reduce smoking and think that it would provide an important benefit by reducing smoking and the associated health risks in Scotland.

Andy Matson: I do not think for a moment that Duncan McNeil was saying that ventilation systems will not solve the problem. He was saying that a hazard has been identified and asking how we should address it. Over the decades, we have identified numerous hazards in the workplace and have put in place measures to address them, while seeking not to impact on employability in certain areas and industries. Our submission seeks to address that issue by saying that a hazard has been identified and that we believe that there are mechanisms available to address it. Stewart Maxwell is not in attendance, but I say to him that we are not suggesting that people wear space suits. The comments that I made on the previous occasion that I gave evidence to the committee in support of filtration systems and the technology that is available in other places and can be utilised were taken a little out of context.

Let me be quite clear. In its written submission on Stewart Maxwell’s member’s bill, Amicus said that it supported some Executive initiatives to reduce the level of smoking but that it did not believe that an all-out ban was the way forward. We do not believe that such a ban is in people’s interests or that the public are asking for one. We believe that choice is essential and that, if Scottish people are presented with a choice, they will sensibly determine whether during their leisure time—which is the primary target of the proposals—they wish to frequent premises where they can smoke or premises where they cannot
smoke. To remove that option is almost to remove a basic right from the population of this country.

The Convener: That concludes the panel's evidence.

17:53

Meeting continued in private until 18:22.
Thank you for the invitation to submit supplementary evidence to the Committee for consideration. I hope the points outlined below help clarify our position and will aid the Committee’s consideration of the Smoking, Health and Social Care (Scotland) Bill (“the Bill”).

In the oral evidence session the Committee discussed the British Hospitality Association’s views on the provisions of the Bill in relation to hotel bedrooms. At present the Bill proposes three things by way of sanction in relation to smoking. In summary, these are as follows:

1. Fine on the proprietor, etc. (Section 1)
2. Fine on the smoker (Section 2).
3. Power to enter and require identification (Section 6).

In relation to hotels (outside of bedrooms), and for restaurants, bars, etc. within hotels, we accept all three sets of sanctions as set out in the Bill as these areas are public places. The intention of the Scottish Executive as stated in the Policy Memorandum is to ban smoking in ‘enclosed public places’. We do not accept that a hotel bedroom is a public place it is patently private and the Executive appears to accept this. The main issue is how best to deal with hotel bedrooms in the legislation.

As currently drafted the Regulations allow hoteliers to designate at their discretion which rooms are smoking and non-smoking. Bedrooms designated as smoking would be completely exempt from the Bill, and rooms which are non-smoking would be subject to the Bill. Therefore, the draft Regulations would exclude bedrooms from all three sanctions if the hotelier specifically allowed guests to smoke, but perversely all three sanctions would apply in non-smoking rooms and that is not equitable.

Our main concern relates to the difficulties of enforcing a ban on smoking in hotel bedrooms which are by their very nature private places, and not ‘public places’. It would clearly be impossible for a hotelier to reasonably to detect whether an individual is smoking in a bedroom. Random checks by enforcement officers would interfere with privacy and clearly be unacceptable without a warrant. Logically it would be unworkable for them practically to enforce a ban on smoking in hotel bedrooms.

The situation created by the Regulations if introduced as currently drafted would create a clear anomaly with the ‘general principles’ of the Bill, so it would be in the hoteliers interests to designate a room as a ‘smoking room’ as they would not then run the risk of prosecution.

The BHA believe that the most effective way of dealing with hotel bedrooms would be to exempt them completely from the legislation either on the ‘face’ of the Bill as suggested in our original submission or via the Regulations. This would allow hoteliers to continue as at present to define their own policy on smoking in bedrooms, including imposing a ban without risking a fine as a result of doing so.

I hope this additional clarification and information will be helpful in assisting the Committee draft its Stage 1 Report.

Yours sincerely

Paddy Crerar
Chair BHA Scotland Committee
1. Recommendations for baseline and post legislation research to measure success of legislation, and on implementation issues.

a. Health Outcome Measures

- We recommend measuring cotinine levels in non-smoking bar staff (before and after implementation) as a proxy for exposure to SHS. Cotinine can be measured by urine or salivary tests.

- In order to measure air quality in pubs – taking into account methodological issues around air quality measurements – we recommend assessing levels of respirable suspended particles (RSP), an accepted marker for levels that are known to increase risk of respiratory disease, cancer, heart disease and stroke. Measurements would need to be taken before and after implementation.

- We recommend assessing exposure of young (i.e. preschool) children to second-hand smoke. It may be possible to base research around routine health visitor annual checks of 1-3 year olds, possibly using salivary cotinine measures as a proxy for second-hand smoke exposure. Extent of exposure may also be measured using hair samples – this provides an accurate depiction of average exposure over a long period, as each 1cm of hair accumulates a reading over a whole month. The study numbers could be contained by a geographical selection – including several areas where smoking rates are known to be high.

- We recommend that hospital admission rates for asthma, bronchiolitis and other respiratory conditions in children are recorded pre-and post implementation.

b. Economic Outcome Measures

- We recommend that economic trends in the hospitality sector are validated by business tax receipts – ideally for 3 years before legislation is implemented. Should cover a range of areas especially rural.

- We recommend data is collected regarding the numbers of bars closing and opening, at least a year before, and possibly drink sales figures.

- We recommend collecting cigarette sales data (pre-and post implementation) and bar sales data.

- We recommend measurement of employment rates in the hospitality sector, pre-and post legislation implementation.

- We recommend data be collected on tourism and travel as an indicator of number of visitors in Scotland pre-and post legislation implementation.

c. Public Opinion Measures

- We recommend revisiting some of the consultation questions one year after implementation

- We recommend measuring increased interest/update of Smokeline/Smoking cessation services, and the number of individuals successfully quitting through smoking cessation services. This data should include information on specific health inequalities target groups (pregnant women, young people, disadvantaged communities)
We recommend that surveys be conducted to measure levels of knowledge and awareness of the dangers of tobacco and second-hand smoke (pre-and post implementation). Data should be collected to show differences across region, age, gender, ethnicity and social class. Implementation will succeed through targeted communications. Surveys such as these will show where and how those communications need to be targeted.

d. Implementation Issues

- We recommend that data be collected on smoking cessation service waiting lists and throughput (pre-and post implementation).
- We recommend that data be collected on compliance with legislation – to include data from EHO’s, data on prosecutions etc, and calls to report violations.
- Intensive and strategic media campaigns are required pre-legislation to increase adults’ awareness of the dangers of secondhand smoke & inadequacy of ventilation to remove these. These campaigns will ensure maximum effect in protecting young people from the adverse health effects of secondhand smoke exposure.

2. The Tobacco Industry: Further Insights

a. Imperial Tobacco

The ongoing (McTear vs Imperial) court case in Scotland has not produced public access to tobacco documents. Imperial's Chief Executive, Gareth Davis, testified in court in 2003 that Imperial did not know whether smoking cigarettes causes lung cancer, citing doubts about the basis of scientific methodology. A similar argument was made about secondhand smoke by Steve Stotesbury, Imperial Tobacco’s Industry Affairs Manager European Union, when presenting at the Scottish Licensed Trade Association’s seminar in Edinburgh on 13th January 2005.

Imperial Tobacco was previously singled out for criticism by members of the House of Commons Select Committee on Public Accounts in 2002. Gareth Davis was accused of being ‘positively parsimonious with the truth as far as this Committee is concerned’ by Rt Hon Alan Williams MP (Labour, Swansea West), and all three witnesses for Imperial Tobacco were overtly accused of lying to the committee by Mr George Osborne MP (Conservative, Tatton) and by Mr Barry Gardiner MP (Labour, Brent North) - who added ‘I believe you are the least credible witnesses that I have ever seen come before the Committee of Public Accounts’.108

b. Tobacco Document Depositories

The 1998 Minnesota Consent Judgement109 was the outcome of legal action by the State of Minnesota and Blue Cross and Blue Shield of Minnesota against Philip Morris and several other tobacco companies, seeking to recover smoking related-health care costs. Under the terms of the judgement several tobacco companies were ordered to make public internal documents produced during the discovery process. These were deposited at two sites, in Guildford and Minnesota.

The Guildford Depository, England110, holds an estimated 6-7 million internal corporate documents from the British American Tobacco Company (BAT) produced during the discovery process. It opened in February 1999 and will remain open until 2009. In contrast to the Minnesota archive (see

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109 Further details of the Minnesota Consent Judgement are available online at: [http://news.corporate.findlaw.com/hdocs/docs/tobacco/consent.html](http://news.corporate.findlaw.com/hdocs/docs/tobacco/consent.html) (Accessed 01/04/05)

below), the depository at Guildford is managed by BAT itself. From the outset, the efforts of researchers to investigate the contents of the documents housed there have been severely hampered. Recently published reports describe how some industry documents held here have been altered, how database searches conducted by visitors are tracked internally, and that BAT refuse to supply some documents requested. These reports suggest minimal compliance with the letter of the Minnesota agreement.\textsuperscript{111}

The British American Tobacco Documents Archive is a joint undertaking by the London School of Hygiene & Tropical Medicine University of California, San Francisco (UCSF) and Mayo Clinic. It aims to expand access to the BAT documents held in the Guildford Depository by scanning the entire collection and hosting them on a website.\textsuperscript{112} It is anticipated that all documents will be available on the website in 2007.

*The Minnesota Depository, United States*\textsuperscript{113}, holds approximately 26 million pages of tobacco industry documents produced in the discovery process from Philip Morris Incorporated, Brown and Williamson Tobacco Corporation, Lorillard Tobacco Company, American Tobacco Company, RJ Reynolds Tobacco Company, The Council for Tobacco Research and The Tobacco Institute. It opened in 1998 and will remain open until 2008. It is operated by an independent paralegal firm Smart Legal Assistance. The collection is continually growing as the depository receives documents produced in other litigation cases as a result of the 1998 Master Settlement Agreement. The Master Settlement Agreement was made on 23rd November 1998 between the five largest US tobacco companies (Brown & Williamson Tobacco corporation, Lorillard Tobacco Company, Philip Morris Incorporated, R.J. Reynolds Tobacco Company, Commonwealth Tobacco, and Liggett & Myers) and 46 states’ attorney generals. Among other provisions it stipulated that the tobacco industry is to make public all documents produced in US lawsuits, at their own expense set up and maintain, until 30th June 2010, a website to include all these documents and to add all documents produced in all future US lawsuits.\textsuperscript{114} The Master Settlement Agreement does not apply to the UK based BAT.

c. What have the Collections Revealed to Date?

- **Tobacco Industry Efforts to Undermine the World Health Organisation**
  A key finding from the Guildford documents has been the extent to which the tobacco industry has engaged in efforts to undermine tobacco control worldwide. In 2000, the World Health Organisation (WHO) published a detailed report of the industry’s efforts to infiltrate and undermine their organisation, for example by placing industry-paid staff within the organisation.\textsuperscript{115}

- **Tobacco Industry Research Strategies**
  In the late 1980s, the international tobacco industry assisted in the establishment of the International Society of the Built Environment, which published the journal Indoor and Built Environment. A research article recently published in the Lancet examines the industry associations of the Society's executive, the journal's editor and board, and the extent to which the journal published papers on environmental tobacco smoke that would be deemed favourable to the tobacco industry. It concludes that the tobacco industry's aim was to dominate the organisation and the content of its academic journal, pushing the view that SHS posed little risk to those exposed to it. In fact, some 90% of articles which were published in this journal that were positive to the

\textsuperscript{111} Muggli, M.E. et al. (2004). *Big tobacco is watching: British American Tobacco’s surveillance and information concealment at the Guildford Depository.* The Lancet, 29 May.


\textsuperscript{113} Further information on the Minnesota Depository is available online at: [http://www.tobaccoarchives.com/doc.html](http://www.tobaccoarchives.com/doc.html) (Accessed 01/04/05)

\textsuperscript{114} For further details see [http://www.tobaccoarchives.com/](http://www.tobaccoarchives.com/). (Accessed 01/04/05).

tobacco industry were written by people with a history of association with them. When article quality, peer review status, article topic, and year of publication were statistically controlled for, the only factor associated with the conclusion that passive smoking was not harmful was whether an author was affiliated with the tobacco industry.\(^{116}\)

Documents have also revealed how the industry built up networks of scientists sympathetic to its position that SHS is an insignificant health risk. The industry funded independent organisations to produce research that appeared separate from the industry and would boost its credibility. Unfavourable research conducted or proposed by industry was prevented from becoming public.\(^{117}\)

- Tobacco Industry Evidence that Second-hand Smoke may be more Dangerous than Directly Inhaled Tobacco Smoke

A extremely significant example of such activity was highlighted in recently discovered tobacco industry documents demonstrating that second-hand smoke may be even more harmful than directly inhaled tobacco smoke. As stated in our main submission to the Health Committee (Feb 2005):

“Recently discovered tobacco industry documents demonstrate that second-hand smoke may be even more harmful, volume for volume, than directly inhaled cigarette smoke.\(^{118}\) Yet the tobacco industry continues to place the highest priority on preventing the introduction of restrictions on smoking in public places, and remain equally active in spreading misinformation about the effects of legislation that has already been introduced successfully in other countries.”

The tobacco industry maintained, for many years, that is was unaware of research about the toxic effects of smoking. However, a recent report in the Lancet\(^ {119}\) documents the way in which one company, Philip Morris, acquired a research facility, INBIFO, in Germany, in order to privately determine for themselves whether smoking had hazardous health impacts. INBIFO appears to have published only a small amount of its research and what has been published appears to differ considerably from what has not. In particular, the unpublished reports provide evidence of the greater toxicity of sidestream smoke compared to mainstream smoke. By contrast, much of its published work comprises papers that cast doubt on methods used to assess the effects of second-hand smoke.

In the 1980's INFIBO conducted a large number of animal experiments on sidestream smoke. One INFIBO report\(^ {120}\) sent to Philip Morris in 1982 describes in great details the results of exposure of rats to sidestream smoke. The report states that secondhand smoke exposure was more irritating than mainstream smoke, and most particularly to the upper airways (nasal cavities and olfactory membranes). Sidestream exposure induced more frequent and more severe lesions in the nasal cavity than mainstream of equal concentration. An accompanying letter to the report concludes that the extent of cornification observed in these animals had “never been seen before.”\(^ {121}\)


\(^{119}\) Diethelm, P. et al. (2004). The whole truth and nothing but the truth? The research that Philip Morris did not want you to see. Published online on November 11 2004, at: http://image.the lancet.com/extras/03art7306web.pdf (Accessed 20/03/05).


These internal documents clearly demonstrate that Philip Morris was, contrary to its contemporary public statements, aware of the greater health risks posed by second-hand smoke from the early 1980s. However, as recently as April 2002, Philip Morris, in an American court, rejected the statement that second-hand smoke causes disease. This public statement is clearly at odds with its own research findings concerning the consequences of exposure to second-hand smoke, and highlights the extremely selective nature of what is eventually published by some scientists with links to the industry.

- Tobacco Industry Efforts to Prevent Legislation on Smoking in Public Places

Documents have also revealed further insights into the tobacco industry’s efforts to prevent legislation on smoking in public places across a number of countries and regions. In a recently published internal document from the Tobacco Institute, vice-president Peter Sparber states, “the tobacco industry has faced more than 1,000 public smoking bills, and has defeated more than 90% of them... By in large, these bills have attempted to restrict smoking in public places.” Those they have defeated are more typically reintroduced year after year, often redrafted to accommodate legislators’ objections.” Sparber continues: “We cannot say that ambient smoke doesn’t harm non-smokers...and in fact the best we can say is that it is not proven that cigarette smoke in the air harms normal, healthy non-smokers”.

- Tobacco Industry Evidence that Second-hand Smoke Exposure Increases the Risk of Sudden Infant Death Syndrome (Cot Death)

A recently published report\(^{123}\) reveals that in 1997, Phillip Morris commissioned a review article on Sudden Infant Death Syndrome (SIDS), in response to company concerns about the possible adverse effects of SHS on maternal and child health. The draft review concluded that prenatal and postnatal smoking exposures are both independent risk factors for SIDS. However, the final draft was modified following exchanges with Philip Morris and tobacco company scientists, to conclude that postnatal SHS effects were “less well established” than those associated with prenatal maternal smoking. The review paper was published in 2001 in the UK journal Paediatric and Perinatal Epidemiology\(^{124}\), stating that the relationship between SIDS and exposure to SHS was ‘difficult to quantify’. The tobacco industry has long fought to counteract scientific evidence that SHS is dangerous to health. By Philip Morris’ own admission, ‘there is perhaps no other issue as powerful facing the industry’ as SHS and maternal and child health issues.\(^{125}\) Three years after its publication, the SIDS review had been cited at least 19 times in the medical literature. This suggests that Phillip Morris succeeded in manipulating the content and presentation of scientific results, to create a review that, until now, has been seen as authoritative and credible.

3. Additional research published since our written submission to the Health Committee

a. Adult Health Risks

A recent study published in the British Medical Journal\(^{126}\) highlights that exposure to second-hand smoke kills more than 11,000 people a year in the UK – a much higher figure than previously thought. This study also gives the first available figure for people dying from second-hand smoke in the workplace – 600 lives are year are lost because of exposure to SHS at work. The study found


\(^{126}\) Jarozik, K. (2005). Estimate of Deaths Among Adults in the United Kingdom Attributable to Passive Smoking: BMJ, doi:10.1136/bmj.38370.496632.8F Abstract available online at: [http://bmj.bmjournals.com/cgi/content/abstract/bmj.38370.496632.8Fv3](http://bmj.bmjournals.com/cgi/content/abstract/bmj.38370.496632.8Fv3). (Accessed 04/03/05)
2,700 deaths among people aged 20 to 64 could be attributed to second-hand smoke and 8,000 in 65-year-olds and over. A further 617 deaths are thought to be caused by workplace passive smoking, including 54 in the hospitality industry. This is in line with recent research that suggests around 1000 Scots die as a result of exposure to second-hand smoke every year.127

b. Benefits of Going Smoke-Free

The SLTA128 continue to argue that the evidence shows that there is little or no effect on smoking incidence among regular users following the introduction of smoke-free legislation. They argue that, in Ireland, according to research Agency Millward Brown, the incidence of smoking 5-plus cigarettes a day, among adults aged 18-64 has increased for both men (by 4%) and for women (by 2%). This is not in accordance with any other estimates of incidence that have been drawn from Ireland (see our main submission). On Tuesday 29th March 2005, the Republic of Ireland celebrated one year of smoke-free success. According to the Irish Finance Minister, cigarette sales have declined by 18%, and it is reported that an estimated 7000 smokers have quit smoking since legislation was introduced one year ago.129 A team of researchers from the Royal College of Surgeons in Ireland have reported that smoking is on the decline among older people in Ireland; with prevalence rates falling between 2-3% over the past 4 years; from 20% to 18% in the east, and from 21% to 17% in the west. By comparison, smoking rates among older people in Northern Ireland have remained stable, at around 19% both in 2000 and 2004.130

In a recent independently conducted poll, an overwhelming 98% of the Irish public responded that workplaces are healthier since the introduction of the smoke-free law, including 94% of smokers. 93% of respondents think the law was a good idea, and 96% of respondents feel that the law is successful.131 A recent survey by the trade union Mandate has found that people working in public houses across the Republic of Ireland believe that smoke-free legislation has yielded huge benefits for their health. 87% of respondents believed that the law had already had a positive impact on their health, with 82% stating that they now found it easier to breathe at work, and 68% reporting that they coughed less.132 A study by the Office of Tobacco Control has found that since the introduction of smoke-free legislation, carbon monoxide levels in non-smoking bar workers have fallen by 45%, and levels in ex-smokers have fallen by 36%. Average levels of the smaller airborne particles in SHS, which are known to be particularly harmful to health, have been reduced by 87.6%24

c. Ventilation

ASH Scotland’s evidence-based research briefing on ventilation is available online at:

http://www.ashscotland.org.uk/ash/downloads/Ventilation.doc

129 ‘One year on for Irish Smoking ban’. BBC news report available online at: http://news.bbc.co.uk/1/hi/northern_ireland/4388507.stm (Accessed 29/03/05)
130 ‘Smoking rates among older people fall’. Irish Health news report available online at: http://irishhealth.com/?level=4&id=7199 (Accessed 29/03/05)
132 ‘Bar staff experiencing benefits of smoking ban – ireland.com’. News article available online at: http://home.eircom.net/content/irelandcom/breaking/5266131?view=Eircomnet (Accessed 29/03/05).
This briefing contains further details of the evidence submitted to the Health Committee, and additional research that clearly demonstrates that ventilation systems are not able to remove the hazardous gases that are present in SHS.

The SLTA recently stated that ETS contamination is subject to exponential decay, and use a chart prepared by Building Services Research and Information Association (BSRIA) to illustrate this point. They argue that most pubs have a natural leakage rate of 1 or more air changes per hour, with air seeping through the fabric of the building. This means that the equivalent of all the air in the room is replaced once each hour with fresh outside air. At even a low rate of ventilation such as 5 air changes per hour, the contamination would reduce by about 85% in about 30 minutes, and effectively to zero within an hour.

BSRIA are far from independent. They have in the past conducted testing on ventilation equipment performance sponsored by Honeywell and other air cleaner manufacturers, under the umbrella of the AIR (Atmosphere Improves Results) initiative. Interestingly, at the time AIR published the results of this testing, relatively few manufacturers agreed that their test results could be published.133

BSRIA has also worked with the Air Cleaner Manufacturers Association (ACMA), which was set up specifically to counter arguments regarding the inadequacy of ventilation systems, and to prove the effectiveness of its members’ equipment to potential purchasers and Regulators. This led to the launch of BSRIA’s certified rating scheme “to clearly show the real performance, rather than the claimed performance of an air cleaning product.” 26 BSRIA are also a member of the AOB group, the same group that is dedicated to opposing the Smoking, Health and Social Care Bill and in partnership with companies such as Imperial Tobacco.26

The SLTA continue to refer to the published “Black Dog study,” 134 which they state clearly demonstrates that well-managed ventilation airflow can prevent ETS drifting from a smoking area to a non-smoking area. The researchers conclude that ventilation techniques for restaurants/pubs with separate smoking and non-smoking areas are capable of achieving non-smoking areas ETS concentrations that are comparable to those of similar facilities that prohibit smoking outright.

The SLTA fail to mention that this piece of research was led by Roger Jenkins, of the Oakridge National Laboratory of Tennessee. Although part of the U.S Department of Energy’s often highly-classified research establishment, Oakridge National Laboratory researchers are also for rent to private companies. Roger Jenkins has conducted several other pieces of research that have been commissioned by the tobacco industry, that typically attempt to show that exposure to SHS is not a health hazard.135 Jenkin’s findings, and Jenkins himself, frequently appear in hearings to oppose local smoke-free measures. As an expert witness for the defence in a lawsuit bought by flight attendants against the tobacco industry over the lung cancer and other diseases they contracted at work, Jenkin’s evidence was excluded by the judge because of his pro-tobacco industry bias.136

It is also noteworthy that the research was published in the Journal of Regulatory Toxicology and Pharmacology, which is sponsored by the International Society for Regulatory Toxicology and Pharmacology (ISRTP). In turn, ISPRT are part sponsored by RJ Reynolds Tobacco Company. 137

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133 Honeywell Online Noticeboard: [http://content.honeywell.com/uk/air-quality/notice_board/archive/notice_board_archive.html#Anchor5](http://content.honeywell.com/uk/air-quality/notice_board/archive/notice_board_archive.html#Anchor5) (Accessed 09/03/05)
136 Roger Jenkins and Oak Ridge National Laboratory. Available online at: [http://www.tobaccoscam.ucsf.edu/vent/vent_hg_internal_4.cfm](http://www.tobaccoscam.ucsf.edu/vent/vent_hg_internal_4.cfm) (Accessed 21/01/05)
137 ISPRT website, at: [http://www.cspinet.org/integrity/nonprofits/international_society_for_regulatory_toxicology_and_pharmacology.html](http://www.cspinet.org/integrity/nonprofits/international_society_for_regulatory_toxicology_and_pharmacology.html) (Accessed 09/03/05)
d. Voluntary Agreements

A recently published European multi-centre study has demonstrated that introducing non-smoking and smoking areas in public places fails to create a completely smoke-free environment. The researchers measured SHS exposure in a range of public places, including transport, educational settings, and bars and restaurants. The researchers measured levels of environmental tobacco smoke in Vienna, Paris, Athens, Florence, Oporto in Portugal, Barcelona and Orebro in Sweden. Whilst there was some variability among cities, the study demonstrates that co-existing smoking and non-smoking areas are not an effective means of controlling the health hazards associated with SHS. Nicotine levels in many of the areas tested that had smoking restrictions were not dissimilar in concentrations to areas where smoking was permitted. The highest nicotine concentrations were found in bars and discos, followed by restaurants. The researchers state that “A person dancing for four hours in a disco with the median concentration found in cities like Vienna or Barcelona is exposed to a similar amount of tobacco smoke as someone living with a smoker for a month.”

Recent reports outline that the city council in Paris have now acknowledged that a voluntary scheme launched three months ago has failed. The scheme aimed at encouraging Paris’s 12,452 cafes, bistros and brasseries to declare themselves smoke-free zones had been adopted by barely thirty. Here is another example of voluntary smoke-free plans failing to work.

e. Economic Impacts

There have been several attempts by the SLTA, TMA and AOB to undermine the International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places that was recently undertaken by Aberdeen University. The Scottish Beer and Pub Association state that the study makes no attempt to analyse the macroeconomic impact of smoke-free legislation on the Scottish economy, that the study is not robust, and that it relies on analyses of incomplete and non-transferable studies.

Firstly, the author of the study acknowledges that the model for Scotland was estimated on the basis of the best available evidence and using expert judgement where the evidence does not exist. The majority of studies that have been undertaken cover both bars and restaurants, as very few existing studies separate out the economic effects for these two sectors.

Secondly, to acknowledge the limited number of existing studies available, the authors combined a literature review with the modelling exercise to place the likely impacts of restrictions on smoking in public places in a Scottish context. The literature review covered a number of distinct areas, including economic impacts of restrictions on the hospitality sector, costs of workplace smoking, and the costs of smoking related diseases.

The model was based upon evidence relating to smoke-free public places, which include workplaces and the leisure and hospitality sector. Smoke-free legislation was modelled, rather than lesser restrictions, because the nature of health effects relating to partial smoke-free restrictions remain unclear. In order to provide as complete an overview of the impacts of smoke-free legislation as possible, some impacts have been modelled on the basis of only limited information.

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138 Nebot, M. et al. (2005). Environmental tobacco smoke exposure in public places of European cities. Tobacco Control, 14, 60-63. Abstract available online at: http://tc.bmjournals.com/cgi/content/abstract/14/1/60 (Accessed 04/03/05)

139 ‘Voluntary smoke-free plan not working in Paris’. News article in the Guardian, 16/02/05. Available online at: http://www.guardian.co.uk/france/story/0,11882,1415452,00.html (Accessed 04/03/05)

Therefore, to reflect this uncertainty, a range of estimates has been produced; central, low and high.

There are a number of challenges inherent in research of this kind. Some of the problems in research design are unavoidable given that the impact of restrictions can only be evaluated where they have been implemented.

Looking at the hard evidence from New York, Ireland, and California, there is not a negative impact on business. The only studies that suggest that there is are funded by the tobacco industry and are of poor quality.

Going smoke-free can offer many business opportunities – around 70% of the Scottish population don’t smoke; smoke-free is popular (especially after it’s been legislated for) and smoky pubs are unpopular. The only industry we know will be hurt by progress on this issue is the tobacco industry.

SUPPLEMENTARY SUBMISSION BY COSLA

You will recall I agreed to clarify COSLA’s position on enforcement of the smoking ban following our oral evidence session with the Health Committee at its 15 March meeting and I hope the following paragraphs will provide that clarification.

There is in fact no substantial difference of opinion between ACPOS and COSLA on the issue of enforcement and it was unfortunate that the context of our evidence session did not give that clear message with much of the debate focussing on the operational aspects of the draft legislation.

We did not intend to give the impression that as soon as the Act is live that we go out and take a robust approach to enforcement. What we do believe is that:

~ the legislation, as currently drafted, is enforceable;

~ there needs to be a mature and stepped approach to the enforcement of the ban;

~ the licensee should be responsible for the behaviours of his or her customers whilst they are in licensed premises; and

~ non-invasive enforcement is the preferred and most likely route to success.

We hope that the situation in Scotland will replicate that in Ireland and that the legislation will be largely self-enforcing. We have to be prepared, however, for any instances where a self-enforcing approach, and steps taken by the licensee are not successful and it is here I think that the confusion arose with the evidence to the Committee. COSLA supports the legislation as you know but, if it is to be effective, it must be enforced. We therefore need to be prepared to deal with instances where the low key approach does not work, otherwise there is the danger that the law will be ignored and so be ineffective. It may be that when the legislation is first enacted, some high action/convictions will be necessary to convey the appropriate messages. If it is not clear from the outset that the legislation will be enforced, then the wrong message will have been sent and the legislation will fail. Both the police and local authorities need to be clear about the approach to be adopted in any instances of persistent flouting of the law.

COSLA is clear, as currently drafted, the legislation is enforceable. There are no grey areas in the draft and from the enforcement point of view there can be no argument. Our point is that, if and when enforcement action is required, the draft legislation is clear on the course of action that can be taken. We either take action against the licensees if they have done all they can to prevent the breach (or indeed remove the individual from the premises), take action against the perpetrator or take action against both.

Against that background COSLA and ACPOS are arranging a meeting to discuss these issues and the possibility of developing enforcement guidelines, jointly badged, by ACPOS and COSLA to ensure a consistent approach from Police and Local Authorities across Scotland. The Scottish
Executive is aware of this intention and will be given the opportunity to be represented at the meeting.
I hope this is helpful. If further information is required, please do not hesitate to contact me. Yours sincerely
Alan McKeown

COSLA

cc Gordon Greenhill
City of Edinburgh Council
I would like to thank you for giving the officials the opportunity to present the contents of the Smoking, Health and Social Care (Scotland) Bill to the Health Committee on the 11th January 2005. I hope that the members of the Committee found this a useful exercise.

There were a number of points raised where officials undertook to provide additional information or felt that further clarification would be of help. Please find attached a paper that provides this information. Again, I hope that this is helpful.

Andy Kerr

Annex A
Proposed Amendments to Part 5 of the Adults with Incapacity (Scotland) Act 2000

1. At the meeting of the Health Committee on 11 January, when Scottish Executive officials provided a briefing on the provisions of the Bill, some issues were raised about the amendments proposed to the Adults with Incapacity (Scotland) Act 2000. It may therefore be useful to the Committee to have this further background to the amendments proposed in the Bill and the rationale for them.

2. Part 5 of the 2000 Act came into operation on 1 July 2002. It gives a general authority to medical practitioners to treat patients who are incapable of consenting to the treatment in question. The authority is conferred by a certificate of incapacity, which can only be issued by a registered medical practitioner. Medical treatment is defined in the 2000 Act as “any procedure or treatment designed to safeguard or promote physical or mental health”. It could therefore range from fundamental healthcare procedures, (including relief of pain and discomfort, eyesight, skin care, and oral hygiene), and nursing care to major surgical operations. Emergency treatment to preserve life or prevent deterioration in a person’s condition can be given without the need for a certificate of incapacity. Other excepted treatments – such as electro-convulsive therapy or sterilisation – specified in The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002, are not authorised by a certificate of incapacity but are subject to an approval regime set out in the regulations.

3. A Code of Practice, which had been the subject of extensive consultation, also came into effect on 1 July 2002.

4. The Code gives guidance on the operation of Part 5. It sets out the assessment process, which should be undertaken before a certificate of incapacity is issued. It makes clear that adults must not be labelled as incapable because of some other circumstance or condition. Rather the assessment of capacity must be made in relation to the particular matter or matters about which a decision or action is required. Thus doctors, in assessing capacity, should bear in mind that they are assessing capacity in relation to a decision about the medical treatment in question. In assessing capacity, it is a statutory requirement to take account of the present and past wishes of the adult, so far as this can be ascertained by any means appropriate to the adult, including communication by human communication or by mechanical aid. It would be reasonable, in this regard, to use the help of the adult’s relatives, friends, social work, clergy or others, who may be in a position to assist. The practitioner’s own knowledge of the patient will also be relevant to the assessment process, as will the experiences of other health professionals – in particular nurses from their (often) close ongoing contact with the patient. The doctor should also ascertain whether it would be reasonable and practicable to seek the views of any existing proxy with welfare powers.

5. The Act currently provides for certificates of incapacity to last for a maximum of 1 year, from the date of examination on which it is based.

6. The Code was due for revision in July 2003, but, in the light of concerns expressed about the operation of Part 5, the Executive agreed to advance the review. In particular, general
practitioners were concerned about the workload implications of the procedure recommended to be followed in the Code of Practice, especially the processes connected with the completion of certificates under Section 47. Dental practitioners were concerned that treatment for an adult with incapacity presenting at their surgeries could be delayed until a certificate of incapacity could be issued by a doctor. This is especially frustrating in the community dental service, where patients—and their capacity to consent or refuse—are often already well known to the dental practitioner.

7. A consultation exercise on the implementation of Part 5 was accordingly launched on 31 March 2003. This sought the views of a wide range of stakeholders on changes or improvements that might be made to the Code of Practice, and whether consideration ought to be given to amending the terms of Part 5 to assist its effective operation including (a) whether health professionals other than registered medical practitioners should be allowed to sign certificates of incapacity and (b) whether the maximum duration of certificates of incapacity should be extended.

8. A qualitative study of the implementation and early operation of Part 5 was also commissioned by the Executive in July 2003. A 3-stage process of data collection was employed across four case study areas of Scotland to focus on the experiences of those who had come into contact with Part 5. This process included a postal questionnaire with health and social care practitioners; 52 interviews with practitioners and representatives of relevant stakeholder organisations; and 4 interviews with carers of adults who had experienced the operation of Part 5 of the Act.

9. An analysis of the responses to these 2 initiatives was placed in the Scottish Parliament Reference Centre, with Bib.Nos.31350 and 32709 respectively. In addition, Executive officials met key stakeholders in February 2004, including the British Medical Association, Alzheimer’s Scotland, the Law Society of Scotland, the Scottish General Practitioners Committee, ENABLE, the Mental Welfare Commission, the Association of Directors of Social Work, CARE, the Society for the Protection of Unborn Child and the Scottish Council on Human Bioethics.

Extending the Range of Health Professionals Who Can Issue Certificates of Incapacity

10. As the analysis of written submissions to the consultation records, the general consensus among respondents was that health professionals other than registered medical practitioners should be allowed to sign certificates of incapacity, subject to various qualifications including the need to ensure that health professionals are equipped with sufficient skills. This was also the view of the meeting with stakeholders in February 2004.

11. Accordingly, the Bill provides that, in addition to the medical practitioner primarily responsible for the medical treatment of the adult, the following may issue certificates of incapacity:

   A person who is;
   - a dental practitioner
   - an ophthalmic optician
   - a registered nurse
   - or a person who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfy such requirements as may be so prescribed,

and who is primarily responsible for medical treatment of the kind in question.

12. The rationale for adding dental practitioners is based on their concerns that the need to obtain a certificate from a doctor before a dental intervention could be carried out was time consuming and could delay the administration of appropriate treatment. This was of particular concern when a patient was in pain, or had a potentially serious infection, which might not fall within the category of emergency treatment.

13. Similar considerations can arise in the case of ophthalmic opticians, where the ability to issue a certificate could facilitate the service given to patients unable to consent. For example, opticians could find themselves with a patient presenting with red eye or a foreign body sensation in their eye which need not necessarily be regarded as an emergency. In cases of incapacity and
in which a certificate has not been issued, the optician at present would need to request and await the issue of a certificate from the medical practitioner primarily responsible, thus potentially prolonging the adult’s discomfort.

14. In respect of nurses, the case has a number of strands including –

(a) in the multi-disciplinary team working, which is now being encouraged as the way ahead for NHS Scotland, the lead clinician may be a consultant nurse with particular responsibilities for the person’s care and treatment. In the evolving primary care sphere, team leaders need not always be general practitioners but rather the professional with the skills most appropriate for the procedure or aspect of care concerned. This does not, however, diminish the key role of general practitioners, who will remain as the central focus in primary care, with the improved modes of communication among health professionals, enabling them to be kept fully informed about their patients.

(b) in care homes, nurses need to carry out a broad range of duties, which come within the wide definition of medical treatment in the 2000 Act, including basic nursing care and changing or applying surgical dressings. It is desirable that they should be able to carry out these tasks without the threat of legal challenge and that, where necessary, and in cases where a certificate has not already been issued by a medical practitioner, they should be able to issue a certificate at their own hand, providing they have the necessary expertise to carry out the required assessment.

(c) in general, it is envisaged that nurse practitioners, practice nurses and nurse consultants are the groups most likely to use these powers.

15. It is envisaged that the Code of Practice will set out the circumstances in which it would be appropriate for nurses and other proposed signatories to issue certificates.

16. It is important to note that these additional categories of potential signatories could only authorise treatment within their specialism. Thus, a dentist could only authorise dental treatment and a nurse could only authorise or carry out treatment, which was within his or her professional competence. Before issuing a certificate of incapacity, they would need to carry out the assessment procedure set out in the Act and the accompanying Code of Practice.

17. The responses to the consultation stressed the need for professionals issuing certificates of incapacity to have the training and expertise to assess capacity. Already, for example, dentists receive general training on issues of consent and some specific training on the 2000 Act. Such training is offered at 3 key stages: through the undergraduate curriculum; and following vocational training, a range of post graduate courses are offered by NES Scotland. But the Executive attaches particular importance to the need for professionals issuing certificates to have the necessary competence to assess capacity and, in consequence, it is discussing with NHS Education Scotland the introduction of training packages and protocols for health professionals involved in the issue of certificates and in assessment procedures.

18. The Bill also makes provision for other groups of health professionals to given the authority to issue certificates, subject to such requirements as may be prescribed in regulations. There is no immediate intention to increase the range of signatories but, if in the future, any such need emerged, any proposed addition would be the subject of consultation and the regulations, would, of course, be laid before the Parliament.

Extending Duration of Certificates of Incapacity

19. In relation to increasing the duration of certificates of incapacity, again the general consensus among respondents to the consultation was that the maximum length of certificates of incapacity could be extended, subject to various qualifications. For example, a number of respondents expressed reservations about extending the duration for adults, where capacity might fluctuate. Accordingly, the Bill proposes that the certificate should be for one year or, if in the opinion of the person issuing the certificate, any of the conditions or circumstances prescribed by Scottish Ministers applies as respects the adult, for up to 3 years. It is envisaged that the
regulations which will prescribe the circumstances in which the certificate can be extended beyond a year would focus on, for example, conditions in which there is progressive deterioration and from which the adult is unlikely to recover. Again, there would be full consultation on the terms of the regulations which would thereafter be laid before the Parliament.

Conclusion

20. In proposing these amendments to the Act, the Executive’s aim has been to find ways to help improve the operation of this important legislation, while at the same time maintaining its principles and ensuring the continuing benefits and protection it provides for this vulnerable group of adults.

SUBMISSION BY MINISTER FOR HEALTH AND COMMUNITY CARE 16.03.05

I am writing to you in response to your letter of 8 March and 9 March following the Health Committee oral evidence sessions on March 1 and 8 March 2005.

The annex to this letter addresses the specific questions asked on hepatitis C, joint ventures and adults with incapacity. It also provides additional information arising from the three oral sessions to date, including 22 February 2005.

Hard copies of HDL (2004)31 (the service alert on the Skipton Fund) and an application pack are also enclosed for your information.

I hope you find this information helpful.

Andy Kerr

ANNEX : SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL
Additional Information for the Health Committee

Hepatitis C

1. The justification for the exclusion from the scheme of those who died before 29 August 2003 (section 24(1)(c));

29 August 2003 is the date that all Health Ministers in the UK announced that a UK scheme would be established and was therefore chosen as the eligibility date for the scheme. The Executive has great sympathy for the relatives and dependants of those who died before the eligibility date for the scheme, but has always made it clear that it has to consider the effects of the financial outlay on this scheme on ability to provide treatment for other patients. For that reason the scheme focuses on those who are currently suffering.

2. Progress in relation to the establishment of a Skipton Fund appeal procedure, including the date on which such a procedure will be operational and the scope for including a haematologist (as well as a GP) on any appeals panel;

The Haemophilia Groups Forum was consulted in October 2004 on an initial draft proposal for the composition of the Appeals panel and the Appeals process. All of the comments submitted in November 2004 are currently under consideration by officials of the four administrations. Officials met on 28 February to progress various issues in relation to the Skipton Fund and are due to meet again on 17 March to discuss these further. I am not currently in a position to give a definite date by which the Appeals panel will be operational but hope to be able to confirm this soon.

3. The justification for including an applicant’s place of residence when the claim is made or at time of their death as an eligibility criterion (section 24(2)(b)), rather than the applicant’s place of residence when that person was infected by hepatitis C as a result of NHS treatment;
For the purposes of the Bill, a person seeking to make a claim under the payment scheme in Scotland, must be resident in Scotland at the time of making the claim. This requirement enables more efficient administration of the scheme in the UK and merely determines which of the four administrations should meet the costs of the claim. The application process is the same for all claimants.

Consequently, if a person infected in Scotland moves elsewhere in the UK and had not yet made a claim to Scottish Ministers, they would be eligible to make a claim as a resident of England, Wales or Northern Ireland instead of Scotland.

4. The extent to which you are aware of problems faced by certain applicants in receiving assistance from clinicians, and particularly consultants, in completing application forms for Skipton Fund payments.

I am aware, from correspondence, of some cases where delays have been experienced. Where specific details have been given officials have been able to make enquiries of the NHS Board involved and to ensure they were taken forward. Where concerns have been raised I have indicated that officials would be willing to make enquiries if individual details were provided.

In the course of enquiries officials became aware that approximately 28 claims may have been delayed awaiting completion by consultants in the NHS Glasgow Board area. I understand that action has been taken by the Board to expedite completion and submission to the Skipton Fund.

A Health Department Letter (NHS HDL (2004) 31 - copy attached) was issued on 4 June alerting NHSScotland to the fact that the Skipton Fund would commence operations from 5 July 2004. You will see that the letter drew attention to the application process and the need for NHS clinicians to complete mandatory sections in the application form. The letter also explained that any charge levied in respect of the completion of the form would have to borne by the applicant. It highlighted the Executive's concern that genuine applications are not disadvantaged in this way and asked Doctors and NHS Boards to respect that concern and not to make a charge for processing claims that appear genuine.

5. The justification for decision to establish the Skipton Fund as a private company.

Legal advice on the setting up of the Skipton Fund advised that it could not be a charitable trust because of the nature of the one-off payments. In order to give the Skipton Fund legal status it was necessary to register it as a Limited Company. This was also important in terms of requiring the Fund to be a legal entity so that it could be referred to in the Department of Works and Pensions Regulations allowing a social security disregard.

6. Clarify whether section 24(3)(b) - which appears to allow for Skipton Fund payments to be taken into account in any other proceedings an applicant may undertake – is a departure from the current arrangement.

During his evidence Mr Maguire suggested that there should be an amendment to 3(b) to make it clear that a person can receive a payment from other schemes in addition to a Skipton payment. Clearly this section must properly reflect what has previously been said by Scottish Ministers. I will consider this section and amend as appropriate.

Joint Ventures

7. How will public finance and public service delivery be safeguarded should a joint venture company or initiative fail?

The risk exposure of a joint venture will depend on the structure that it takes. For a company limited by share capital the risk of failure is limited to the share investment. For companies limited by guarantee the exposure will be dependent on the extent of guarantees given to underwrite losses and support the rights of creditors.
As with any contract between parties, terms covering the default by either party to a contract will be covered. There are a number of events that could trigger a default including breach of the contract by a party or failure to perform and deliver specified services specified in the contract.

With public private joint venture structures there is a real incentive for both the public and private partners to make the joint venture a success as both parties are sharing risk in the form of their investment in the company and the returns that both parties expect over the duration of the partnering agreement.

We will ensure, through standardised documentation, that any partnering agreement between the public and private sectors requires a joint venture to perform its obligations at its own risk and without recourse to Government or public funds.

8. Will the Scottish PPP staffing protocol apply to joint venture companies established under these provisions?

The STUC Protocol with Scottish Ministers and subsequent guidance clearly indicates that it applies to all Public Private Partnerships (PPP). Public Private JV’s are a form of PPP and therefore the protocol would apply in such cases.

9. To what extent has discussion taken place with CoSLA and the NHS Confederation about the policy intentions behind these provisions and their implementation?

In 2003, COSLA officers and nominees participated in and contributed to the original Short Life Working Group on Joint Premises Development which produced the report which recommended that:

• Recommendation 20 - Public Private Partnerships: The Scottish Executive should introduce legislation that will enable Scottish Ministers, NHS bodies and contractors, local authorities and private sector providers to enter into Joint Venture agreements in order to make available another vehicle to support joint premises development. The first stage would be to consult on proposals.

• Recommendation 21 - LIFT (Local Improvement Finance Trusts): The Scottish Executive should consult within its proposals for Joint Venture Organisations such as LIFT on the basis that such arrangements offer flexibility for joint premises developments in community care under the umbrella of community planning partnership(s).”

As part of the SLWG consideration of whether to recommend consultation on Joint Ventures, COSLA representatives attended detailed presentations on NHS LIFT and were involved in a visit to a LIFT project in Newcastle and North Tyneside.

In 2004, COSLA responded to the subsequent Scottish Executive consultation on Joint Ventures and attended events that contributed to the consultation report. At the same time, East Ayrshire Council and NHS Ayrshire and Arran participated in the development of a good practice toolkit for Joint Premises development which was published by the Scottish Executive as part of the report recommendations.

In 2005, following the Joint Venture consultation, Ministers approved the establishment of a Joint Premises Project Board to oversee the implementation of the report recommendations and consultation findings. The Board is remitted, amongst other things, to scope the detailed options for Joint Venture models.

COSLA have provided co-chairmanship for this Board and have nominated representatives from an estates and policy perspective. Social work are represented on the Board by a member of the Association of Directors of Social Work. The Project Board held its first meeting on 21 January 2005 and is currently in its set up phase.

The NHS Confederation has been invited to take a place on the Stakeholders Forum with which the JPPB will have ongoing dialogue.
10 What consideration has been given to the possibility of conflict of interest in relation to governance arrangements given that NHS and other public sector representatives are likely to play a role in joint venture company boards?

The issue of conflict of interest is not unique to joint ventures but applies to all corporate bodies, both public and private. In the context of joint ventures this issue being considered both from an employee and organisational governance standpoint.

The Civil Service Code covers the requirements on civil servants, including those of propriety, honesty and use of public funds. The terms and conditions of other staff groups will generally incorporate reference to conflicts of interest and general probity issues.

Detailed guidance has been prepared for Government Departments and Public Bodies thinking of forming joint ventures which includes issues around governance and conflict of interest within joint venture companies. This guidance will be fully considered in the development of joint venture models developed as a result of the provisions within the Bill.

The structure of a company is framed within the Articles of Association and Shareholders Agreement.

All corporate bodies whether public or private have to recognise the possibility of conflicts of interests and make appropriate arrangements to deal with such events. In such cases Board members are required to declare such conflicts of interest. Whilst individual integrity is the basis of such a position we would wish to protect the interests of individuals and the organisations that they represent. The Executive is committed to ensuring appropriate guidance is produced to support the operation of joint venture companies at a local level to deal with such issues.

In general terms the governance arrangements for any joint venture company will be compliant with The Combined Code on Corporate Governance issued in July 2003 by the Financial Reporting Council.

It assists greatly if the joint venture is established to deliver a common agenda with public sector participants. Given the participation of the public sector in the first place there has to be a commonality of interest. The objects of the joint venture can be constructed in such a way to ally interests and minimise conflicts of interest. The NHS LIFT initiative is a working example of how this approach can and has been put into practice.

11. What consideration has been given to alternatives to the Bill; for example, extending prudential borrowing rights to Health Boards?

Westminster legislation provides Local Authorities with the powers to raise funds through borrowing. These arrangements have been well established over many years. The prudential borrowing regime which was recently introduced has provided greater flexibility to Local Authorities in terms of increasing borrowing to fund projects with identified income to repay the borrowed funds and their costs.

The use of prudential borrowing arrangements is already available to local partnerships as a method to fund the development of joint schemes. The local authority raising funds where the income for the scheme is identified by the partnership from their respective resources. As with all funding methods, local partnerships are expected to consider the delivery of Value for Money in whatever funding method is chosen.

The extension of borrowing powers to individual NHS Boards in Scotland has not been considered since the Scottish Ministers have no powers to raise extra resources by borrowing or sanctioning borrowing. Capital funding in the NHS is controlled by rules issued by HM Treasury, the Scottish Executive has no power to change these rules which are a reserved matter for Westminster.

The powers in the Bill pave the way for new methods of funding for joint premises to be developed which are intended to be additional to these traditional routes and which are aimed at providing improved value for money.
12. What guarantees can be offered that joint ventures will prioritise health services and facilities, rather than commercial development?

The influence on the direction taken and prioritisation of schemes would be achieved through the governance arrangements established for the joint venture company.

In the context of a LIFT type development, the Strategic Partnering Board (SPB) fulfils this role via the Strategic Service Development Plan (SSDP).

The SSDP is a whole system approach to service planning intended to be a tool to co-ordinate the plans and aspirations of all users and carers, of health, social care and other identified services in the local area. It is complementary to existing planning processes and is the document which brings all relevant strands together.

It is a useful performance management tool for local teams, NHS Boards, Community Health Partnerships, Local Authorities, and the Scottish Executive etc. and will enable measurement of change by identifying a baseline from which to work and considering the delivery of the vision as further SSDP’s are developed in the coming years.

It will be the document that gives stakeholder approval for the development of a LIFT company. It is expected that should this model be adopted it would be a pre-requisite for Scottish Executive approval. It would explicitly give stakeholder undertaking to commit to the revenue consequences of the first wave of schemes to be delivered by the local LIFT company.

The SSDP is also the basis on which a LIFT partner would be procured and would form the main elements of the Memorandum of Information issued to all parties who respond to the OJEU notice.

It will be specific about the first schemes to be delivered by the LIFT company and therefore the basis of capital investment approval by the stakeholders.

The Strategic Partnering Board (SPB), which is made up of representatives of local public sector partners, will agree the needs of the local community and determine the requirements for local services and facilities to be provided by the LIFT Company. It enables the NHS Boards and local authorities to come together with representatives of other interests (e.g. medical and dental practitioners, voluntary groups, patient representatives etc.) to agree priorities for service development and improvement. The Strategic Partnering Board would approve the SSDP, which is updated annually. The LIFT Company is invited to develop proposals for improvements to facilities and/or services to meet the requirements of the SSDP.

The role and rights of the public sector can be adequately defined and protected within the rights of minority shareholders within the Articles of Association of the Joint Venture.

In Scotland, consideration is being given to how Community Planning Partnerships and Community Health Partnerships can fulfil this role.

13. Is it intended that joint venture companies in Scotland will mirror or differ from the operation of NHS LIFT projects in England?

The LIFT model is one model that could be applied in Scotland. The decision to seek powers for the creation of joint ventures in a health context was taken by Ministers on recommendation of the Short Life Working Group on Joint Premises which reported in July 2003 and which contained members from the Scottish Executive, COSLA, and Local Authority together with other contributors from NHSScotland and local government.

The role of the Joint Premises Project Board, established in December 2004, is to take these issues forward in an inclusive way. The JPPB involves the Scottish Executive, NHSScotland, COSLA, Staff Partnership Representatives and Partnerships UK.
On the basis of work undertaken to date on the application of possible models we are of the view that the NHS LIFT model would be capable of adaptation for use in Scotland but we are committed to the development of a model that meets the service needs of communities within Scotland. We are aware that the National Audit Office is due to issue a report in April on the NHS LIFT initiative in England and we will be informed by the findings of that report.

It is, and will be, possible for alternative models to be developed. But there are cost and time implications in doing so both nationally and for local partners. Cost implications will include the actual costs of developing alternative models together with the impact on financing terms of an untried and untested model. The powers we are seeking are generic and do not restrict either Scottish Ministers or NHS Boards to one particular model.

14. In PFI projects, the assets revert to the health service at the end of the period of the contract. What will happen to assets and the land on which they are built at the end of the project, under the joint venture provisions?

There are a number of points to consider:

Where contracts require the property to revert to the Public Sector Organisation (PSO) at the end of the concessionary period the payments made to the Company will reflect this fact, i.e. the PSO would be paying for both the serviced facility over the period and also the value of the property at the end of period, spread across the payments. It will be less costly if the option to own remains open.

In public private joint ventures envisaged there could be a wide range of public and private sector users involved (e.g. Social Work, Benefits Agency, Health Board, GP’s, Pharmacists etc.) and it would be difficult to spread the ownership across them all in a meaningful way. There would also be more flexibility for users individually or collectively at the end of the period. For example by having the right to buy the premises at market value, extend the lease or walk away it will be possible for users to make a decision that will fit in to the way services have developed by that point in time and not be tied in to a potentially unfit building for modern services.

It should also be noted that the lease of premises for use as Local Authority premises, GP facilities, NHS offices etc is not unusual and it is only in PFI that ownership transfers at the end of the period.

Adults with Incapacity

15. When will the regulations associated with section 30 of the Bill be available for review by the Committee?

The Executive anticipates being able to put forward to the Committee in June, regulations on the extension of the period of a certificate of incapacity.

Disclosure of Information

16. Executive officials agreed to provide supplementary information on whether the Bill requires individuals currently listed as dental, ophthalmic or pharmaceutical practitioners to disclose information for inclusion in the proposed extended lists.

17. There is nothing in the Bill that would prevent there being a requirement on those currently listed as dental, ophthalmic or pharmaceutical practitioners to disclose information. Currently listed dental and ophthalmic practitioners would be listed in the future in the first part of the new extended lists. In relation to pharmacists, those that will be performing pharmaceutical care services would be listed in the new list of pharmaceutical care service performers.

18. There are powers to make transitional provision between the existing listing arrangements and those introduced by the Bill. It should be noted that regulations in relation to the extended lists under what will be section 17W, 25(2), and 26(2) of the National Health Service (Scotland) Act 1978 may make provision to both applications for inclusion to the lists and requirements with which a person included in the lists must comply.
19. In relation to enhanced criminal records certificates, the amendments to the Police Act 1997 made by Schedule 2 of the Bill will not prevent such certificates being obtained in relation to those applying to or already included on the extended lists.

Pharmaceutical Care Services Regulations

20. Skeletal drafts of the regulations arising from Part 3 of the Bill will be available for Stage 2 but much of the detail will be dependent on negotiations and discussions that will be taking place between the Executive and the Scottish Pharmaceutical General Council (SPGC) over and beyond the summer.

21. Part 3 of the Bill contains regulation provisions in four main areas. The following lists those areas and summarises what should be available. In all cases we are committed to consulting SPGC throughout the drafting process.

Health Boards’ duty to plan and secure, and publish information about, pharmaceutical care service provision.

22. It will not be possible to provide a draft for this area. Development work is currently in hand to establish model criteria for both the planning and administrative processes. Prior to drafting regulations, we plan to test out the recommended arrangements in two or three Health Board areas. We do not expect to be in a position to commence drafting in detail until around September or October of this year.

Describing pharmaceutical care services

23. The draft will define the services to be regarded as ‘essential’ and additional’ and provide a broad outline of what they will comprise, e.g. dispensing services. Descriptions of the clinical and professional requirements for the services will be in directions, the detail of which will not be available at Stage 2 as the subject matter is for continuing negotiations.

Pharmaceutical Care Contracts

24. The draft will provide the framework with the sections on some of the contract operation issues populated but still subject to discussions with SPGC.

25. The Bill also contains powers of direction for the remuneration/reimbursement elements of the contract. These will not be finalised until close to contract implementation in April 2006 and, therefore, will not be available until that time.

Persons performing pharmaceutical care services - including ‘listing’ of performers.

26. The draft is likely to be at a stage that gives a reasonably clear picture of how the listing of performers of PCS will be regulated.

NHS Tribunal

27. In serious cases a referral to the NHS Tribunal can be made but where the allegation against the practitioner is of lesser importance a health board may refer the case to a discipline committee.

28. Discipline committees are established by each health board for each of the primary care/family health service professions. They have a legally qualified chair and equal numbers of lay and professional members. To ensure impartiality, cases are considered by a discipline committee established by a separate health board to the one which makes the referral. The sanctions available to a health board when one of its practitioners has been found in breach of their terms of service are to give a warning or order a recovery of remuneration. In the case of dentists they may be required for a period to obtain prior approval of certain work.
The table below shows the number of complaints made concerning NHS primary care/family health services, the number of Health Board Discipline Committees held and the number of NHS Tribunals held for the last four years. As officials advised the Committee, there are currently 2 NHS Tribunal cases under consideration (year ending March 2005).

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Application of Bill discipline provisions to NHS 24

30. All health care professionals (contracted and directly) employed who provide general medical services can be referred to the NHS Tribunal.

31. NHS 24 employees do not provide general medical services. Individual health professionals employed by NHS 24, including nurse advisers, general practitioners and pharmacists are governed by the disciplinary proceedings by NHS 24 insofar as any acts or omissions that may arise while carrying out duties for NHS 24.

32. As with all health professionals, these individuals will also be accountable to their respective regulatory bodies, for example the Royal College of Nursing.

SUBMISSION BY MINISTER FOR HEALTH AND COMMUNITY CARE 18.03.05

I am writing to you in advance of my giving evidence to the Health Committee on the Smoking, Health and Social Care (Scotland) Bill. I feel it would be helpful to the Committees consideration of the Bill if I give an indication of the additional topics that the Executive is considering introducing as amendments at Stage 2 of the Bill process. These topics are within the scope of the Bill.

The attached annex lists those areas where the Executive is currently bringing forward Stage 2 amendments, subject to clearance through the Executive’s internal processes. It is possible that there may be a number of amendments in addition to these which are not sufficiently advanced for me to provide a description.

In addition I am anticipating that there will be a number of Executive amendments to the existing provisions in the Bill to provide clarification or correction, or that are amendments consequential to the provisions within the Bill.

I trust you find this information helpful

Andy Kerr

ANNEX: SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

Topics for Stage 2 Amendments by Scottish Executive.

1. Section 25 Regulation of Care (Scotland) Act 2001. Amendment to enable Ministers by order to vary (below but not above current statutory levels) the minimum frequency of inspection of care services by the Care Commission. Power to be capable of being exercised in different ways in respect of different categories of care. Power to be exercised only after consultation. Orders to be subject affirmative resolution.

2. The Care Commission has a statutory duty to inspect care services under Section 25 of the Regulation of Care (Scotland) Act 2001 ("the Act"). There are 2 sub-sections which specify the frequency of inspection which must be met by the Commission:-
• Sub-section (3) requires at least 2 inspections a year of any of the care services set out in sub-section (4) - broadly speaking, all care services which offer overnight accommodation - and that at least one of those inspections is done without prior notification to the providers.

• Sub-section (5) requires the Care Commission to inspect all other care services at least once a year.

3. By requiring minimum inspection frequencies, the 2001 Act inhibits the ability of the Care Commission to target its resources where they will have the most effect in improving users’ experience of care services. The proposed amendment would address this.

4. Mental Health (Care and Treatment) (Scotland) Act 2003. Mental Health Tribunal for Scotland: Recruitment of Members. The purpose of this amendment is the removal of the upper age limit for members of the Mental Health Tribunal for Scotland. The recruitment of 300 Tribunal members is essential if the Tribunal is to successfully carry out its functions and removal of the age limit would greatly assist in the recruitment and retention of all members. The amendment will delete paragraphs 4(3)(b) and 4(6)(b) of Schedule 2 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

5. Section 157 Public Health (Scotland) Act 1897. The amendment will provide a right of appeal against the removal to hospital, detention or continuing detention in hospital for persons suffering from an infectious disease. Section 157 of the 1897 Act has the effect of denying any appeal or review of orders under Sections 54, 55 and 96. These orders cover the removal to hospital, the detention or continuing detention in hospital for persons suffering from an infectious disease. The absence of appeal provision means this Act is incompatible with the European Convention on Human Rights.
Smoking, Health and Social Care (Scotland) Bill: Stage 1

14:03

The Convener: Item 2 is consideration of the Smoking, Health and Social Care (Scotland) Bill. I welcome to the committee the Minister for Health and Community Care. Members have received copies of the committee papers, which include submissions from the minister in letters dated 31 January, 16 March and 18 March, draft regulations that were circulated for last week's meeting and the Finance Committee's report. The Subordinate Legislation Committee's report will be available after the Easter recess. We will go through the various parts of the bill in turn. It is inescapable that this will be a long evidence session, although it will perhaps be more gruelling for the minister than for any member of the committee. I understand that the minister will be accompanied by different officials depending on which parts of the bill we are discussing. We will try to allow space for folk to move about when discussion on the part with which they are dealing is over.

Part 1 of the bill is on the prohibition of smoking in certain wholly enclosed spaces. For this part of the bill the minister is accompanied by Roderick Duncan, bill team leader, tobacco control division; Sarah Davidson, head of tobacco control division; and Joanna Keating, solicitor in the office of the solicitor to the Scottish Executive. I ask members of the committee to indicate questions that they want to ask about this part of the bill. Sorry, I am being hissed at that the minister will make a brief introductory statement. Sorry, minister.

The Minister for Health and Community Care (Mr Andy Kerr): Thank you. You can rest assured that my statement will be brief. It is good to be back before the committee and to have the opportunity to explain more of what the bill is about.

As you know, the bill is wide-ranging, so there will be occasional reshuffles at this end of the table of the officials who are here to support me. The bill is an important health measure and one that I think will deliver a significant change in the health of the Scottish people.

The bill has three main purposes. The first is the restriction of smoking by prohibiting smoking in certain enclosed places. The second relates to the provision of services by the national health service and, in particular, continuing the NHS modernisation programme. Within that broad area, the bill contains provisions for dental, ophthalmic and community pharmacy services as well as measures relating to discipline and measures that aim to impact on the operation of the NHS—for
example, to allow the NHS to participate in joint ventures to support the delivery of facilities and services. The third area comes under the theme of social care, and the bill incorporates a small number of provisions including amendments to the Regulation of Care (Scotland) Act 2001.

As we are all aware, the keynote provision of the bill is that which relates to smoke-free public places. I have said before that I consider the bill to be the most important piece of public health legislation in a generation. The decision to legislate on smoking was not taken lightly, but we believe that it is the right thing for Scotland.

First and foremost, as we are improving the health of the people of Scotland, we can no longer tolerate Scotland’s reputation as the sick man—or, indeed, sick woman—of Europe. Action on tackling smoking will, undoubtedly, help us to improve our health record. The supporting papers that we have submitted highlight the health risks that are associated with passive smoking. Those risks are now clear and irrefutable, as is the potential health gain from reduced exposure to environmental tobacco smoke and smoking itself. I have monitored the work of the committee and I am pleased that the committee accepts that the health risks exist. I hope that you will be equally convinced of the potential health benefits that the bill will bring. As are other aspects of the bill, the smoking provisions are firmly embedded in health and, as such, lie clearly within the competence of the Scottish Parliament.

Although I am convinced of the benefits that will flow from a smoking ban, I am aware of the fears of business interests, particularly the licensed trade, of the possible adverse impact of the bill. I understand those fears but, as is clear in the regulatory impact assessment that accompanies the regulations, they are not borne out by international evidence and experience. Overall, as you are aware, we expect the bill to have a nil or a positive economic impact. I am also working with businesses, through the smoke-free areas implementation group, to involve them in the process of delivering the policy in terms of how we will make the bill work if it is passed by the Parliament in due course. We cannot allow one area of business to dictate the health of the nation; hence, we want to ensure that the bill is comprehensive in its scope and properly enforced.

We have driven for a bill that can be clearly understood and that will be simple to enforce. There are those who have questioned whether the comprehensive nature of the bill is compatible with individuals’ rights and freedom to choose, and the issue of the European convention on human rights has been raised. However, as I have said in the past, just as smokers have rights, so non-smokers have a right to clean air.

Although, as the Minister for Health and Community Care, I would prefer people not to smoke for their own sake, nothing in the bill impinges on their right to do so. Nevertheless, it is clear that we want to provide the 70 per cent of Scots who do not smoke with a proper environment in which to partake of life, whether socially, through the workforce, through recreation or in any other way. We feel that the imposition of a comprehensive ban is the best way to protect the public’s health; therefore, the draft regulations propose very few exemptions from the ban and for humanitarian reasons only.

The bill is an important step forward for the health of Scotland. I look forward to our discussion this afternoon and commend the bill to the committee.

The Convener: Thank you, minister. I welcome Stewart Maxwell MSP to the meeting.

Kate Maclean (Dundee West) (Lab): I have a question on the final point that you covered: exemptions. In a controversial bill, exemptions will probably be the most hotly disputed issue, once the principles have been agreed. What criteria were used when the list of premises that will be exempt from the smoking ban was compiled?

Mr Kerr: The approach was largely humanitarian and involved common sense, in my view. Residential homes are where people live and have their home. We felt that, as long as there was a smoking policy in such places, people would have the right to smoke where it was deemed to be their home, just as others in the community have that right. That applies to adult care homes, but not to children’s homes.

Adult hospices are on the list of exempt premises for obvious humanitarian reasons. Psychiatric hospitals and units are included on the list because clinicians and others told us that that would be appropriate, if individuals’ overall mental health and well-being were to be looked after. There were obvious humanitarian and other reasons for that exemption. An exemption was sought for police rooms because it has the potential to help the police with investigations and interrogations.

The ban is not so comprehensive when it comes to hotel bedrooms. Although all public areas within hotels will be smoke free, it is felt that if an hotelier opts to have smoking rooms within an hotel, an exemption would be appropriate in those circumstances, because those rooms would be clients’ homes for the night or nights for which they stayed at the hotel.

I argue that there is clarity with the vast majority of public enclosed spaces. That will allow us to legislate effectively and to monitor and control smokers in those environments.
Kate Maclean: Hotel rooms will be treated flexibly on the ground that they are people's homes for the evening, but one could argue that if an adult cannot stay in their house on their own and must attend a day care centre, that centre is their daytime home for five days a week. Why have the same humanitarian criteria that have been applied to adult residential homes, or other places that could be deemed to be people's homes while they are staying there, not been applied to adult day care centres?

Mr Kerr: The reason for that is that adult day care centres are not the homes of the adults who attend them. I would argue that it is quite unusual for someone to attend such a centre five days a week, although that does happen, but regardless of how long they spend there, it is a place that they visit only temporarily; they still have their own home, in which they can smoke.

Kate Maclean: Does the same logic not apply to hotel rooms?

Mr Kerr: No, because guests hire hotel rooms for entire evenings; indeed, they could be in their room 24 hours a day for seven or 14 days. The situation is different for people who attend day care centres. They might spend just the morning or half a day there; how long someone spends in a day care centre is very much down to their individual circumstances.

Our approach has been to say that we want a ban that is as comprehensive as possible. To enhance public health, we want to provide as few opportunities as possible for people to smoke in public places. To all intents and purposes, a care home is the home of its residents; the same is not true of a day care centre. That has been the key determinant in our approach.

The Convener: I want to follow that up. Will you monitor that? If you found that, in a year's time, the number of people who were accessing day care centres was dropping because of the ban, would you revisit the issue? Would you keep an eye on that aspect of the ban if you found that people were missing out on day care as a result of it?

Mr Kerr: If any good evidence came to us during the parliamentary process, I would consider such matters immediately. As I have said, I think that day care centres are different because they are not home environments. If we created an exception for day care facilities, which are not people's homes, my worry would be that that would create an opportunity for people to come in behind that with other definitions that would weaken the comprehensive nature of the ban. We are determined that the ban's scope should be as broad as possible.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I would like clarification on the position of children's homes. Given that it is legal to buy and use tobacco products at the age of 16, how would the ban affect a child of that age who was in a home? Would they be allowed to smoke in that environment, which is their home?

Mr Kerr: No. We have taken the view that the majority of children in such homes are under the age of 16. If people can bring us other evidence on that, we will consider it. Although it is legal for a 16-year-old to purchase tobacco products, we would consider a children's home to be an inappropriate environment in which to allow smoking, so we will not do so under the bill.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I have known people decline to go to a day care centre because they knew that other people would be smoking. Likewise, the opposite might happen and people might not go because they could not smoke there. We know that it is better not to smoke, but some people can get distressed, after they get over the first stage of an illness when they cannot have a cigarette. Smoking is an addiction and it is difficult to deal with an addiction in someone who is in their 70s or 80s. Do you have a step-down process that will operate in relation to frail and elderly people and those who go into hospital with lung conditions?

14:15

Mr Kerr: Our intention is to ensure that environments that are used by non-smokers are smoke free. A day care centre fits that bill and, further, is also a place of employment for people who we would want to protect.

Having spoken to a number of people who work in cessation services, I would say no to your second point. When people are in hospital and have had a big scare, making it easy for them to smoke by providing a smoking facility undermines our cessation efforts. People who buddy such patients—either voluntarily or through the provision of health care services—would be aghast if we were to make that concession. When people experience a health scare, that is the time to harness their willpower and support them in their efforts to stop smoking. That is what the cessation services do. Having visited Wishaw hospital, where the smoking cessation team work in the critical care parts of the hospital that deal with coronary heart disease and respiratory illness, I know that that period of a patient's recovery period is key and I think that we would fail them if we made it easy for them to smoke at that time.

Further, we have to send a message to the public about public health. We should recognise
what Greater Glasgow NHS Board has done to make all of its health environments non-smoking. That sends the right message.

Kate Maclean: I support the legislation, but I think that I would find it difficult to justify allowing someone to smoke in a hotel bedroom—a room in which they might be spending only one night, mostly asleep—and not allowing someone to smoke who is being picked up at 8 o’clock in the morning to go to an adult day care centre and is dropped off at 6 o’clock at night. I am not saying that people should be allowed to smoke in adult day care centres; I am saying that, if they are not, it makes it hard to justify allowing someone to smoke in a hotel bedroom, even though they are capable of walking out to the street to have a cigarette.

I welcome the fact that private clubs will not be exempt from the legislation. Have any private clubs made a plea for support to be put in place? Does the Executive intend to make available to private clubs any support that would not be available to public houses or other licensed premises?

Mr Kerr: I am unaware of any special pleading on behalf of private clubs. My officials might be able to say whether there has been any. I understand the point that you made in the first part of your question but, again, I would point out that our policy is about the provision of smoke-free areas for members of the public who do not smoke. A hotel room is not a public area; an adult day care centre is. That is one of the key differences that we are talking about.

I move on to enforcement. One of the things that struck the committee when it went to Ireland was how the Irish bill has been successfully implemented and enforced. There is a non-confrontational approach to enforcement and the system is very much self-policing. Often, if a public health inspector finds that smoking is taking place in an establishment he will visit it the next day and the matter will be sorted out without a public confrontation.

Sarah Davidson (Scottish Executive Health Department): The Royal British Legion might have made representations at the time of the initial consultation exercise, but I am not aware of that. No such representations have been made to us in recent weeks, but we are aware of the concerns that were expressed to this committee.

The Convener: The question about private clubs arises from evidence that we took last week from a representative of the Royal British Legion in Scotland who indicated that many of its clubs’ finances are marginal and that they are liable to close as a result of the proposal. I do not know whether that representation has been made directly to you.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I move on to enforcement. One of the things that struck the committee when it went to Ireland was how the Irish bill has been successfully implemented and enforced. There is a non-confrontational approach to enforcement and the system is very much self-policing. Often, if a public health inspector finds that smoking is taking place in an establishment he will visit it the next day and the matter will be sorted out without a public confrontation.

During our evidence-taking session last week, some of us were more than slightly alarmed by the approach of the City of Edinburgh Council, as opposed to the approach of the police. The council seemed to take the view that the law is the law and that section 1, which creates the “Offence of permitting others to smoke in no-smoking premises”, is of equal measure with section 2, which creates the “Offence of smoking in no-smoking premises” on an individual basis. The council gave the impression that there could be a situation, say on a Friday or Saturday night in Edinburgh, of officials going out and slapping fixed-penalty notices on individuals who were breaking the law. We wonder whether that would be counterproductive to the enforcement of the law. Surely the best approach is the non-confrontational one that has been adopted in Ireland.

Mr Kerr: I certainly hear your view that the handling of the matter is critical, and I share your view of the need for a sensible, non-confrontational approach and I give due credit to professionals in the field. That is how they should be working and I am sure that that is what will happen. As I am sure you discovered in Ireland, people are generally law-abiding. That is an
important point; we should not forget that people want to obey the law and that they will invariably do so.

How environmental health officers apply the legislation is important. I have spoken to the Royal Environmental Health Institute of Scotland more than once and what struck me was that very point about the need for a sensible approach. Through the smoke-free areas implementation group’s work with the licensed trade we want to ensure that everyone knows their role, understands how we will enforce the provisions and can handle any situations that arise. As long as the person who manages a bar has done what they need to do in relation to the legislation, we will understand the efforts that they have made. We expect certain things of bar owners in ensuring that they meet their end of the smoke-free bargain: to put up signage, to manage their clientele as best they can, and to ensure that ashtrays are not provided. We want to ensure that we work sensibly with bar owners and their staff as well as with the public.

I support the view that implementation and enforcement should be sensible. If observations are made in the evening, particularly on a Friday or Saturday night, it should perhaps be the next day when environmental health officers visit the bar owner and say, “You need to get a grip on this.” Professionals have appropriate ways in which to approach members of the public whom they encounter and I am sure that they will continue to act in that way in the future. That also applies to provisions in other pieces of legislation, such as fixed-penalty fines for parking offences and—dare I say it—the provisions in the dog-fouling legislation. In handling such situations, professionals aim to reduce confrontation and tension, and I am sure that the enforcement of this bill’s provisions will be no different.

Mike Rumbles: I am delighted to hear that the Executive’s view is the same as the committee’s view. However, when we put our questions to the people who will enforce the legislation, their view seemed to be that there is no hierarchy of offences in sections 1 and 2 and that the offences that are created in those sections will give them the authority to go out on a Friday or Saturday night and issue fixed-penalty notices. Can the sensible enforcement method that you have described be achieved by issuing guidance to local authorities, or should section 2 be amended? Should the bill be changed or should a direction or advice to local authorities be sufficient?

Mr Kerr: First, I will raise the subject at the next meeting of the smoke-free areas implementation group, so that we have an agreed commonsense approach on the right way to proceed. Guidance would be appropriate. I see no reason to change the bill. However, as I said in response to previous questions, if we find evidence that leads us to conclude that we need to amend the bill, we will do so, although I do not think that that is the case in this instance. We might come back to the issue at a later stage, following discussions with REHIS and others on implementation. However, I am sure that the approach that we have identified with REHIS is the best one, therefore I hope that we will simply produce guidance, rather than amend the bill.

The Convener: Our concerns arise out of last week’s evidence, because what we heard from the City of Edinburgh Council was distinctly different.

Mr Kerr: I heard about that.

The Convener: There was general concern that if that one approach was pursued throughout Scotland, we would be in a different kettle of fish to that which we envisaged.

Mr McNeill: We saw at first hand in Ireland the positive implementation of the law and the high level of compliance with it. You mentioned that we have to send a clear message. Our observation as a committee was that a broad-brush approach was taken in Ireland. Will the integrity or enforcement of the bill be harmed by the contradictions that will arise, given the lax enforcement of the law against the under-age purchasing of cigarettes, and the openly illegal sale of tobacco products that can be witnessed at any market week in, week out? People also smoke in and around schools and nurseries—as they drop kids off in the morning—and in and around NHS premises. At the same time, we are embarking on legislation that will take action against people for smoking in public places. I worry about that contradiction, and whether it will affect compliance and enforcement. What influence or powers can you bring to bear to address those issues with other ministers, directly or indirectly, even in the short term during the progress of the bill?

Mr Kerr: The package is bigger than the bill that we are discussing today. For example, our considerable additional investment in cessation services will go a long way towards supporting smokers. We are not out to get the smoker, we are out to help the smoker get off tobacco. That is why we have substantially increased those resources. In terms of the health service, we are getting cuter about smoking cessation teams and the work that they do, by intervening at the right point in people’s lives, giving them long-term support, and providing the different tools to help them to quit cigarettes.

There is a balance to be struck. There is also a balance to be struck around the Executive’s media work, in terms of health education. Our “smoke snakes” adverts, the message that we are trying to get across particularly to young girls, and the work
that we are doing to denormalise smoking, are all part of that package. Also raised was the enforcement of current legislation—which I am happy to consider with other ministers—and our powers on the age at which people can buy cigarettes. It is a balanced package, and I argue that we have it in hand at the moment.

The bill is not all about the ban; we are trying to achieve a balance of measures. We are trying to convince young people that to embark on smoking is not the right thing to do. We are also assisting smokers to give up smoking through cessation measures and denormalising cigarette smoking through the work that we are doing in the media. However, if other legislation is to be introduced—such as the Lord Advocate signing off the use of test-purchasing—it can all become part of the package. I accept that there are other things that we can do. We are taking a rounded approach to trying to denormalise and restrict smoking.

14:30

Mr McNeil: Do you accept the point that we thinking of the people who would say, “I’m an adult and I am being prevented from smoking in a public place, when at the same time a 16-year-old can buy cigarettes or an under-age person can be provided with them. Why should I, as an adult, be fined for smoking in a public place—mainly down the pub—while other people are openly selling tobacco products illegally and not being prosecuted?” Surely that is what those people will say.

Mr Kerr: People who are selling products in that way are breaking the law and I hope that we would hammer them for their conduct, which is reprehensible. If people are doing that, we should use test purchasing to detect it and we should enforce consumer and trading standards. The police should enforce the law on illegal sales.

You raised the issue of 16-year-olds smoking, but that is the current age at which someone can buy cigarettes. I accept that one way in which we could try to change young people’s attitudes to smoking is through increasing the age at which people can purchase tobacco. I suggest that the issue is more one of denormalising smoking. We need to make smoking untrendy; we need to make it clear that it affects young people’s lifestyles and choices. An age barrier could make smoking sexier for young people—prohibition can do that—but I am happy to have a debate on the issue.

The Convener: We are in danger of going off-topic and I want to bring us back to its provisions. We have a lot of work to get through this afternoon, I call Helen Eadie.

Helen Eadie (Dunfermline East) (Lab): I want to address the issue of penalties. As you said, minister, we need to begin to hammer people for not obeying the law. What provisions are there for ensuring that the penalties address the issue?

Mr Kerr: I am sorry, but did you say, “What measures”?

Helen Eadie: I asked about the provisions. What provisions are being made for penalties to increase over time? Let us return to the example of parking fines. If someone does not pay the fine, they are given the option of paying £30; if they do not pay that fine, they have to pay £60; and if they continue not to pay, the fine rises to £90. The issue of penalties came up last week in our evidence taking. The committee took the view that some landlords could arrive at a considered view each year on fines. They could add a sum of, say, £10,000 into their balance sheet for the year as the amount that they are prepared to write off for fines.

Mr Kerr: As you know, fine levels are set out in regulations; they will be £200 for an owner and £50 for the individual. The fines that we are putting in place are set at what we think is an appropriate level. Again, our proposals will be consulted on and views will be gathered.

Speaking bluntly, I believe that it is easy to spot cases in which someone is taking an economic gamble by saying that they can afford to get caught X number of times. In cases in which a landlord is deliberately buying their way out of their obligations under the legislation by simply paying fines, the ultimate sanction of licence removal should prevail.

The levels of fines, which are the subject of consultation at the moment, must be appropriate. We are clever enough, as are our enforcement officers, to detect such practice. As I said, if we detect it, we will impose the most drastic of sanctions, which is the removal of the licence.

Helen Eadie: The Finance Committee report says:

“the costs of enforcement are largely unknown.”

How will the Executive ensure that the funding to meet the costs is made available? Is the Executive committed to funding additional enforcement costs?

Mr Kerr: I appreciate the point that the Finance Committee made. I am also aware of what the Convention of Scottish Local Authorities has said about its expectations of the bill. The financial memorandum to the bill shows a figure of £6 million, which we think is the upper level of the costs.
Given that Ireland has about 50-odd enforcement officers, we thought that we should have 70-odd officers. We think that that is the appropriate number, based on the fact that, if enforcement has worked in Ireland with 50-odd officers, we should add an appropriate number of officers to the Irish total. We tried to work through the methodologies that the Irish had employed. The numbers have not been plucked out of the air, but they are up for discussion with the people on the front line—COSLA and REHIS people, and others. However, we think that we have made a fair assessment of the costs of enforcement and the number of people whom we would require for that job.

As committee members will be aware—from your visits and other work—we think that the costs will tail off fairly sharply. That has been the experience elsewhere, once legislation has been put in place and has become normal. In a few years’ time, I genuinely think that people will look back and say, “What was all that about? You mean that people used to smoke in pubs here?” I think that we will get to that position fairly quickly and that the costs of enforcement will drop dramatically.

Mr McNeil: You said that an important objective of the bill was to reduce smoking overall. I agree with that objective; it is the big challenge to us all. You recently announced £12 million or so for cessation policies. How did you arrive at that figure? How will that £12 million be used? Is it sufficient? Will it target communities such as Shona Robison’s, with 18,000 smokers? Will such communities gain more benefit than, for example, Mike Rumbles’s communities, with fewer smokers? Will there be effective targeting?

Mr Kerr: Money will be distributed to the health boards in the normal way. Going into the details of that would probably be unhelpful, but we can consider different routes to cessation. Some are more expensive than others. If I remember correctly, £350 buys nicotine-reduction therapy plus some counselling. Other cessation tools can cost less.

We have a set of possible interventions. We are dealing with individuals, so we will allow the smoking cessation teams in the health service to tailor the package for each individual. Some innovative work is going on. We will consider the available tools, such as chewing gum, patches and therapy; we will consider the individuals, who are all different; and we will then decide what will work best for each individual. It is therefore difficult to say that 30,000 or 25,000 people will receive treatment. It is horses for courses.

Mr McNeil: Surely the £12 million will not be distributed equally to each health board.
reported in local and national newspapers. As people know all about it, I see no reason to stall or phase implementation. We need to get this done and start improving health; indeed, we must remember that, as soon as people stop smoking, their lungs begin to recover.

Mrs Milne: It was made plain to us that there had to be awareness-raising campaigns to let the public know what was happening. What smoking cessation campaigns are proposed in the run-up to and beyond the ban?

Mr Kerr: That is precisely what is being discussed by the smoke-free areas implementation group, which includes representatives of the Scottish licensed trade and club owners, for example. As a result, we are working with the people on the front line.

We are also recruiting advertising agencies to help us in the substantial task of putting together a comprehensive set of public awareness and information campaigns that, in the build-up to implementation, will inform people about our smoke-free Scotland policy and, after that, will inform them about their rights and responsibilities. Again, convener, in the interests of time, I am happy to forward an outline of those measures to you.

The Convener: That would be very useful.

We have pretty much reached the end of our questions about smoking. However, before we move off the subject, I wonder whether, given his background, Stewart Maxwell wants to raise any questions.

Mr Stewart Maxwell (West of Scotland) (SNP): I have one small question for clarification.

The Convener: Could you ask it very quickly?

Mr Maxwell: Yes. Has the minister thought about approaching the issue of adult care homes from the other angle by including in the smoking ban public areas in adult care homes but, because people live there, providing for smoking rooms, which might be bedrooms or some other arrangement in the home?

Mr Kerr: I am happy to bring Sarah Davidson in on this question, because she was closer to some of the discussions on that matter. We found that, because of health and safety issues, people could not smoke in their rooms, which meant that we had to delineate what could or could not be done. As a result, we have said that each care home must have a very clear smoking policy.

Sarah Davidson: I do not have anything much to add to that comment, other than to say that we will discuss with the Scottish Commission for the Regulation of Care the effective implementation of extensive smoke-free areas in those premises to ensure that staff, patients and visitors who do not want to be exposed to smoke can avoid it completely.

The Convener: Thank you very much. If officials want to swap places, we will move on to part 2 of the bill, which covers general dental services, general ophthalmic services and personal dental services.

Shona Robison (Dundee East) (SNP): The Finance Committee has expressed concerns about the financial implications of free dental checks. It stated in its report:

“the Committee is deeply concerned that it is being asked to scrutinise the financial implications of a Bill where the staffing and service implications which crucially determine the cost do not appear to have costed in a manner that gives the Committee confidence in the figures ... The Committee is extremely concerned that Parliament is being asked to authorise the release of funds when it is not certain of what the cost of legislation is likely to be.”

Given that we have now heard a ministerial statement, do we have more information for the financial memorandum and its contents?

14:45

Mr Kerr: Last week’s announcement on dentistry went a long way towards addressing some of the issues about which the committee is concerned. Although, in our own minds, we have the budget that we require to implement what we want to implement with respect to eye and dental checks, a negotiation is involved. We want that negotiation to be carried out properly, so we do not want to declare our hand at this point with regard to what we expect the enhanced examinations to be.

What we are seeking is health improvement. The issue is different from that of sight tests, to refer to the ophthalmic side; it is about an engagement with the professions on how best to deliver the service and then a negotiation over the price. I am not sure if that is the clarity—or the lack of clarity—that you would expect, but to start allocating costs to the particular tests concerned would be inappropriate.

Shona Robison: I am not clear about where that leaves the financial memorandum. As you have said, the figure of £9 million to £12 million for dental checks will change as negotiations continue on the extent and cost of oral health assessments. With respect to the parliamentary process, when will we get a true figure in relation to the financial memorandum? We surely cannot be expected to sign blank cheques. The Parliament must know what the costs will be before it can approve the financial resolution.

Mr Kerr: To be fair, the existing financial memorandum is based on the cost of the existing...
check. My understanding is that the memorandum is accurate with respect to the proposed legislation. What is now required, as a result of Rhona Brankin’s statement last week, is a discussion with the profession around the enhanced check. I am confident about the financial memorandum with regard to the current check and the £7.05 figure.

That does not reflect what we now envisage in the action plan on modernising dentistry, in which we have said that we are taking a—I was going to say “holistic” approach, but I hate that word—health improvement approach to dental examination. In our minds, we have costed some of the impacts of that, but we need to have a negotiation with the profession around what the examination is and what it will cost the taxpayer.

Shona Robison: I am not clear about what you are saying. I understood that the free dental check, which is referred to in the financial memorandum, would effectively cease to exist, as it would be replaced by the new oral health assessment. I thought that that was what the bill was introducing. Are you now saying that the free dental check will be a basic check and that the oral health assessment might be something different?

Mr Kerr: The financial memorandum reflects the old form of the dental check. Hamish Wilson can add further light to that.

Dr Hamish Wilson (Scottish Executive Health Department): I can confirm that that was the basis on which the financial memorandum was drawn up. We intend to discuss with the dental profession the nature and frequency of the oral health assessment and the effect that that might have on the existing dental check. An oral health assessment might be carried out as an initial assessment; a dental check will be an updating of that assessment on an on-going basis. It might be that both will exist in the future. The financial memorandum was based on the existing set of arrangements.

Shona Robison: I am not entirely clear about the distinction. I take it that you will be keeping the committee abreast of any further financial implications as the negotiations proceed. That would certainly be helpful.

I turn to the 25 per cent increase in the cost of checks as a result of people being more likely to take up the free dental checks and/or oral health assessment, depending on what we are talking about. What was the basis of that figure of 25 per cent? How was it calculated?

Mr Kerr: I will deal first with the point about the check. It is an enhanced check and it will cost more because it does a different job. You would be right to criticise us if we did not engage with the profession on what that check should be and how much it should cost the taxpayer. It is correct that we should come back to the committee when we can to talk about those issues.

The 25 per cent increase is based on our experience of the change in the public’s behaviour when we introduced the free sight check for the over-60s. That was the only sound piece of evidence that showed how people behaved once a check became free.

Dr Wilson: That is absolutely right. We were trying to make the memorandum as helpful as possible by explaining that the best evidence for what might happen came from our experience of extending free sight checks to the over-60s. In that case, uptake increased by about 25 per cent. We thought that it would be helpful to put that into the financial memorandum to show the scale of the possible increase.

Shona Robison: I take it that you will have room for manoeuvre if the uptake is significantly more than that.

Let us move on to consider the workforce that will be needed to deliver the checks and oral health assessment. How likely is it that there will be a sufficient number of dentists to deliver the proposals? How have you calculated what you require?

Mr Kerr: This is almost “Groundhog Day”, as a lot of these issues were discussed last week in the statement on the modernising dentistry action plan. We have already increased the number of students who are in training; we are increasing the number of allied professionals; and we are seeking to support the education of our dentists via the Aberdeen facility. A range of measures has been put in place that will allow us to be confident that we can fill the gap in dental services. The increased use of allied dental professionals will ensure that dentists can focus on the work that they are required to do. I have every confidence that the substantial investment that we announced last week will deliver that. Training and qualification take time, but we are sure that we can meet the target number of dentists who have to be in training to make the system work.

Mr McNeil: You have referred to the importance of professionals who are allied to dentistry. I am sure that you are aware of the recent study that highlighted the importance of those professionals and of an increase in dentists’ productivity. It also highlighted the shortage of dental nurses. What incentives have you put in place to recruit and retain those professionals?

The Convener: Can you be brief please, minister?
**Mr Kerr:** The incentives largely relate to the announcements made last week for support for training, particularly for people in rural areas, through training grants, facilities, information technology equipment and premises. We will also give support for the provision of places in our education system to attract people into the field. We have a basket of supporting measures.

In addition, we are trying to ensure that dentists who are tempted by the private sector will stay with us by reducing from 450 to 50 the number of item-of-service payments. That will reduce the red tape around dentistry and incentivise the process much more effectively. We hope to work with dentists to help young people to see dentistry as a career opportunity as well as using additional incentives to persuade dentists to stay with us.

**Mr McNeil:** How do we ensure that the dental nurses and hygienists also benefit from that process?

**Mr Kerr:** It is all part of our workforce planning measures.

**Mr McNeil:** Are you talking about pay and conditions?

**Mr Kerr:** Yes. Those are the additional incentives that we put in place to encourage people to enter dentistry. The package applies to them as well.

**Shona Robison:** I come back to “Groundhog Day”. I do not know whether you are aware that Stewart Stevenson has just received an answer to a question that he asked about the percentage of dentists in Scotland who accept NHS patients. The reply was that that information is not held centrally. It seems strange that you would not have that information if you were trying to gauge what is required to meet the commitments in the bill. You do not know your starting point, which is how many dentists carry out the work.

**Mr Kerr:** Those matters are dealt with through the health boards, which is where the information lies.

**Shona Robison:** Yes, but you need to know the numbers, because you are sitting here telling us what you think is required in terms of the workforce to meet your legislative commitments. Surely you need to have the information to make an assessment.

**Mr Kerr:** We do not carry out workforce planning in isolation; we work with employee representatives, the boards and personnel people from the health service to determine the future shape of the workforce and to identify the pressures that exist locally. We discuss with health boards workforce planning measures and what they need to deliver the service. The workforce planning processes that Executive officials carry out include getting information that the health boards hold. That has informed the conclusions that we have reached about what we need to do to ensure that everybody has access to dentistry in Scotland.

**Shona Robison:** I turn finally to vulnerable groups’ take-up of free dental checks. What plans do you have to address the physical access problems that exist in so many dental surgeries? Have you considered screening programmes to target the most vulnerable groups?

**Mr Kerr:** Sadly, there are huge inequalities in health, which relate to poverty and rurality. Some of the pilots on which we want to embark will ensure that we focus on the people affected by those factors. The statistics for dental decay in Glasgow show those inequalities. We are working on the grants that we apply to the dental service relating to premises. We will discuss later joint ventures, which apply to dentistry as much as to other community health settings and for which we will try to increase resources. My colleague Rhona Brankin recently attended the opening of a new centre. The issue is investment. There have been pretty substantial increases in investment; there have been increases of more than 70 per cent since 1999 in some of our capital investments. That comes back to the idea of having a package of measures.

We are focused on addressing issues of physical accessibility of dental services. We acknowledge that specialist dental services might be needed for those with special education needs or physical disabilities. We are focused on that part of our community to ensure that inequalities are ironed out and that a proper service is provided. The issue is about our having a spectrum of measures.

**Mike Rumbles:** For the benefit of the committee, I want to be absolutely clear about oral health assessments and comprehensive eye examinations. Are you saying that the Executive’s intention is to provide a comprehensive oral health assessment and follow-up dental checks and a comprehensive eye examination and sight tests? The bill is not about one test replacing another, but about a comprehensive package. Is that correct?

**Mr Kerr:** Our proposals are about preventive health in action; they are about preventive measures. You have postulated a position in which the oral health examination might be followed up by checks. Let us talk to the professionals about that and come back to the committee. I do not want to be prescriptive about the best way of proceeding. I am happy to listen to professionals about what is the most effective way of delivering what we want, which is all about preventive health. In the action plan that we
published last week, we set targets on dental decay for different age groups.

Dr Turner: I know that you cannot say exactly what the oral health assessment will add up to. However, it might lead to more orthodontic crowns and bridge treatments. Worries have been expressed about that. Will there be a restrictive approach to treatments that result from enhanced oral checks? The NHS does not carry out all bridge treatments; some are private.

Mr Kerr: I will defer to Hamish Wilson on that point. As I understand it, what is provided currently will not be affected detrimentally as a result of the process. Anything that we do in health that takes the preventive route creates a bounce effect elsewhere in the service, for which we plan.

Dr Wilson: That is correct. An oral health assessment can perhaps more accurately determine the needs of the patient and, therefore, the treatment plan that will be required for that patient. There is no intention to reduce what is available under general dental services.

Dr Turner: So you are prepared for an expansion in treatment. Thank you.

15:00

Helen Eadie: One of the challenges that still besets you and your colleagues, minister, is the fact that, historically, much of the statistical information just has not been gathered. It seems to the committee that there is a lack of information at health board level about oral health. In that context, we wonder what plans you have to gather information to inform your decisions about implementing the proposals that will deliver general dental services.

Mr Kerr: I am not short of stats; I am just short of stats that make a difference. That is what I want to sort out. We are working with the information and statistics division and other professionals around the service to address the point about measurement that you make. We have set out in the dentistry paper targets for how many adults we expect to have some of their own teeth and how many fillings we expect our young people to have. Those imply that measures will be taken to ensure that, overall, we improve the oral health of the people of Scotland. We are not devoid of stats, but I share your view that we need stats that make a difference. That is what I want to deliver for the people of Scotland. We are not devoid of stats, but some are private.

Mr Kerr indicated agreement.

The Convener: Thank you.

Mr Kerr: Sorry, I should have said yes. For the Official Report, the minister nodded and then said yes.

The Convener: Let us move on to general ophthalmic services.

Kate Maclean: As the minister is probably aware, I chair the cross-party group on visual impairment, which is an area in which I have a particular interest. I have a couple of questions on the eye examination. There could be an eye test to determine whether someone needs spectacles and what prescription for spectacles they need. There could also be an eye examination to diagnose other health problems or eye problems, which, if carried out early enough, could prevent or reduce sight loss later in life. What type of eye examination is proposed under the scheme for free eye tests? Will any specific measures be introduced to help groups that are difficult to test, for example people who have learning disabilities or Alzheimer’s? Also, what measures can be introduced to ensure that people take up the tests? At the moment, 20 per cent of schoolchildren have some degree of undiagnosed sight loss, despite the fact that they are entitled to free eye tests and checks. What measures will you introduce to ensure that the groups that are least likely to take up the free tests to which they are entitled take them up in future?

Mr Kerr: Your latter point about active management of individuals’ health and not waiting for customers to come through the door is a broader point for the whole health service. We are doing much more on that through the pilot schemes that we are organising. The general medical services contract for GPs is much more assertive about looking for problems that can be resolved earlier in people’s lives and that should apply equally to the use of eye examinations.

The free examination is an eye examination. A sight test will be carried out if one is required, but the examination is about detecting the sort of problems that you identified. It is also about preventing problems that could arise, and I am sure that it will cover all such problems. The examinations are not free for the general population at the moment, but the fact that they will be free will be an incentive for people to take them up. It is part of the education process in which we are all involved.

The Convener: Before we move on to general ophthalmic services, will you clarify for the Official Report that both the basic dental check and the more comprehensive oral health assessment will be free?
and so on that will ensure that problems do not go undetected in the way that you describe.

I am hopeful that the fact that the service is free will mean that uptake will increase.

**Kate Maclean:** I do not think that that will necessarily follow. Although I regard myself as being a good mother, I never took either of my two children for a sight test because they never had any symptoms that would have led me to do that. That is probably the case with many people. Going to the dentist every six months is one thing, but I think that it is less common for people to take their kids to have their eyes tested regularly, even though it is free. I am not sure how the fact that the service is free will encourage a group of people who do not tend to get screened for lots of conditions to get their eyes tested.

**Mr Kerr:** As I said in relation to a previous question, our experience is that uptake increases by 25 per cent, which means that a larger pool of people will be coming forward to take the tests. The argument that you make applies equally to tooth brushing and to all the other preventive health measures that we are involved in. It relates to the campaign of educating people about their rights and responsibilities and to the role of parents and our schools.

In relation to the review of eye care that is being undertaken, we will consider issues such as access and uptake to ensure that we increase the number of people who get their eyes tested. As the Minister for Health and Community Care, I can say that it makes sense to identify conditions at an early stage not only in the interests of people’s quality of life and so on but financially as well. The professions will assist us in that process and I am happy to come back to the committee to talk about any innovations that we think are appropriate.

**Kate Maclean:** Would the Executive consider setting up a sight-screening programme that would test children in primary 1 and again when they go into secondary school? Around 20 per cent of that vulnerable group have undiagnosed sight problems and such a programme would ensure that those were picked up at an early stage.

**Mr Kerr:** I would take advice from those in the professional field on whether a national screening programme would be worthwhile. Not all national screening programmes provide value for the individual patient. I do not approach the issue from a financial perspective, but the question clearly relates to whether we want to devote our resources to that task. I would not rule out having such a programme, but I would have to consider its effect on the prevention that we want our measures to achieve.

**Kate Maclean:** I know that the Executive is conducting an eye care review. What impact will it have on this provision or vice versa? Are the two linked at all?

Following on from Shona Robison’s question about dental checks, do you have a firmer idea yet of the cost of the free eye checks?

**Mr Kerr:** We are conducting two pieces of work in relation to the points that you ask about. The eye care review will examine children’s services and the issues that you have raised before coming up with proposals, and a report is being prepared on screening. I am happy to share the proposals and the report with the committee.

I cannot say, off the top of my head, how much the free eye checks will cost. We have not yet talked to the profession.

**Kate Maclean:** I just wondered whether you had a firmer idea of how much the policy would cost. I guess that you would give the same answer as you gave to the question about dental checks.

**Mr Kerr:** We have an estimate, within a banding, of the costs that we expect to incur and, later, we will enter into negotiations with the profession about the scope and cost of the examination.

**Mrs Milne:** Most of the witnesses were happy with the new listing arrangements for ophthalmic practitioners and dentists. However, I gather that it is proposed that the disclosure provisions will apply only to new entrants to the lists. Why will they not apply to existing listed practitioners?

**Mr Kerr:** I can reassure you that they will also apply to existing practitioners.

**Dr Wilson:** That is, they can apply if we so wish.

**Mr Kerr:** Oh, that is a different answer. I ask Hamish Wilson to continue.

**Dr Wilson:** The bill allows us to apply the disclosure requirements both to existing and to new practitioners.

**Mrs Milne:** So the bill allows the Executive to do that, but it will not necessarily ensure that that happens. It seems appropriate and sensible to require existing practitioners on the list who have not already done so to go through the disclosure procedure as well.

**Dr Wilson:** That is what the legislation allows.

**Mrs Milne:** We have all heard about the length of time that can be involved in the disclosure procedure. What steps will be taken to ensure that extending the list of those who are required to go through the disclosure procedure will not exacerbate an already difficult situation?

**Mr Kerr:** Given our work on the subject, we hope that the new measures that will be put in place will make the process quicker rather than
slower. There is no reason to suggest that that will not be the case. The provisions will allow quicker reactions from health boards and quicker determination of individual cases. Again, I ask Hamish Wilson to confirm that.

Dr Wilson: We need to discuss the details with Disclosure Scotland to ensure that there are no delays in the system. Therefore, the potential volume of checks if we were suddenly to include all existing practitioners as well as all new practitioners is relevant. We need a sensible and practical approach to allow us to do the most effective thing quickly.

The Convener: We will now move on to consider part 3 of the bill, which deals with pharmaceutical care services. Nanette Milne and Jean Turner want to raise an issue about part 3.

Mrs Milne: A number of us have received representations from people who deal with those who need stoma appliances. In my reading of the bill, I found it hard to see where this slots in, but people are clearly concerned that the service that is currently available to patients who require such appliances might be impaired if the appliances need to come directly from community pharmacists. I think that the stoma appliances that are currently provided by ileostomists and so on are almost bespoke devices.

Mr Kerr: I do not think that the bill particularly affects that situation. We considered the procurement route for stoma appliances, which is captured by the section that deals with appliance suppliers. The policy intention with regard to the fitting of stoma appliances and other such products remains the same. Although the provision of such appliances will become a service in its own right, that should not change the patient’s understanding of the treatment that they receive. However, unless Hamish Wilson can help me out, I will need to re-examine the evidence that the committee has received about the impact that the bill will have on such patients.

Dr Wilson: Given the correspondence that we have seen—I think, literally for the first time today—I think that there might have been a misunderstanding on the part of some patient groups. As the minister said, the intention is that the supply of such appliances will become a specific service in its own right that health boards will secure either from existing appliance suppliers or from a small number of community pharmacies that currently provide the service. Such appliances are not part of pharmaceutical care services but are a separate service that requires its own standards and quality assurance, which it has not had in the past. The intention is not only to protect the existing service but to improve it in future.

Mrs Milne: There was concern that if health boards were given the responsibility for such things, they might not have the funding to cope.

Dr Wilson: That is not the intention.

Mr Kerr: The arrangements that are available for patients to engage with people in securing the appliances and having them fitted will remain the same. As Hamish Wilson indicated, we think that patient groups might have misunderstood our intention, given the correspondence that has been received. I will deal with that later, but I can reassure patients that the net effect of the provisions will be to ensure service improvement rather than diminution. The appliances will remain the same and the fitting procedures will remain the same, but the service will become a specialist service within the NHS.

Mrs Milne: That is helpful.

The Convener: Is Jean Turner’s question on a separate issue?

Dr Turner: No, it is connected with that issue. Some patients deal directly with manufacturers and have made-to-measure appliances. For them, the issue is very personal. Confidence comes into it, and there is a worry that they might not be able to continue to deal directly with the manufacturer, which some people definitely feel is the only way in which they can get the service that they want; they feel that they would not be able to get it through a pharmacy. If they were hindered by having to use another company, that would not suit them.

15:15

Mr Kerr: There are set quality criteria for health care services. As long as the existing supplier matches those quality criteria, whether that supplier operates directly or through another provider, there will be no change. The bill deals with the organisation of the service in its own right; we want to increase quality and provide a better service.

Dr Turner: So no one need worry.

Mr Kerr: Absolutely. If we have received correspondence from groups that are worried about a diminution in the number of suppliers or about not being able to use their regular supplier—I have not seen any such correspondence—we will be able to reassure them about that.

The Convener: Thank you. We need to move on to part 4 of the bill, which deals with discipline. The minister is still accompanied by the same officials. Janis Hughes will lead off.

Janis Hughes (Glasgow Rutherglen) (Lab): Although it is fair to say that there was broad agreement on part 4 among the people from
whom we took evidence, a few issues were raised that we would like the minister to clarify. One witness suggested that the bill should include a definition of professional and personal misconduct. What do you think about that suggestion?

**Mr Kerr:** It would be quite restrictive to include such a definition in the bill; I would prefer the definitions to be dealt with through guidance.

**Janis Hughes:** Concerns were raised about the regulatory bodies having disciplinary procedures that are different from those of the NHS tribunal and about duplication of work by those bodies. What efforts have been made to harmonise disciplinary procedures and to save time and effort by joint working?

**Mr Kerr:** That is a valid point. I am assured that consultations on that are on-going. In an effort to ensure that there is no duplication, we are discussing the matter with the relevant bodies.

**Janis Hughes:** When will we know the outcome of that consultation?

**Dr Wilson:** As a result of the Shipman inquiry, all the national regulatory bodies are under review. Although we can continue our discussions, it could be difficult to conclude them until we are sure about the precise future role of the regulatory bodies. I am sorry, but I cannot give you a timescale for that.

**Janis Hughes:** Are you likely to be able to conclude your discussions prior to the conclusion of our consideration of the bill?

**Dr Wilson:** I am afraid that that is not within our direct control, as matters to do with the regulatory bodies are reserved.

**Janis Hughes:** The bill proposes that if a family health service professional is suspended for investigation, they will still be paid. In other words, they will continue to receive full pay pending the result of the investigation. In sectors such as optometry and dentistry, practitioners would find suspension very difficult, as they are self-employed and do not get paid unless they work, although they would continue to have staff and premises costs. What are your views on that?

**Mr Kerr:** We are discussing that with the professional bodies involved and we have not come to a conclusion. I imagine that we will be able to come back to the committee on that more quickly than we indicated before, because those matters are within our control. That issue has not yet been resolved.

**Janis Hughes:** That would be helpful, because there is a concern about the apparent disparity, which would affect staff.

**Mr Kerr:** Suspension should have a neutral effect. The fact that someone has been suspended suggests that the matter has not been investigated and that they have not been found guilty of malpractice or anything else. We are discussing the matter with the relevant bodies.

**Janis Hughes:** So you will come back to us on that.

Has the Executive considered including trainee professionals and students under the discipline umbrella, given their close contact with patients?

**Dr Wilson:** Students are in a different position from trainees because students are not registered and are not on a list. The discipline procedures relate to the listing. Whoever is listed to perform services becomes subject to the disciplinary process. Students are not listed but some trainees will be. There is a distinction to be made.

**Janis Hughes:** Another omission that has been highlighted is to do with NHS 24. The minister has told us that employees of NHS 24 will not be covered by an NHS tribunal. Are parallel procedures being worked on?

**Mr Kerr:** There are existing procedures. As we develop one side of the business, we will have to ensure that there is a matching effect in NHS 24.

**Dr Wilson:** In this context, NHS 24 is a health board like any other, and the employees of a health board are subject to their own internal disciplinary procedures.

**The Convener:** We now move to part 5 of the bill, which is on hepatitis C. I will allow a moment for new officials to come to the table.

**Shona Robison:** The Executive's justification for the exclusion from the compensation scheme of those who died before 29 August 2003 is that that was the date on which health ministers across the UK announced the UK scheme. Do you believe that that is a good enough reason for determining eligibility?

**Mr Kerr:** Yes, I do. In such difficult circumstances, one has to draw a line somewhere. We are compensating people for changes to their lifestyle because of what happened to them. We are thinking about supporting people who are still with us. We drew the line at that date so that the announcements of the four relevant UK ministers coincided.

I fully understand some of the views on this issue—they have been expressed to me forcefully. However, we must bear in mind the effects of different methodologies on the NHS. We must also bear in mind what all this is about—trying to assist those who are suffering as a result of contracting hep C through past engagement with the NHS. Sadly, it is not about those who, unfortunately, have passed away; it is about supporting those who are still with us.
Shona Robison: I am sure that you would accept that many relatives will also be suffering financially, especially if they have lost the main breadwinner of the family. Are you prepared to keep the issue under review? Evidence from Skipton Fund Ltd seems to indicate an underspend. At the moment, it has spent £9.81 million out of the £15 million that was allocated. Skipton Fund has indicated that it has not received as many applications as were expected, so it expects an underspend. If that turns out to be the case, will you reconsider extending the eligibility to allow relatives whose loved ones died before 29 August 2003 to come within the scheme?

Mr Kerr: I am always happy to discuss these matters, especially with the Haemophilia Society, which has been in to see me and with which I have corresponded. However, I say again that I have to consider the protection of the health service as a whole. The costs of taking the radical step that you propose would affect the health service, so I am not inclined to take it.

I do not think that it is a question of how much money is left over from the amount we set aside and whether we should change the principle as a result. The principle remains sound in relation to what we want to achieve. The situation is unfortunate and distressing for those involved, but I believe that the principles of the decision made by the four UK health ministers stand. Whether or not there is money left in the budget is a different matter. The money might be used later, because there are a number of outstanding claims that we expect to come in. I am always willing to listen to those who are directly involved and to discuss the issues with them, but at the moment I do not see a change of view on the issue.

Shona Robison: Will you commit to keeping that £15 million set aside for people with hepatitis C one way or another, or, if there is an underspend, do you envisage the money going elsewhere?

Mr Kerr: We will have a long tail on the fund—much beyond my tenure as Minister for Health and Community Care, I am sure—to ensure that, when people come forward, their cases can be dealt with. A diagnosis might be made many years in the future, and the rights of those individuals must be protected. I am not saying that the fund will go on for ever, but I do not envisage any change to the approach for now.

Shona Robison: The appeals process is not yet in place. In your correspondence, you say that you hope to get it in place soon. Will you be more specific?

Mr Kerr: Sadly not, because others from the rest of the UK are involved. I raised the issue with John Reid, the UK Secretary of State for Health, just yesterday. It is a pressing matter and I fully understand why the Haemophilia Society in Scotland is concerned about it, but I continue to try to push as hard as I can to get a result. We have a four-nation agreement and we need to stick to it when considering arrangements for the appeals process, so I will alert the committee as soon as I am aware of significant moves in that direction.

Shona Robison: The Haemophilia Society in Scotland has raised the point that those who can claim should be defined according to whether they were infected by NHS Scotland rather than according to their place of residence at the time of making their claim, as the bill currently proposes. Your letter seems to imply that, as long as the person is resident at the time of the claim, it does not matter if they move after that. Is that the case?

Mr Kerr: Yes.

Shona Robison: If they happened to have moved two weeks before the scheme was announced, say to America, so that their family could look after them, would they be ineligible? Would they be debarred from making a claim? That does not really seem fair.

Mr Kerr: I would need to seek legal advice on that point, because the fund is based on residence in the UK. I am not sure whether anybody else could claim. I apologise for not having that information, but I can provide the committee with information on overseas residents claiming two weeks after contracting hepatitis C. Is that your point?

Shona Robison: No. The point is that someone could have been eligible for money from the scheme, but they might happen to have moved out of the country shortly before the scheme was announced. Under your residency rules, that would debar them. It does not seem fair that, because they happen to have left the country—perhaps because they were not well and their family had offered to look after them—they will be debarred. We cannot be talking about a large number of people who are in that situation.

Mr Kerr: I do not make legal decisions in committees, because that would be a dangerous thing to do, but that is a valuable and fair point and I am happy to consider it and come back to you.

The Convener: Perhaps we could get that information from you in writing.

Dr Turner: What justification is there for the Skipton Fund rule that states that, if eligible persons die after 5 July 2004, payments will be made to their estate only if the eligible person claimed while they were alive? Thompsons the lawyers have indicated that at a stressful time in someone’s illness, things can fall apart in many ways, and that might well be the case. People
might have been busy dealing with their illness and their relatives might have been coping with such matters, so that people who perhaps should have claimed did not do so before they died, although they would have been eligible. That is what I took from the information that we got.

Mr Kerr: Recently, I met the Haemophilia Society in Scotland and its legal advisers, and they never raised that issue with me, but I am happy to consider your point. We are involved in a UK deal, so I have to think about the implications of what I say for the rest of the UK. The point is valid, and I am happy to get back to the committee with clarification.

15:30

Dr Turner: If people are paid from the Skipton Fund, will they be able to take up other procedures? Is it a separate issue?

Mr Kerr: What do you mean by “take up other procedures”?

Dr Turner: Will they be able to go down a legal route that is separate from their claim?

The Convener: You said recently that you would consider an amendment to rectify an anomaly in respect of Skipton Fund payments being taken into account in other proceedings.

Mr Kerr: Yes.

The Convener: Is that still likely to form an Executive amendment?

Mr Kerr: Yes. We have had questions about the Skipton Fund that are not directly relevant to the bill, but the issue is relevant. We wish to ensure that people who benefit from Skipton are not affected elsewhere in the system. We will do that.

The Convener: We move on to authorisation of medical treatment in cases of incapacity. Jean Turner has a question.

Dr Turner: I am anxious about the increase in the duration of a certificate of incapacity to three years. I know how busy general practitioners are. It could be that everyone who is involved in a case is busy and that the annual, or more frequent, checks could be ignored; three years can go in quickly. Everybody might think that the checks have been done but—golly—the three years might pass with nobody having examined the patient.

Mr Kerr: I share that concern, but I do not think that that will happen. As we expand the range of people who are able to authorise medical treatment, we will provide superior treatment for patients and we will reduce and change the workload of people who are under pressure. We are responding to feedback on that point.

Three years of cover can be given as long as it is the absolute exception, for example in cases in which there is—to put it bluntly—little prospect of improvement because, for example, of degenerative illness or because the diagnosis is that a condition will not improve. That will not change the clinical engagement with the individual concerned, or the treatment and support that they will get from the health service. The bill will increase the term of certificates under current legislation, but I will seek to ensure that that does not affect the care that is given to patients.

Dr Turner: So there will be some way of monitoring patients in between assessments.

Mr Kerr: That would go on anyway—it is in the nature of the service. Of course, the people who will be able to fill out the forms will be given training to enhance their skills and understanding, therefore I hope that we will improve the condition of patients, not just for one year, but for the three years.

Helen Eadie: You have a list of professionals to whom you propose to extend powers of assessment. How did you compile that list?

Mr Kerr: It was arrived at by considering who has an impact on the well-being of particular people and the services that are provided to them. That was the key driving force in producing the list of professions.

Helen Eadie: Why are some professions, such as clinical psychologists, not included?

Mr Kerr: First, the list is not exhaustive. If good arguments are made by professional bodies, the committee or others for the inclusion of particular people, we can make the change. Secondly, it is about interventions and the effect that the clinician can have on the patient. A judgment was made about who would be on or off the list. As far as the treatment of individuals is concerned, we felt that dentistry, ophthalmology and—crikey, I have just forgotten the last one. [Interruption.] Nurse specialists, dentists and ophthalmologists have the biggest direct impact on patients. We are more than happy to consider any valid arguments for other inclusions; however, we focused on the interventions that professionals apply to patients.

Helen Eadie: Has there been progress in ensuring that GPs and medical practitioners receive proper training under the Adults with Incapacity (Scotland) Act 2000?

Mr Kerr: The medical profession has received training from, I think, NHS Education for Scotland. Joe Logan will come in on this question, but I believe that NES is extending the scope of its modular support and training.

Joe Logan (Scottish Executive Health Department): At the moment, we are consulting
NES on a specific proposal, on which we intend thereafter to consult various professional groups. We think that, under that proposal, GPs will be supplied with further training.

**The Convener:** Evidence that we received last week suggests that there are still issues to address about application of existing procedures and that, so far, training has not been particularly effective in quite a few areas. Do you accept that?

**Mr Kerr:** We want to revisit some of those issues.

**Joe Logan:** Take-up of the initial training has been patchy. Having said that, I point out that training has been offered on the code of practice, and that a video and leaflets about the Adults with Incapacity (Scotland) Act 2000 were produced. Furthermore, one of our professional advisers in the Executive held a series of roadshows across Scotland in an attempt to reach as many people who would be affected by the act as possible. However, we accept that take-up has been a bit patchier than we hoped. We hope to do something about that with the proposed follow-up training, which, with NES’s involvement, will be more detailed.

**Janis Hughes:** You said that the medical profession will receive the training, but will every other profession that is involved in treating patients with incapacity also receive it?

**Joe Logan:** It will go across all the professions.

**Mr Kerr:** It is all to do with professionals’ ability to sign off such certificates.

**Janis Hughes:** Okay.

**Mr Kerr:** You cannot sign off the certificates unless you have been through the training.

**Janis Hughes:** Does the current consultation include organisations that support patients with incapacity?

**Joe Logan:** The consultation on NHS Education for Scotland’s specific proposal has still to take place, but it will include representatives from the patient bodies.

**Janis Hughes:** The minister indicated that draft regulations will be available in June. Will you confirm that those are still on schedule? Obviously, the committee will want to see those regulations before stage 3, if the bill should reach that stage.

**Mr Kerr:** That is our target—we will deliver on it.

**Helen Eadie:** The powers in the bill intended to cover only the introduction of projects under the English local improvement finance trust—LIFT—model? If so, why are they so broad?

**Mr Kerr:** With the joint ventures proposals, we want to enhance local authorities’ ability to work with health boards, and to allow the private sector to put additional investment into our health service. Their purpose is no broader than that.

We are dramatically increasing the amount of capital that is available to our health boards in Scotland, but we want to ensure that the additional resource is available to them not only to attract new investment, in addition to the substantial increases that they have already had, but to ensure that there is joint-venture planning with local authorities. There are some good examples of such work; the bill’s provisions on joint ventures are designed to allow such work to take place. It is about the LIFT model being used in Scotland to deliver joint ventures, be they public-public or public-private projects.

**Helen Eadie:** In your letter to the committee, you refer to the way in which risk will be shared between parties to a joint venture, but there is no comment on how services will be provided if a project collapses. Will you comment on that?

**Mr Kerr:** Are you talking about property joint ventures?

**Helen Eadie:** Yes.

**Mr Kerr:** As with any public-private partnership, the legal provisions around the project will ensure that the risk is transferred, if that is the design, to the private-sector provider in the partnership, who will ensure delivery. In that sense, such a scheme will work like any large PPP scheme; it will provide surety to the taxpayer and patients in respect of delivery. Such projects will be simply PPP schemes at local level that will work as amalgamations of smaller community-based projects, so the risk will remain with the provider.

**Helen Eadie:** What is the Executive’s position on the future of co-operative development agencies? I know that it was positive towards and supportive of them. Have you and your officials examined the projects in Plymouth that have gone down the mutual route? Do you see scope for that route in Scotland?

**Mr Kerr:** I am not sure about the projects in Plymouth; I will defer to my colleagues if they know more. On mutuals, the Executive has never taken a position against them; that is another model that people work up and which becomes available. We provide traditional capital substantially to renew and modernise our NHS.
estate. It is the best-value approach that matters, whether in respect of the large increases that are available through traditional capital routes, the LIFT schemes that will exist if the legislation progresses, or mutuals. The delivery vehicle for investment is the choice of the boards. As long as they get the delivery vehicle to stack up and it goes through the public sector comparator, that will continue to be the case.

Helen Eadie: I ought to declare an interest as a sponsored member of the Scottish Co-operative Party.

Mr Kerr: Mike Baxter has more detail on the matter.

Mike Baxter (Scottish Executive Health Department): We have a governance arrangement that was established through the joint premises project board, which will consider the various models. The powers that we seek are generic. To be fair, the LIFT model is established; it is working and appears to be delivering. We can learn many lessons from that. The National Audit Office has also examined the LIFT model and is due to issue a report on it in April or May; we will also consider the lessons from that. We would be interested to hear details of the projects in Plymouth, although we have had contact with schemes in England on the planning and delivery processes that have been used there.

The Convener: The evidence that we took was that none of the schemes south of the border is far enough down the line for us to be able to use it as a clear model. However, you said that those schemes can be used as models. How can you be sure?

Mike Baxter: There are several aspects. First, the joint-venture concept, as it has been developed in the LIFT model, is about providing a vehicle to bring various parties round the table. It is based on a strategic planning framework. We can look at the experience to date and consider how that framework has developed by examining the broader service strategy and how it relates to premises development.

The second aspect is the commercial model itself and how its finances work. Deals have been signed and premises are being built; there is acceptance of the market and the commercial model has been tested.

The Convener: Is not it the case that there has not been much service delivery yet?

Mike Baxter: In terms of the operational phase of the schemes, I accept that that is the case.

Dr Turner: Evidence that we heard at a previous meeting suggests that LIFT schemes are usually smaller projects, such as small health centres or practices, rather than the bigger PPP-type hospitals. Concerns were expressed that some of them were getting involved with strictly commercial ventures, which were not necessarily related to the NHS; for example, shops that were not opticians.

15:45

The Convener: There is evidence that in some ventures south of the border, parts of premises have been used for ordinary commercial ventures such as newsagents, which surprised us.

Mr Kerr: I am impressed by such projects, which allow investment in areas where community regeneration has otherwise been at a standstill. If we aggregate public sector expenditure, bringing in health services—say, a dentist, a doctor and a physiotherapist—a post office, a police station, a newsagent's and a hairdresser's, that is good news for the community.

The Convener: Is that what is envisaged?

Mr Kerr: Yes—that is what joint ventures can and should deliver.

Dr Turner: That sounds good but, as time goes by, medical premises have sometimes to expand, so it might be difficult for practices, once they are tied into such commercial joint-venture arrangements, to have enough flexibility to pluck out what the NHS requires. We have some doubt about that.

Mr Kerr: The skill lies in contract negotiations and specification procedures, which allow scalability in projects. Mike Baxter has worked on that.

Mike Baxter: We do not envisage a one-size-fits-all approach. The needs of communities vary throughout the country, as will the opportunities for joint working between health and local government and the commercial opportunities at particular sites. We are keen that there be diversification in premises development. The commercial spin-offs of third-party revenues of joint-venture companies can bring financial benefits to the public sector. The public sector will be a stakeholder in any such companies; therefore, any profits will be shared proportionally between the public and private sectors. The ability to generate third-party revenue will have an impact on the level of rent that can be charged to the public sector tenant. There will not be commercial opportunities in every case, but the model is flexible enough to allow that.

The Convener: Last week's evidence from the Convention of Scottish Local Authorities and the NHS Confederation in Scotland suggests that they do not feel that they have been properly consulted, as they wished. Are there plans for further discussions with those bodies about the proposals and their implementation? They clearly indicated
to us that they do not feel that they have been consulted much so far.

Mr Kerr: We have been long and weary in discussions since July 2002, I think. Far more structures have been set up, and there is co-chairing of those structures. Many papers have been produced and much official time has been put in. I was surprised by that evidence, but I seek to resolve any concerns that exist.

The net gain could be substantial. The Dalmellington centre might represent a different model of delivery, but the change that such a facility can make to a community, with the service delivery that it can offer, is simply fantastic. Lothian community treatment centre is another example of the sort of development that I want more of. If there is not enough faith or confidence among partners, however, that is a problem for me, which I will seek to remedy.

The Convener: It would be useful if you could do that, and if you could keep us informed in that regard.

Company law dictates that directors’ first responsibility is to shareholders; your letter addresses the issue of guarantees being offered so that joint ventures prioritise health services and facilities over commercial development. Those two things seem to present a bit of a contradiction. Commercial development might be more profitable. Are you confident that you can bring those two apparently contradictory positions together?

Mr Kerr: I am confident that we can do that as long as we correctly carry out the planning process for delivery of individual projects. We are all aware of what the balance of the package is with respect to commercial development opportunities—pure commerce—the provision of the NHS facility and the position of the local authority. As long as they are all aligned in the project, the partners will know what each will gain from it. That will be determined by the overall bundling of the project.

The risk will be transferred to the private sector partners and their funders, who must ensure that a project continues to be delivered if it goes wrong. Such situations have happened in the past with, for instance, East Lothian schools. Although an uncomfortable delay occurred when the company from Holland that was involved—its name escapes me—went bust, another provider was found and the project’s financial stability was underpinned by the bank that was involved in it. All the players round the table will agree on the commercial involvement in the project, and the public sector will sign off the project. If it goes wrong, protection exists in contractual arrangements to ensure that the public’s needs are met. I am therefore relatively comfortable with the arrangements.

The Convener: My question was more about whether the proposals are robust enough to overcome the issue of directors’ first responsibility being to shareholders.

Mr Kerr: I am happy to pass that to Mike Baxter—I am not sure that I understand the question.

Mike Baxter: There are a number of ways in which that issue is dealt with. As we said in the letter, the situation is not unique to joint ventures. Any corporate body needs to be able to deal with conflicts of interest. In the articles of association and shareholder agreements for the companies that have been established under the LIFT model in England, the objects of the company are closely aligned to public sector bodies, which provides a mechanism for minimising such conflicts of interest.

The Convener: So you are confident that the proposals are robust enough to overcome any difficulty in that respect.

Mike Baxter: Yes.

The Convener: As far as I understand the matter, under the joint-venture set-up about which we are talking, the assets would not revert to the health service at the end of the joint-venture period. However, in PFI projects, the assets revert to the health service at the end of the contract. As we have a choice between a situation in which, in the final analysis, the assets come to the health service and one in which they do not, why are we opting for a situation in which they will not?

Mr Kerr: The contract value and the price that the public sector pays reflect the fact that we do not get the asset at the end of contract.

The Convener: So it is cheaper.

Mr Kerr: Yes.

The Convener: Right. So it comes down to the calculation that it is cheaper to concede the asset. You have calculated that, in the long run, that will be better.

Mike Baxter: Under the joint-venture model, the property will not transfer back to the health service at the end of the period, so the residual value of the property and the risk will stay with the private sector firm. That is the prime risk transfer, which is a fundamental difference from traditional PFI models in which, as you rightly say, the asset transfers back. From a public sector point of view, joint ventures will also provide more flexibility in the way we manage our estate, because tenants or shareholders can disinvest from the premises.
The Convener: Does that relate to the issue that Jean Turner raised about the possibility that requirements will change over the years, which might mean that premises are no longer particularly appropriate for what they were originally built for?

Mr Kerr: Yes, but under the traditional PFI/PPP model, it is for the procurer—that is, the public sector—to decide whether it wants to take the asset back; it can decide not take the asset back. It is not a must-do under PFI/PPP, but it is under LIFT. That reflects the smaller size of the properties that are involved in LIFT.

Shona Robison: On disinvestment, can both parties—the private sector and the public sector—disinvest? If so, and the public sector wanted to disinvest early, would there be a financial penalty for doing so and how would it be worked out?

Mike Baxter: Options for exit strategies from the firm will be contained in the shareholders agreement, which sets out the rights and obligations of shareholders, including lock-in periods; that is, how long they must stay involved with the firm. The condition for disinvestment is that the other shareholders agree to the selling on of the disinvesting shareholder’s shares. There are provisions in the contract arrangements and the shareholders agreement on the shareholders’ obligations to maintain or exit from the joint-venture company.

Mr Kerr: It is a standard form of contract.

The Convener: Do the details of the contracts, such as the shareholders agreements, have the capacity to vary from project to project? Will each one be a stand-alone contract?

Mr Kerr: Each contract will suit local circumstances. What the private sector and other public sector players bring to contracts will vary, as will the scope and length of contracts and the provision of facilities. However, underlying values will require us to assess each contract against the public sector comparator to ensure that the risk that is transferred is appropriate and the cost represents best value. At the moment, PPP contracts, whether in education or health, are various in their approach, but the underpinning values are still there in the relationship between the public procurer and the private supplier.

The Convener: We have almost exhausted our questions, but I want to sweep up one thing. We had a letter from the minister dated 18 March, which signified the Executive’s intentions for stage 2. Although it is only a short time since you wrote the letter, I wonder whether there is anything you want to add to it. Are there more issues about, or do you want to comment on, stage 2?

Mr Kerr: I am desperately trying to ensure that there are no significant amendments at stage 2.

The Convener: That would be useful.

Mr Kerr: We still have only three amendments. I hope that they are pretty straightforward. That is the way I want to keep it.

The Convener: I thank you for coming along. I also thank all your officials for attending.

I suspend the meeting until 4.05 pm.

15:56

Meeting suspended.
Dear Roseanna

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

I am writing to you following the Health Committee session on 22 March 2005 where I gave oral evidence on the Smoking, Health and Social Care (Scotland) Bill.

I indicated at that session that I would follow up on a number of points raised by Committee members. Annex A to this letter addresses the specific questions raised on smoking, dental & ophthalmic services, pharmacy, discipline, hepatitis C payments, authorisation of medical treatment and joint ventures. I have also indicated where information will follow if it is not readily available at present.

I have also enclosed the National Smoke-free Areas Implementation Group membership list at Annex B and a copy of Smoking Cessation Guidelines for Scotland: Update 2004. These are in response to questions 4 and 5.

I trust that you find this information helpful.

All the best

Andy

ANDY KERR

ANNEX A

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL
Additional Information for the Health Committee

Part 1: Prohibition of Smoking in Certain Enclosed Public Spaces

1. Has the Executive considered the impact of the smoking provisions on private clubs, with specific reference to the British Legion?

The use to which funding raised in clubs can be put depends on the relationship between clubs and the Legion, and the charity’s constitution. It is for the charity to seek advice from the Office of the Scottish Charity Regulator (OSCR) on the issue. However, in terms of reducing exposure to second-hand smoke to improve the health of both staff and members of clubs, it is quicker, easier and cheaper to go completely smoke-free, than install expensive ventilation equipment. Ventilation systems improve comfort by removing the smell and visibility of the smoke. They do not remove toxic carcinogens from the air.

2. Will guidance be issued on how enforcement of the ban should be carried out?

Executive officials have already met with CoSLA officials to discuss a number of issues relating to enforcement, including the need for guidance. A small group will be set up comprising CoSLA, Environmental Health and local authority interests which will take the issues forward, with input from the National Smoke-free Areas Implementation Group.
3. Will sanctions in this Bill or in other legislation extend to loss of licence for non-compliance in the case of certain businesses?

The Licensing Bill provides for licence review procedures if either a premises licence holder or a personal licence holder commits a ‘relevant offence’. The nature of those offences would be set out in regulations following the passage of the Bill and it is intended to include smoking offences. The Licensing Board would decide on the appropriate sanction. For a premises licence holder this can range from a written warning, a variation of the terms of the licence, a suspension of the licence up to, ultimately, revocation of the licence. For a personal licence holder the sanctions would be endorsement of the licence, suspension for up to 6 months or revocation.

In the latter case, the conviction of a personal licence holder, who may be the manager of the premises, wouldn’t necessarily impact on the premises licence itself unless the Licensing Board considered that the premises was being run in a way which conflicted with the licensing objectives set out in the Bill. In those circumstances, the Board could also call the premises licence holder to account.

4. How will the funding to aid smoking cessation be distributed among health boards?

We are currently considering the most appropriate targeting of the new cessation funding which was recently announced in order to support our overall tobacco control objectives. We will provide details of this and the accountability arrangements which will apply to the Committee as soon as decisions have reached. Meantime, the Committee may be interested to see the “Smoking Cessation Guidelines for Scotland: Update 2004” which has been widely disseminated across Scotland to provide up to date evidence on effective smoking cessation interventions and practical guidance on the planning and delivery of smoking services. Implementation of the recommendations made will assist all health and related professionals to play an effective role and maximise the effectiveness of specialist smoking cessation. A copy of the Guidelines and accompanying desk top guide are enclosed for information. The publication is also available on www.healthscotland.com/tobacco

5. What publicity and public awareness raising campaigns will the Executive undertake prior to implementation of the ban next Spring?

Membership of the National Smoke-free Areas Implementation Group is attached (Annex B). The Executive is planning for an extensive public awareness campaign in the lead up to implementation of the smoke-free legislation and beyond, which will communicate to all Scotland, and those sectors most likely to be affected by the proposed law, the purpose, effect, liability, enforcement, and benefits of the legislation. We are currently in the process of choosing a contractor for this work. Two members of the Implementation Group are involved in this process and will also be working with the chosen agency, along with some other members of the Implementation Group, to advise on, and test, the proposals.

Part 2: General Dental Services, General Ophthalmic Services and Personal Dental Services

6. What will the new oral health assessment comprise and how much will it cost?

We have had discussions with the profession on the content of the oral health assessment and this is nearing finalisation. We have still to discuss the fee that will be involved and will attempt to conclude this by June 2005. We will keep the Committee updated on progress.

7. Will the Executive measure the uptake of the free checks?

Systems will be put in place to monitor the uptake of the free oral/sight checks following implementation of the provisions.

8. How is the Executive tackling the poor uptake of sight tests?
This will form part of our discussions with the profession. We will also consult with consumer bodies on how to promote uptake in terms of information to the public. An initial report of the eyecare review will be submitted to Ministers shortly and could be made available to the Committee shortly thereafter.

Part 3: Pharmaceutical Care Services

9. In the written evidence submitted for this Bill some organisations have expressed confusion regarding the procedures for the supply of appliances under the new PCS arrangements, particularly for patients who deal directly with the supplier at the moment. Can the Executive clarify this?

In addition to responding fully to all correspondence on this issue, we shall write to Health Boards and the organisations that represent both appliance suppliers and their users to clarify the proposed new arrangements.

Part 4: Discipline

10. What is the process for pay arrangements for suspended professionals under the new discipline procedures?

We are currently discussing arrangements with each of the contractor professions and aim to complete negotiations by the summer. It will then be necessary to lay amendment regulations for each of the contractor professions; the amendments should come into force by October.

Part 5: Miscellaneous

Infection with hepatitis C

11. When will an appeals process be established for the scheme?

Officials from the four UK administrations have met twice this year, 28 February and 17 March to progress establishing the Agency Agreement and Appeals Process. Officials from the Executive noted the issue raised by the Scottish representatives of the Haemophilia Society during their evidence session to the Health Committee and these were highlighted in the discussions. The Department of Health for England is leading on setting up the Appeals Process and I have alerted John Reid to the need to establish this as a matter of urgency. I am personally monitoring progress towards a swift solution.

12. Can the Executive clarify why the scheme requires a claimant to reside in Scotland when the application for payment from the Skipton Fund is made? For example, what happens in the case of an individual who moved away from Scotland prior to the introduction of the scheme?

For the purposes of the Bill, it is irrelevant where in the UK the treatment was received. In order to be eligible to claim under a scheme made under the Bill, the person requires to be resident in Scotland at the time of making a claim. Consequently, if a person infected in Scotland moves elsewhere within the UK (and had not at that time made a claim to Scottish Ministers) they would not be eligible to make a claim under the provisions in the Bill.

If they are resident in England, Wales or Northern Ireland they would, however, be eligible to make a claim in England, Wales or Northern Ireland as appropriate. The provisions, in essence, enable more efficient administration and merely determine which of the four administrations will meet the costs of the claim. This will make no difference to the claimant – the form and process will be the same.

Officials are in discussion with officials from the other UK administrations on the matter of individuals now living abroad and I will respond to the Committee with the outcome of these discussions once they are complete.
13. Can the Executive clarify the position of the eligibility of those who died after August 2003 but before the Skipton Fund was established and who therefore could not have submitted a claim. Are their relatives entitled to claim?

We have great sympathy for relatives and dependants of those deceased infected persons who had not submitted a claim prior to death and are not entitled to payment but we have to consider the effects of the financial outlay on this scheme on the ability to provide treatment for other patients. For this reason, the UK-wide scheme focuses on those who are currently suffering.

The Skipton Fund, unlike both the Macfarlane and Eileen Trusts, is not a charitable trust. It has been designed to make lump sum ex-gratia payments on compassionate grounds and does not make follow up or day to day payments. However, the lump sums are comparable to those made by the Macfarlane and Eileen Trusts. Whilst the others do include dependants under their eligibility criteria, the Skipton Fund is distinct and was never designed to compensate for bereavement or loss of earnings.

14. Will the Executive amend the Bill to ensure claimants from the Skipton fund are not disadvantaged in respect of claims made elsewhere?

Section 24(3)(b) of the Bill is concerned with the right of a claimant to initiate or pursue court proceedings notwithstanding that a payment is received from Skipton. Ministers have power to specify conditions for eligibility and the Executive has made it clear that a person is eligible to receive a payment from Skipton notwithstanding that the person may have received a payment from other schemes.

An amendment is proposed for Stage 2 to make this clear.

Authorisation of Medical Treatment

15. Will professionals issuing incapacity certificates receive training?

I wish to assure the Committee that only those professionals who have undergone relevant training will be allowed to issue a section 47 certificate. We have asked NHS Education for Scotland (NES) to develop a suitable training package. These changes will be reflected in an updated Code of Practice which we hope to issue in the Autumn. I am also giving consideration to bringing forward an amendment at stage 2 of the Bill, where this would add greater clarity.

Joint Ventures

16. What discussions have taken place between the Executive and CoSLA and the NHS Federation on the issue of Joint Ventures?

The Executive is committed to an inclusive process for developing joint ventures as provided for in the Bill. The Joint Premises Project Board (JPPB) which was established in December 2004 has involved CoSLA directly from the start. I will be monitoring its work closely and will be receiving recommendations from it in due course. I look forward to discussing such issues directly with CoSLA on an ongoing basis. In support of the JPPB a wider body of interests has been brought together to inform its deliberations and work plan. This Joint Premises Stakeholder Forum meets for the first time on 16th May. The NHS Confederation has been invited to join this Forum.
ANNEX B

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

The National Smoke Free Areas Implementation Group Membership

Chair
Andy Kerr, Minister for Health and Community Care

Members

• Paul Ballard, NHS Tayside
• Patrick Brown, Scottish Beer and Pub Association
• Gordon Greenhill, Society of Chief Officers in Environmental Health
• Prof. Gerard Hastings, University of Stirling
• Will Holt, Consolidated Communications
• Councillor Eric Jackson, COSLA
• John Loudon, British Hospitality Association
• Rory MacKail, Federation of Small Businesses
• Lindsay MacHardy, NHS Health Scotland
• Ken McGowan, Scottish & Newcastle Plc
• Alan Rankin, Scottish Tourism Forum
• Marjory Rodger, Confederation of Passenger Transport
• Jacqui Roberts, Care Commission
• Eddie Tobin, Bar Entertainment & Dance Association Ltd
• Alan Tomkins, Glasgow Restaurateurs Association
• Melanie Ward, National Union of Students
• Paul Waterson, Scottish Licensed Trade Association
ANNEX D: OTHER WRITTEN EVIDENCE

PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES - ORGANISATIONS

SUBMISSION BY THE AGAINST AN OUTRIGHT BAN (AOB) GROUP – PETITION 819

The AOB Group was formed in the Autumn of 2004 to communicate the views of the majority of pub owners in Scotland as to how to maximise the potential health and financial benefits from tobacco restrictions.

The membership of the AOB Group includes the Scottish Licensed Trade Association, the Scottish Beer and Pub Association, the Scottish Wholesalers Association and several multiple pub groups which are based in central Scotland. Altogether, we represent more than 3,500 licensed trade retailers in Scotland as well as the bulk of the brewing industry in Scotland.

Whilst we support tobacco restrictions, we are strongly in favour of choice and we fully endorse the views expressed at Westminster by Dr John Reid in November 2004.

“We believe that, in a free society, men and women ultimately have the right within the law to choose their own lifestyle.”

Our membership has been heavily involved in working with the Scottish Executive to reduce tobacco consumption in licensed premises. We were the principal contributors to the Scottish Voluntary Charter Group which promoted the introduction of smoke free areas and better quality ventilation from year 2000 onwards. We came to recognise that voluntary action does not provide a level playing field as individual licensees are naturally reluctant to take steps to restrict smoking if such steps place them at a competitive disadvantage. So, in May 2004, we asked the (then) Deputy Health Minister to introduce through legislation five measures which would have been compulsory for all licensed premises ranging from pubs, hotels, restaurants, sports clubs, social clubs and entertainment venues. The measures were:

- Smoking should be banned at the bar counter in all licensed premises.
- Smoking should not be permitted in any area where and when hot food is being served.
- All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be ratcheted upwards to 40% in year 2 and 50% in year 3.
- Every licensed premise should have a smoking policy sign at the entrance.
- Smoking should not be permitted in any area of licensed premises from which the public are excluded (ie back of house).

At the end of year 3 a review of progress would be made and appropriate further steps taken in the light of public opinion prevailing at that time.

The model proposed by us is very similar to the Norwegian model which has increased restrictions over a period of several years.

We do not underestimate the difficulties in introducing these measures but we believe that they will help Scotland to make a huge stride forward in improving choice for non-smokers and protecting their health as well as the health of employees in the industry. A firm message will be conveyed to the Scottish public in general and smokers in particular and, over a period of time, we anticipate a significant increase in the presence of non-smokers in licensed premises.
Our position remains unchanged from that of May 2004. We are even more convinced, having reviewed all the consultation documents and reports, that our own proposals would bring greater health and financial benefits to Scotland.

The reasons why we say that are as follows:

1. There is no public support for the provisions of the Bill. The Executive’s own research has demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in licensed premises. This is not to say that the public do not want increased restrictions on smoking – but they do not want, and are not ready for, an all out ban.

   The mruk opinion poll concluded that although a majority of those surveyed supported a ban on smoking in enclosed public places, two-thirds of those also believed that exemptions should be considered for the licensed trade. Only 18% of those surveyed supported a total smoking ban.

   The Scottish Executive evidence report gives a summary of the outcome of focus group studies and on page 21 states that “there was a deeply ingrained assumption that the pub is one of the few places where smoking should be freely allowed.”

   Further, in the evidence report on the outcome of youth consultation, the Scottish Executive states clearly that 66% of young Scottish people believe there should be some places where smoking is allowed (page 28). On page 29 the report goes on to say that “whilst smoking could be banned in most public places, some young people felt that some places should be exempt. Pubs and clubs were mentioned as the key areas that should be exempt. Young people suggested that there could be some “smoking bars” or there could be designated areas within pubs for smokers.”

   In the survey conducted by the UK Department of Health in 2003, 80% of participants wanted tobacco restrictions but, of these, 80% wanted exemptions for the licensed trade.

   In the most recent poll, conducted by Populus, more than 75% of Scots were found to believe that smokers should have the right to smoke in public provided they do not inconvenience non-smokers.

   In our opinion, the Scottish Government has wholly underestimated the importance of public support as part of major cultural change of this type.

2. One of the consequences of the lack of public support for this legislation is, potentially, a sharp increase in the number of smokers choosing to switch their disposable income from pub going to take home consumption. This has been the experience in Ireland, as is highlighted in the cebtr report referred to in point number 5 underneath.

3. There has been no Scottish Executive research into the potential health consequences of smokers ceasing to visit licensed premises and switching their disposable spend into take home drinking.

The Evidence Report states that the best estimate of Scottish deaths from health problems resulting from ETS is 865 per annum. However, almost all of the research conducted in to ETS has taken place in the home.

Approximately six-sevenths of health problems encountered from ETS are derived from domestic situations. It is quite possible that the outright ban approach will result in greater health problems as a result of increased smoking at home.

Under our own proposals, people will have the right to choose either a smoking or a non-smoking pub. Under the Executive proposals, people will have no such right of choice. Currently, more than 60% of pubgoers are smokers. If this legislation results in a significant switch from pubgoing to take home drinking/smoking, the risk of ETS exposure in domestic environments will increase. Non-smoking partners, relatives and children of smokers will have no escape from the impact of
ETS – or at least they have less chance of escape from the impact than those who visit licensed premises.

The most recent addition of the British Medical Journal carried a report of research which has concluded that children exposed to ETS in domestic environments are more than three times more likely to experience lung cancer and related diseases in later life than children who are not exposed to ETS in domestic environments.

This underlines the requirement for further research on the potential “shift” of ETS problems.

4. The Scottish Executive has failed to carry out any research on whether or not smoking cessation is greater following an outright ban on tobacco usage in public places than it is following phased restrictions on tobacco usage in public places.

There is no evidence from Ireland on this very important issue. However, Norway has recently released some statistics which show that the number of Norwegians between the age of 16 and 74 who smoke daily, which had dropped from 29% to 26% in 2003 without a smoking ban, has dropped by only 0.3% in 2004 following the ban. The number of daily smokers among young Norwegians aged 16 to 24 has actually increased since the smoking ban came into force, rising to 23.7% from 22.8% in 2003.

5. The Scottish Executive has not fully researched the benefits of effective ventilation systems.

In the 1998 UK White Paper *Smoking Kills* para 7.23 states “ventilation systems can improve the comfort and welfare of public and employees. The best systems can, provided they are properly operated and maintained, protect non-smokers from exposure to carcinogens.”

The Executive has ignored the conclusions of the University of Glamorgan report which found that the contaminants in the atmosphere of a smoking-permitted, well ventilated pub in Glasgow (the Doublet) were fewer than in the atmosphere of a no-smoking non-ventilated pub in Glasgow (the Phoenix).

The University of Glamorgan report has been criticised in a peer group review but the authors of the report remain convinced that their conclusions are correct. We believe that there has been insufficient follow up by the Scottish Executive to ascertain whether or not the University of Glamorgan report is correct in its findings. If it is, a better health option for the Scottish Executive would be to insist on all smoking-permitted pubs to have ventilation installed to a minimum standard.

6. The Scottish Executive has based its decision to proceed with a blanket smoking ban on a range of research which we believe to be fundamentally flawed. Much of it is irrelevant and it is incomplete. The principal piece of research was the “international review” undertaken by the University of Aberdeen. However, the international review considered the “specific effects on the hospitality sector” of a smoking ban using a number of studies - eleven of which related to restaurants and four to hotels. Significantly, only one related to the experience in bars (in California) and the report indicated that “this was the only study available to model results for Scotland”.

The AOB Group has commissioned the Moffat Centre for Travel and Tourism Business Development, Glasgow Caledonian University, to undertake a project to source, review and evaluate existing research which has been undertaken in analogous destinations and countries which have legislated for either an outright or a phased ban on smoking in workplaces. This included the aforementioned international review undertaken by the University of Aberdeen.
The Moffat Centre conclusions include:

The weakness of the international review is its lack of relevant evidence to:

(a) support the argument that an outright ban in all workplaces will reduce the number of smokers when increases in smoking may be displaced elsewhere eg in the home.

and

(b) make a claim that a no smoking policy will not harm the hospitality business, particularly bars.

Nearly all the governments in the countries and states reviewed for this work, with the exception of Ireland, have given significant notice of their intention to introduce a total ban on smoking in hospitality establishments. This is only fair given the apparent difference in perception of the public towards smoking in different categories of hospitality premises. The Scottish Executive could take a lead from the experiences of other nations’ legislature.

It has been acknowledged as a weakness in the Executive’s commissioned research that the studies reviewed do not include analysis of a total ban situation. This is compounded by the lack of transferability of the cases used in their argument.

A Government backed investigation into the effects of the ban in Ireland could be undertaken, using a cross sectoral group that encompasses health experts, industry practitioners and Government policy makers. This would surely provide a consensus on the effects of and timescale for introducing a total ban, if that was the conclusion of the group.

7. The AOB Group has been alarmed by the lack of any in depth study of the financial impact of the smoking ban. We commissioned the Centre for Economics and Business Research (London) to independently review the economic impact on both the licensed trade and the beer industry in Scotland.

The cebr report is attached as appendix 2. Its findings include:

The value of annual turnover in the licensed trade will decline by £105m.

Annual profits in licensed premises may decline by £86m.

Employment in the licensed trade can be expected to decline by 2,300 jobs initially.

About 142 average sized licensed premises may close as a result of decreased trade.

The Chancellor of the Exchequer may lose out on a total of £59m in annual tax revenues from the Scottish licensed trade.

8. The AOB Group proposal is similar to the UK Government’s proposal in that it provides choice for both smokers and for non-smokers. To create a divide in smoking policy between Scotland and England will put our nation at a significant competitive disadvantage. Currently 80% of visitors to Scotland come from England. There is a strong possibility that tourists will favour English destinations – where the visitor is free to choose between smoking and non-smoking venues – as opposed to Scottish destinations where there is no choice. The Moffat Centre research makes it clear that “boundary hopping” is common in the USA where different States have different regulations.

9. What we have found most surprising throughout the consultation process is the apparent assumption that a blanket ban is the best possible option to improve public health and benefit the economy. The debate seems to have been dominated by “black versus white” – either an outright ban or the status quo. There have been no discussions between the Scottish Executive and the AOB Group concerning the practicalities of the proposals which we have put forward. For us, this has been a source of considerable frustration. There appears to have been no serious
consideration given to the introduction of tobacco restrictions along the lines of those successfully implemented in countries such as Australia and Norway where a phased approach has proved to be acceptable to all stakeholders.

10. Little recognition seems to have been afforded to the ramifications of a downturn in the Scottish leisure industry and the consequences of lower employment. The fear of unemployment affects the mental and physical welfare of all those who work in any industry which is subjected to such sudden cultural change as that being proposed.

11. Moreover, no assessment has been made by the Scottish Executive of the potential disruption of communities and social disorder through the provision of this legislation. Scotland has many licensed premises which form part of tenemental buildings and it is not possible for licensees in these landlocked situations to provide external smoking facilities for their customers, due to neighbourhood nuisance and noise issues. The likelihood is therefore that many Scottish streets will be disrupted by groups of smokers indulging their addiction on pavements outside the front of pubs and clubs. This will in turn bring new problems for the authorities to deal with and it will not be easy to introduce a law which forbids people to stand and smoke in unenclosed areas (unless tobacco is banned altogether). Once they leave the freehold of the premises, customers of licensed establishments cease to be the responsibility of the licensees.

Further, it is universally agreed that smoking is more prevalent in the less affluent areas of Scotland’s cities and towns. Smoking bans are likely to hit hard in the more deprived communities, driving people to stay at home rather than make their regular visits to their favourite hostelleries. As UK Secretary of State for Health Dr John Reid has said on various occasions, - one of the few pleasures of the working man is to have a drink and a cigarette with his friends – if this right is denied him, community life will change radically, ripping the heart out of many localities.

Conclusions

The licensed trade has always been, and will always remain, supportive of the ultimate objective of a healthier Scotland. However, we strongly believe that the Scottish Executive has not afforded the time and consideration necessary to identify the best move for public health. As we have stated, there is a significant body of evidence to suggest that an alternative strategy, with the same aim, may further increase the health benefits achievable from restricting the use of tobacco in licensed premises.

Surely what is effectively the most radical move in public health policy this Executive has proposed deserves greater attention to detail?

We urge the Health Committee to request more time to conduct research into the financial and health benefits of alternative approaches. In addition, we would urge the Government to consider new and innovative ways to tackle smoking. This debate seems to have been dominated by an “all or nothing” approach. At no point in the process would it seem that anyone has really sat down and looked for the optimum solution.

Should the Executive decide to give the decision a bit more thought we would be delighted to help in any way whatsoever and we would be pleased to give oral evidence to the Health Committee, should you so wish.

SUBMISSION BY ASTHMA UK SCOTLAND

Second-hand tobacco smoke has a massive impact on people with asthma. Not only can it make asthma worse, but research has found it can actually cause asthma. • Even at low levels of exposure, second-hand smoke is associated with asthma symptoms.1 • Second-hand smoke is a major asthma trigger, reduces lung function and causes more frequent attacks.2 • Research published at the end of 2003 concluded that secondhand smoke also causes asthma in adults. For people exposed to asthma at work the risk of developing adult onset asthma is doubled, for people exposed to asthma in the home the risk is increased five fold.3 Research from Asthma UK
Scotland has found that: • 4 out of 5 people with asthma say other people’s smoke makes their asthma worse. • 55% of parents of children with asthma avoided restaurants and places with smoky atmospheres. • Second-hand smoke is the second most common asthma trigger in the workplace.

• 1 in 5 people with asthma feel excluded from parts of their workplace where people smoke.
• 60% of people with asthma say that government is not doing enough to protect them.
Those with more severe asthma symptoms are most severely affected:
• 44% reported missing out when friends or family go to restaurants or pubs where smoking is allowed.
• When we asked people with severe asthma “If you could get the government to do just one thing to improve your asthma, what would it be?” 21% said “Ban smoking in public places.”

(National Asthma Campaign’s National Asthma Panel fieldwork December 2003).

Asthma UK Scotland understands that prohibiting smoking in public places will cause concern for smokers and other industries such as restaurant owners. However, we believe that the overwhelming health arguments outweigh these personal liberty arguments put forward by smokers, particularly when compared with the personal liberty of people with asthma, who have a right to go to a restaurant without fear of having an asthma attack. Concerns have been raised that by introducing smoke free public places more people may smoke at home. This fear has not been borne out in countries that have already introduced smoke-free public places. Rather, people who smoke have taken this opportunity to stop smoking. Asthma UK Scotland expect that by introducing smoke-free enclosed public places will not lead to a rise in smoking in the home. Smoke-free areas have been compared to swimming in the chlorine free half of a swimming pool. It simply does not exist. Smoke-free areas are still contaminated by cigarette smoke and the carcinogens and toxins that it contains. Ventilation systems have also been suggested as a possible way forward. Again, scientific research has shown that ventilation systems are simply not effective in removing toxins and carcinogens from the air.4 We welcome the recognition given to this by the Health Committee and the Executive and hope that this resolve remains throughout the passage of this Bill.

Conclusion

Preventing smoking in public places is the only way that we can protect people from the adverse effects of second-hand smoke. Other measures that try to find common ground between interest groups, such as ventilation or smoke-free areas are a compromise, and a compromise that is dangerous to health. While in politics we often try to find a common path, or a compromise that brings different groups together, on this issue such a policy could lead to solutions that are detrimental to health and therefore cannot be pursued. Asthma UK Scotland understands that there will be calls for exemptions to be introduced in the Bill. Ideally we would like to see all enclosed public places smoke-free. This is the only way to protect the people who have to work in an environment that is seriously dangerous to their health. It is worth re-stating that people exposed to second-hand smoke for six or more hours per week are 50% more likely to develop asthma symptoms.5 We know that places that could be considered a home will not fall under this Bill, however we would ask the committee to consider this question and recommend protection for those who have to work in this dangerous environment. Asthma UK Scotland therefore supports this Bill that will introduce smoke-free enclosed public places as a positive way forward in improving the health of people in Scotland, and in particular those people with asthma.

A Personal Perspective

Elaine has asthma and explains how smoking in pubs and restaurants affects her life: “About 14 years ago and after a very healthy and busy social life where I played squash for my university and ran up the hills of Snowdonia I developed late onset asthma. How life changed! The most vicious trigger was cigarette smoke and so overnight I became a prisoner in my own home. I could not go with my friends and family to pubs, parties or restaurants. They all found this hard but not half as hard as I did. Imagine declining all meals out, going to pubs with friends, school/ parent socials and parties. Sometimes I would sit at home alone and send my husband out to enjoy himself because I didn’t see why he should be a victim too. I pathetically looked forward to the annual Christian Aid Ceilidh in the local Church hall because smoking was not allowed. I sometimes became very angry
at the ignorant rhetoric in the papers about the rights of smokers. They have no right whatsoever to pollute the air I or any other person breathes. Restricted areas are not effective as the smoke is still hanging in the air, evidenced by how people smell when they come out! Eventually I found a non-smoking restaurant in Edinburgh called Parrots and took all my friends and family there. More recently others have sprung up, probably about three and of course Starbucks are all non smoking so at least we can go for a coffee now. The first non smoking pub/restaurant in Edinburgh has emerged and this is great news.” Elaine goes on and asks: “Please can we have a ban on smoking in public places? At the moment many people with asthma have had their choice and freedom of movement removed. With a ban, people who smoke can still choose where to go however their choice to pollute the air we breathe will be removed. That is justice.”

SUBMISSION BY BARNARDO’S SCOTLAND

Barnardo’s Scotland - children's charity with over 60 community-based projects across Scotland. We provided a response to the consultation paper so our comments are brief. We would be happy to give oral evidence to expand on this written evidence.

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

Because of the public health dimension -smoking is the leading cause of premature illness and death in developed countries

Smoking behaviour is established in adolescence and young smokers may become addicted before reaching adulthood. Legislation that restricts opportunities to smoke along with educational and public health messages and effective cessation interventions should help force the pace of change - a wide range of tobacco control measures are essential

If not, why not? N/A Are there any other comments you would like to make?

The legislation will ban smoking in public places. This tobacco-control measure will complement the work of some of our projects that work with young people on lifestyle issues and healthy living. The fact that tobacco is a possible 'gateway' route into taking cannabis is another important consideration.

Some of our projects also work with expectant mothers and parents on the impact of second-hand smoke on developing embryos, babies and children. This is important work since exposure to second-hand smoke causes illness and premature loss of life, at all ages from the prenatal to late adult life.

Our projects need to work sensitively in this area since for many children, young people and parents, smoking is a normal part of their life and they believe it helps them deal with the many problems and difficulties they face.
SUBMISSION BY BELLHAVEN GROUP

The Belhaven Group is Scotland's leading regional brewery operating a range of activities which include beer brewing, drinks distribution, licensed retailing and tenanted estate management. We own and operate 270 pubs in Scotland and we supply beer and other drink products to approximately 2,000 licensees throughout the country. We employ approximately 1,600 people and we are Scotland's only publicly quoted (on the London Stock Exchange) company which derives its livelihood almost exclusively from the Scottish licensed trade.

We are a member of both the Scottish Beer & Pub Association and the Against an Outright Ban Group. We fully endorse the submission from the AOB Group which is attached herewith for easy reference.

I would emphasise the strong feeling within our company that the five point plan proposed in the AOB submission will deliver greater health and financial benefits for Scotland than the provisions contained in the Holyrood Bill.

Please take time to conduct the research which this hugely important subject deserves. To date, the research on which the Scottish Parliament decision has been predicated is, we believe, fundamentally flawed, incomplete and, in parts, quite irrelevant.

Thank you for having afforded us the chance to communicate our views to you. We will be happy to give oral evidence, should you so wish.

Yours faithfully
STUART ROSS
CHIEF EXECUTIVE

SUBMISSION BY BLANTYRE BOWLING CLUB

We are very concerned about the No Smoking ban that the Scottish Executive is going to impose on the Licensed Trade, and others, during 2006. We feel that a total ban on smoking is not in our best interest and that a partial ban would be better.

If a partial ban was brought in, we would set aside 50% (or more if necessary) of our clubhouse for non smokers and increase the ventilation to a set standard, as imposed by the authorities.

Our club depends on the revenue from the bar to keep our fees lower, improve the fabric of the club and maintain and buy machinery for the upkeep of the green.

I have spoken to members from other clubs in the district and the majority of them, like us, would prefer to have smoking and non smoking areas within the clubs. We sincerely hope that you will take into consideration our concern and public feeling before you make a decision on this important matter.

Yours on behalf of the Committee

SUBMISSION BY BMA SCOTLAND

Part 1: Prohibition of smoking in certain wholly enclosed places

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The
BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

Introduction

The BMA welcomes the opportunity to comment on Part 1 of the Smoking, Health and Social Care (Scotland) Bill which aims to prohibit smoking in enclosed public places. In previous evidence to the Health Committee on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, the BMA supported the general principles of the restrictions proposed in the Bill.

Written evidence to the Committee stated: “Ideally the BMA would like to see the introduction of primary legislation to make all enclosed public places smoke free.”

The BMA therefore fully supports the principles outlined in Part 1 of the Smoking Health and Social Care (Scotland) Bill which seeks to provide comprehensive legislation to create smoke free enclosed public places.

Smoke free public places and the public health

The BMA welcomes the Committee’s recognition that passive smoking harms health. International evidence has proven that legislation to create smoke free enclosed public places, as part of a wider strategy, works at reducing exposure of non-smokers to deadly tobacco smoke. Evidence has also found partial and voluntary restrictions to be ineffective in protecting the public.

Each year in Scotland 13,000 deaths are caused by tobacco related diseases such as cancer and heart disease. Secondhand smoke also kills hundreds of Scots each year, causes cancer, heart disease and asthma, aggravates asthma in adults and is known to cause middle ear and respiratory infections in children. Exposure to secondhand smoke is also a cause of cot death.

The BMA’s publication, Towards Smoke-Free Public Places, states that no safe level of exposure to second-hand smoke has been identified. The BMA welcomes the commitment to introduce this legislation as a public health measure to protect the public from the harmful health effects of exposure to secondhand smoke.

Section 4 (7) of the Bill enables ministers to add or remove, through regulations, premises that would be included within the legislation. The BMA understands that exemptions to legislation will be included in regulations to be published at Stage 2 of the Bill process. However, the BMA would emphasise that comprehensive legislation is needed, and that any exemptions should be extremely limited, as has been the case in Ireland. The central reason for this legislation is to protect health and the BMA believes that everyone should have the right to the protection from the significant health risks of secondhand smoke. If the regulations were to provide for large scale exemptions, such as those proposed and supported by the tobacco industry and licensed trade, it would be significantly less effective as a public health measure.

Alternative approach

Alternative approaches, such as voluntary agreements and partial bans, have proved to be ineffective in protecting the public from the harmful effects of secondhand smoke. A review of the hospitality industry revealed that despite repeated government support for voluntary measures, less than half of all businesses in Scotland surveyed even knew about the Voluntary Charter. This experience has been shared worldwide. In Australia, compliance with the Voluntary Code of Practice was also poor and played an insignificant part in the adoption of non-smoking policies.

There are 4,000 toxins and more than 50 cancer-causing substances in tobacco smoke and many of these are odourless, invisible gasses, which are not removed by ventilation systems Ventilation has been proposed as a solution to the problem of passive smoking. However, the evidence shows that ventilation and air-cleaning systems do not provide effective protection against the health hazards of second-hand smoke.

Ventilation systems commonly involve the partial dilution and recirculation of filtered air. They are inadequate in offering protection from the harmful effects of secondhand smoke. Air cleaning
systems usually involve the filtration of air, which is then re-circulated. Because filtration systems can only filter out particles, they do not remove the gas phase of secondhand tobacco smoke. An assessment of filtered tobacco smoke concluded that it is as potent in inducing cancer as unfiltered smoke.1

Because only the particulate matter in smoke is visible, ventilation filtration systems can give the non-smoker the impression that they are safe from the exposure to tobacco smoke. Many people underestimate the extent to which they are exposed to tobacco smoke. Businesses installing expensive ventilation systems in the belief that they are protecting staff and the public from the ill effects of secondhand smoke are mistaken, even those of the highest quality do not provide adequate protection4.

Financial Implications

One of the key arguments against smoke free enclosed public places is that businesses in the hospitality sector would suffer financial hardship. There is no independent evidence from anywhere in the world that supports the claim that the hospitality trade has been adversely affected by the introduction of smoke free policies.

Figures circulated by the Scottish Licensed Trade Association are remarkably similar to those predicted by Irish licensed trade representatives who warned that turnover would drop by 20 to 25 per cent and 30,000 jobs would be lost as a consequence of the legislation which came in to force at the end of March 2004. These predictions have not been realised. A report from the Irish Central Statistics Office revealed that in November 2004 bar sales were down just 2.8% per cent compared with the previous year. The decrease in the year before was 7.1%. Scare stories about declining hospitality industry sales should be viewed in the context of the long term trend in Irish bar sales.

Furthermore, a report commissioned by the CMO in England revealed that concern about falling profits is unfounded. In other parts of the world where legislation to create smoke-free public places and workplaces has been introduced, profits in the hospitality and leisure industries have risen7.

However, there is one industry which stands to suffer significant losses as a result of this legislation. A recent review of the introduction of smoke free workplaces estimated that if all UK workplaces became smoke free, consumption would fall, costing the tobacco industry £310 million annually in loss of sales1. Internal tobacco industry documents have shown how the tobacco industry worldwide has vigorously opposed smoke free legislation, including funding “smokers’ rights” groups and lobby groups representing the hospitality trade.

Public Opinion

The majority of the public support smoke free enclosed public places. The recent survey commissioned by the Scottish Executive which shows that 70% of those surveyed do not support a ban in bars and restaurants is cited by the hospitality industry as proof that this move would go against the public’s wishes. It fails to highlight the fact that over 50% of the sample were smokers. This sample is not representative as only 30% of the Scottish population smokes. The evidence from other countries that have gone smoke free shows that public support increases after legislation is announced, and continues to increase as the measures are introduced.

Conclusion

International experience clearly illustrates that comprehensive tobacco control programmes, supported with national legislation, work. If smoke free public places were introduced, it is estimated that smoking rates could drop by 4% and tobacco consumption would fall by 30%. Indeed, after legislation for smoke free public places was introduced in Australia, children’s exposure to passive smoke in the home fell, both because when fewer adults smoke, fewer children are exposed, but also because more families introduced smoke free homes.
Smoke free enclosed public places would save hundreds of lives each year and reduce the impact of chronic disease on individuals and the health service. It would be the best possible measure that the Scottish Parliament could take to improve the health of the nation.

SUBMISSION BY BRITISH LUNG FOUNDATION SCOTLAND

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the Bill? Yes

If yes, why?

The British Lung Foundation (BLF) is pleased with the sections in the Bill that will ban smoking in wholly enclosed public places in Scotland.

The health risks associated with secondhand smoke have long been acknowledged and the BLF is delighted that Scotland is leading the way for the rest of the UK on this issue.

We believe the Bill will be instrumental in reducing the estimated 1,000 deaths per year in Scotland attributed to secondhand smoke. In addition to this, there are more than 800,000 people living with a lung disease in Scotland whose conditions are severely aggravated by exposure to secondhand smoke. These people will finally be able to socialise and work in smoke-free environments which do not damage their health.

We also agree with the assertion that a complete ban will provide the most comprehensive protection and will also be simpler to implement than other compromise measures that have, for instance, been announced for England in the Choosing Health? White Paper.

If not, why not?

N/a

Are there any other comments you would like to make?

It is noted that the Bill makes provision for certain exemptions to be prescribed through regulations. The BLF would urge the Executive to minimise these exemptions as much as possible to ensure that the health of all workers in Scotland is protected by this Bill.

We feel that enforcement by local authority environmental health officers is appropriate and believe that making it an offence ‘to permit others to smoke in and on no-smoking premises’ will facilitate compliance by ensuring owners and managers enforce the ban.

The BLF thinks it is vital that the implementation of this Bill is under-pinned by support for smokers who wish to quit. We feel that this is the most important element of any comprehensive package to reduce the burden of smoking related disease. Many smokers find giving up incredibly difficult – in 2000, the Royal College of Physicians published a report on nicotine addiction which concluded that “cigarettes are highly efficient nicotine delivery devices and are as addictive as drugs such as heroin or cocaine.” The BLF believes it is essential for NHS Scotland to lead the way in providing effective support to quitters in the most appropriate settings and at the most convenient times.

If you require additional information, please do not hesitate to contact us. We are happy to provide further evidence at a later date if this would be useful to the Committee.

Andrew Powrie-Smith
Head of BLF Scotland
SUBMISSION BY BROOMHOUSE CENTRE

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? no

If yes, why?

If not, why not?

No. I am the co-ordinator of a small group providing day care to elderly people with dementia in a small public building. I see allowing smoking after meals as a part of the provision of care for elderly people with dementia as many of them have smoked all their lives.

I am concerned that when smoking is banned in public places, people will not wish to attend our day centre, putting further strain on already lengthy waiting lists at social work day centres in the area (where I understand there will be no ban).

Day care can help combat social isolation and such problems as becoming de-skilled and unmotivated in people with dementia and isolation and stress in carers, and the successful care of people in the community depends on readily available services.

I would therefore like to see provision in the bill to allow a public place in use for the provision of care to be treated as private space where appropriate.

SUBMISSION BY CAMRA

Thank you for the opportunity to express our views on the above Bill.

1.0 The Prohibition of Smoking in Public Places

1.1 CAMRA supports action to manage the issue of smoking in licensed premises, but does not support a complete ban on smoking in all licensed premises by next spring.

1.2 CAMRA believes that a complete ban on smoking in all licensed premises by next spring is the wrong approach for the following two reasons:

- Lack of public support. We highlight the finding of an opinion poll commissioned by the Scottish Executive, which reveals 57% of the public consider pubs should be exempt from a ban on smoking in public places.
- Adverse economic impact on licensed premises. As a higher proportion of licensed trade customers are smokers than the population as a whole we believe that licensed premises will be particularly hard hit as a result of a ban. Research by BDO Hayward (2004) reveals that 46% of licensed trade customers smoke compared to only 26% in the population at large.

1.3 The implementation of a complete smoking ban in all licensed premises next spring will have an adverse effect on licensed premises, as smokers choose to drink at home rather than in licensed premises. The resultant loss in trade will mean:

- Significant job losses as licensed premises reduce staffing levels to cope with a downturn in trade.
- Reduced investment in maintenance of licensed premises.
- An increase in pub closures particularly in rural areas.
1.4 It is argued that banning smoking will mean non-smokers will be more likely to visit licensed premises. However an increase in licensed premises visits by non-smokers is unlikely to happen overnight, but is likely to build slowly over time.

2.0 Proposed Exemptions for Licensed Premises

2.1 CAMRA urges the committee to consider the following exemptions, which we believe will mitigate the adverse economic impact of a ban on licensed premises:

- Licensed premises should be exempt from a smoking ban until spring 2008 to allow a three-year period for licensed premises to prepare for a smoking ban.
- Where a licensed premise has two or more separate rooms then smoking should be allowed to continue in the smaller of those rooms, provided measures are introduced to minimise harm to staff.

2.2 CAMRA believes that a delay in implementation of a smoking ban until spring 2008 will mitigate the impact of ban on smoking in licensed premises by allowing time to:

- Attract non-smokers to licensed premises by introducing new no smoking areas.
- Develop other areas of the business, such as food, to help compensate for any loss in trade.

3.1 CAMRA believes that where a licensed premises has two or more separate rooms then smoking should be allowed to continue in the smaller of these rooms for the following reasons:

- Non-smokers will not be subjected to other peoples smoke as they can choose to sit in the larger non smoking room.
- Measures can be introduced to allow employees to opt out of working in the smoking area of any licensed premise.

Thank you for considering our views. Please contact us if you require any clarification or further information.

Yours sincerely

Jonathan Mail
Public Affairs Manager

SUBMISSION BY CANCER RESEARCH UK SCOTLAND

Cancer Research UK Scotland thanks the Committee for the opportunity to present evidence for the above Bill, which we regard as one of the most important pieces of legislation for the improvement of Scotland’s health. We are pleased to see the evidence for the health hazards posed by second-hand smoke acknowledged by the Scottish Executive in the Policy Memorandum for this Bill.

Cancer Research UK Scotland is both a participating member of Scotland CAN! (Cleaner Air Now), the coalition of organisations that lobby for smoke-free enclosed public places in Scotland, and a member of the Steering Group of the parent coalition SCOT (Scottish Coalition on Tobacco). Having consulted on and contributed to the coalition’s submission of evidence Cancer Research UK Scotland endorses the arguments submitted by that body to the Health Committee.

We particularly endorse the evidence showing that the hospitality groups and tobacco industry present flawed arguments in their proposals for alternative legislation. Cancer Research UK has been tracking the activities of the tobacco industry on smoking regulation issues for many years and is familiar with their lack of peer-reviewed reports and the tactics used to mislead the public on the dangers of second-hand smoke.
Should you require oral evidence, our research experts in Scotland or further afield remain at your disposal. Our position as part-funders of the current International Tobacco Control study on smoking legislation may be of particular value.

Please contact me in the first instance on 0131 311 4802 or e mail me on Lesley.Conway@cancer.org.uk

Yours sincerely

Lesley Conway
Public Affairs Officer for Scotland

SUBMISSION BY CARLTON CLUBS

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the Bill?

No

Carlton Clubs believes that the proposed ban on smoking as it currently stands would have a huge detrimental impact on our fourteen clubs in Scotland. A total ban on smoking in public places in the timescale proposed could seriously impact on the future viability of our business, with the potential loss of 400 Scottish jobs. Just as importantly, the closure of local bingo clubs would also remove from Scotland’s local communities a safe, social, fun and friendly leisure facility.

Carlton Clubs has been investing heavily in appropriate ventilation systems within the clubs over a number of years with a view to providing freedom of choice to our smoking and non-smoking customers. In 2005, for example, we have committed over half a million pounds to a state of the art ventilation system in a new build club, this investment decision was taken in summer 2004 before the bill was announced. A total ban will render this significant investment totally unnecessary.

It is our belief that an enhancement of building regulations to provide better ventilation and air quality systems within smoking premises would provide the best solution to both smokers and non-smokers. This change in the law, combined with the Executive’s continuing successful campaign of public health education about smoking, would be enthusiastically welcomed by our members and the wider public - who believe an imposed blanket ban on smoking in public places will seriously and unfavourably affect their current social activities.

Are there any other comments you would like to make?

Carlton Clubs is an indigenous Scottish company with a remarkable 69-year corporate history. Today, with its headquarters still in its home town of Inverness, the UK’s largest independent bingo operator has evolved and grown to a £20 million turnover organisation with fourteen clubs across Scotland and four in England employing 500 staff in total.

The company adheres to strong ethical principles of social responsibility towards its customers, suppliers, staff and the local community. Indeed in December 2003 Carlton Clubs became the first bingo company in the UK to be awarded a GamCare certificate of Social Responsibility. Carlton Clubs regularly seeks the views of its members particularly where changes will have a direct impact on their leisure activity. Over four days in December last year, Carlton Clubs sought members’ opinions on the Executive’s proposed ban on smoking in public places. Research conducted within our clubs indicates that 67% of our customers are smokers leaving 33% of non-smokers, demonstrating by their frequency of visits, that they are comfortable playing bingo in this environment.
Feedback from our membership, smokers and non-smokers alike was strong. Over 7,100
members, or more than two thirds of the people who were in the clubs over those four days,
signing a petition expressing their view against the proposed ban of smoking in all public places.
This petition has been sent to the Health Minister and shared with MSPs local to our bingo clubs.

Our members feel that any imposed ban will affect them adversely and that they will not be able to
continue to enjoy playing bingo if they are not able to exercise their right to smoke and therefore
may stop this social activity. In reality this could result in hundreds of our members spilling onto the
streets between our main session games to smoke. This merely shifts the problems associated
with smoking, not to mention creating other problems in terms of managing large groups of people
converging on the pavements and roads in our local towns.

I feel that our petition reflects much the same findings of the MRUK opinion poll, commissioned by
the Scottish Executive in September 2004, which found that of the two thirds of the sample who
would support such a law, 57% of those thought pubs should be exempt.

Carlton Clubs do not advocate smoking to our members, but we do recognise their expressed
preferences and individual rights as customers and to this end offer smoking and non-smoking
areas plus ventilation in our clubs.

Bingo is the second largest participative leisure activity, for the over eighteen population, in the UK.
It offers a safe and social environment for those who take part, the majority of which are women.

Carlton Clubs is therefore urging you to reconsider the blanket ban and amend the Smoking,
Health and Social Care (Scotland) Bill to reflect the views of our members and the Scottish public.

Carlton Clubs would welcome the opportunity to discuss any aspect of our submission with the
Committee should further clarification be required.

9 February 2005

SUBMISSION BY CHARTERED SOCIETY OF PHYSIOTHERAPY SCOTLAND

1 The Chartered Society of Physiotherapy Scotland

1.1 The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union
body representing physiotherapists, physiotherapy students and assistants. More than 98% of all
physiotherapists in Scotland are members of CSP Scotland and physiotherapy is the fourth largest
health care profession in the UK, and the largest of the allied health professions.

1.2. CSP Scotland has around 4,000 members in Scotland. Approximately sixty percent of
chartered physiotherapists work in the NHS. The remainder are in education (including students),
independent practice, the voluntary sector and with other employers, such as sports clubs or large
businesses. Three Scottish universities offer degrees in physiotherapy. These are among the most
over-subscribed university courses in the country. Approximately 150 newly qualified
physiotherapists graduate in Scotland each year.

1.3 Physiotherapy involves the skilled use of physical interventions to promote, maintain and
restore physical, psychological and social well being. Using problem solving and clinical reasoning,
physiotherapists work to restore functional movement or reduce impairment utilising movement,
exercise and the application of electro-physical modalities.

2 The Smoking, Health and Social Care (Scotland) Bill

• Part 1 – Prohibition of smoking in certain wholly enclosed places
2.1 In respect of Part I (Prohibition of Smoking) - health promotion remains a crucial aspect of the work of chartered physiotherapists. In addition, chartered physiotherapists have a primary interest in the cessation of smoking and reduction in exposure to cigarette smoke, as so many come in to direct contact with the harmful effects of smoking on patients. This is particularly true for chartered physiotherapists working in oncology and in respiratory care in Scotland. Physiotherapy also plays an important role in cardiac rehabilitation and amputee rehabilitation, conditions that often result from smoking.

Prohibition of Smoking
The Smoking, Health and Social Care (Scotland) Bill
Part 1 – Prohibition of smoking in certain wholly enclosed places
3.1 The Chartered Society of Physiotherapy has policy supporting a total ban on smoking in enclosed spaces, in support of public health promotion. A more detailed submission to the Scottish Executive consultation concluded;

CSP Scotland welcomes the Health Committees own report conclusions in reference to the Prohibition of Smoking in Regulated Areas (Scotland) Bill. CSP Scotland welcomes the view that a ban on smoking would be positive for the public health of Scotland, and supports the majority view of the Committee that the private member’s bill did not go far enough. With the majority of committee members, CSP Scotland would support a full rather than partial ban on smoking in enclosed public places.

4. CSP Scotland has drawn on three major elements in support of its policy on the prohibition of smoking.

4.1 Public Health
that an outright ban on smoking in public places is both a progressive step for the health of the nation and a necessary step to protect non-smokers from the harmful effects of tobacco smoke. The Scottish Executive is right to consult widely, and must face this issue as a question of promoting public health and protecting non-smokers from the harmful effects of tobacco smoke.

4.2 The Physiotherapy
The Physiotherapy profession is heavily involved in the treatment of patients suffering diseases caused by tobacco inhalation, and has a primary interest in supporting moves to ban smoking in public places. While the main & obvious effects of smoking are in respiratory conditions and oncology, another main set of conditions is cardiovascular. Physiotherapy plays an important role in cardiac rehabilitation and amputee rehabilitation also.

4.3 Chronic Obstructive Pulmonary Disease (COPD)
This condition deserves particular mention by the Society with reference to the harmful effects of tobacco smoke inhalation. Chronic Obstructive Pulmonary Disease (COPD) is a disease caused by smoking that is well known to chartered physiotherapists but receives less publicity than other conditions.

4.3.1 A survey by the Chartered Society of Physiotherapy among physiotherapists specialising in respiratory care revealed that a staggering 83 per cent have cited smoking as the cause of COPD (chronic obstructive pulmonary disease) in patients. COPD is a frightening disease, characterised by airflow obstruction - a disorder that persistently obstructs breathing. The airflow obstruction is usually progressive, is not fully reversible and does not change markedly over several months. This condition receives far less publicity attention than other smoking-related disorders such as lung cancer.

4.3.2 Chartered physiotherapists in respiratory care report that a significant proportion of their workload (see 5.4 below) is devoted to this patient group. Physiotherapists are involved in the care of COPD from acute hospital admissions through to maintaining patients in the community, employing evidence based initiatives such as early supported discharge, non invasive ventilation and pulmonary rehabilitation. This patient group often has complex management problems and physiotherapists often assist in helping to manage chest clearance, coping strategies, breathlessness and anxiety management in conjunction with other multidisciplinary team members.
4.3.3 A survey of members of the CSP clinical interest group, the Association of Chartered Physiotherapists in Respiratory Care (ACPRC), also revealed that physiotherapists spend over 50 per cent of their workload treating patients with the disease.

4.3.4 The number of acute cases presented to hospital represent only a fraction of the cases in the population, and people suffering from mild to moderate symptoms of COPD often go unidentified. Chartered Physiotherapists report that people who have been smoking for as little as five years could start to suffer symptoms of COPD.

4.3.5 Physiotherapists working in this area tend to see patients at the severe end of the spectrum. Some patients may also have secondary diseases such as heart failure, vascular disease or circulatory problems, and lung cancer. Not all COPD patients present with same symptoms. Some patients may also suffer from anxiety, which could lead to depression because they are physically limited due to breathlessness and have a poor quality of life.

4.3.6 In Glasgow there are currently initiatives on going to identify these patients earlier to try to optimise their medical care to prevent deterioration and subsequent hospital admissions; smoking cessation advice is an integral part of this drive.

4.3.7 Early detection of the condition is key so that physiotherapists can employ a proactive approach - it is estimated only 25 per cent of cases are currently being diagnosed.

4.3.8 Physiotherapists can treat COPD through management strategies that can prevent the condition progressing to the severe category. They can also promote disease mastery, develop coping strategies for breathlessness, reduce work of breathing and teach patients to clear secretions and manage anxiety through relaxation techniques.

4.3.9 Pulmonary Rehabilitation has an excellent evidence base for the benefits gained, and improvement in quality of life is a major benefit. Smoking cessation can only benefit the health of physiotherapy patients and the health of the nation.

5 Conclusion to Part 1
In its submission to the Scottish Executive consultation on smoking in public places, Chartered Society of Physiotherapy Scotland asserted the following:

“Chartered Physiotherapists have a primary interest in reducing the harmful effects of tobacco smoke. Health promotion remains central to the practice of physiotherapy, and the profession is engaged in the treatment of tobacco-related diseases. Certain conditions rely heavily on the health benefits of physiotherapy.

CSP Scotland fully supports the campaign to ban smoking in public places. The Scottish Executive must take the steps necessary to protect the staff and customers of licensed premises, and protect members of the public in public places, from the harmful effects of inhaling tobacco smoke. Such steps would contribute to the health of Scottish society, assist the aim of reducing smoking among the Scottish population.”

The full submission can be viewed at http://admin.csp.org.uk/admin2/uploads/1a42792-fff954676e-7c8e/smokingbansubmission30904.doc

7.1 Chartered Society of Physiotherapy Scotland takes an active interest in the above legislative measures. Health promotion and safe effective practice are essential to the physiotherapy profession, and CSP Scotland is committed to patient centred services and continual measures to improve patient care.

7.2 CSP Scotland is also interested to learn more detail on the nature of training to be offered to health professionals to assess the capacity of patients.

Kendryck Lloyd-Jones
Children in Scotland is Scotland’s national agency for organisations and professionals working with and for children and their families. It exists to identify and promote the interests of children and their families and to ensure that relevant policies, services and other provisions are of the highest possible quality and are able to meet the needs of a diverse society. Children in Scotland represents over 350 members, including all the major voluntary, statutory and private children’s agencies, professional associations and local authorities as well as many smaller community groups and children's services. The work of Children in Scotland encompasses extensive information, policy, research and practice development programmes. The agency works closely with MSPs, the Scottish Executive, local authorities and practitioners. It also services a number of groups such as: the Cross Party Parliamentary Group on Children and Young People; the National Children’s Voluntary Forum; the National Early Years Forum and the Special Needs Advisory Group. Children in Scotland also hosts Enquire, which is a national information program for parents of children with additional support needs.

Children in Scotland welcomes the introduction of the Smoking, Health and Social Care (Scotland) Bill and the opportunity to provide evidence to the Health Committee. This evidence is informed by discussions with Children in Scotland’s Policy Committee and by consultation with children and young people through the Participation Network.

Children in Scotland strongly supports the objectives in Part 1 of the Smoking, Health and Social Care (Scotland) Bill.

Prohibiting smoking in enclosed public places is a significant measure in protecting the fundamental rights of children and young people. Introducing this bill would contribute towards the UK’s compliance with Article 24 of the United Nations Convention on the Rights of the Child (UNCRC):

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

Research suggests that young children in households where both parents smoke have a 72% increased risk of respiratory illness. More than 17,000 children under the age of five are admitted to hospital every year as a result of the effects of passive smoking.

Part one of the bill would also help to ensure the rights of young people to be protected from health risks in the work place:

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child’s health or physical, mental, spiritual, moral or social development. UN Convention on the Rights of the Child, Article 32

In addition to contributing to the safeguarding of children and young people’s rights in relation to health and employment, the introduction of Part 1 of the bill would represent a vital first step in promoting a cultural shift towards lower rates of smoking, particularly amongst young people.
I would like to take this opportunity to make a formal written submission to the Health Committee concerning the Health and Social Care (Scotland) Bill. I own a number of bars, restaurants and night clubs in Glasgow employing over 600 people and servicing over 1 million customers every year, and am a member of the SLTA.

Whilst I am fully supportive of the government initiatives to protect the public from passive smoking, supporting smokers in their attempts to quit and am delighted that the government is making proactive steps to safeguard the nation's health, I have been alarmed by the way in which the legislation has been progressed and am worried that the Executive has not taken enough time to review all the necessary information in making its decisions.

I would like to concentrate on what I consider to be the main issues.

1) The Executive is about to impose the most radical piece of health legislation the devolved parliament has seen - based on incomplete research; against overwhelming public opinion; with no idea of how to police the legislation; and no real guarantee that it will improve the nation's health. It is with absolute incredulity that I witness the speed at which the Executive has forced the Health and Social Care Bill through the Scottish Parliament. As I have said, I am totally in favour of increasing smoking restrictions but surely the Executive should take some more time to truly consider whether an outright ban is the most effective way to tackle the smoking issue. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

2) I believe that one of the most formidable arguments against the forthcoming legislation is that the public is opposed to it. The Executive's own MRUK opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in public places - 77% of Scots who were consulted did not want a total ban in pubs yet we are to have it. This is not to say that they would not support increased restrictions on smoking policy - but they do not want, and are not ready, for an all-out ban.

In my opinion the government has wholly underestimated the importance of public support as part of the legal system. One of the vital assumptions made when imposing new laws is that the majority of the individuals will comply. If there is evidence to suggest that the law will be rejected you create extreme policing difficulties and threaten to make a mockery of the legislation. We are to be criminalized if we do smoke and possibly lose our livelihoods if we allow it.

I could understand the government making a decision against public opinion if it was absolutely sure that it was in the nation's best interest, but the Scottish Executive has rushed its research and failed to fully consider the possibility that the gradual introduction of smoking legislation which would give the general public time to adjust, may make a more definitive move for public health.

3) As an interested party, naturally we have read through the economic research and health reviews used to guide the Executive's decision. We were astounded to note the following points.

Firstly, as far as the economic impact of the ban on smoking is concerned, the International review conducted by the University of Aberdeen acknowledged that studies undertaken did not actually include an analysis of a total ban situation. Therefore, the conclusion drawn from smoking policy in foreign countries were non-transferable.

Secondly, the Executive did not take the time properly to assess the Irish situation, which is the closest benchmark we have, and even if it did it would have to assume that any negative impact would be felt more greatly in Scotland which has a much less stable licensed trade industry. We as
a profession were ignored when we pointed out that since 20th March 2004 there has been a drop in sales of around 23 million pints (as reported by the Irish Brewers Association) and that 42 pubs/clubs are already for sale in Dublin alone with 3000 jobs on the line and a further estimate of between 10,000-15,000 jobs to be lost.

4) I was extremely disappointed by the Scottish Executive's management of the consultation process. This is the most important stage in the introduction of new, legislation, where individuals and organisations can offer valuable advice and opinions on government proposals. There are certain guidelines that should be followed during any consultation to ensure a degree of scientific integrity. Consultation documents should present all the facts, should be simple, wholly, unbiased, without presumption or implication. They should allow any individual to make an informed and objective judgement.

The document presented as part of the Executive's consultation was a far cry from these guidelines. Both the First Minister and the Deputy First Minister pre-empted the consultation process by indicating firmly and clearly their preference for a total ban. The preface of the questionnaire was extremely heavily weighted towards the health issue and makes no attempt to introduce all necessary factors that need to be taken into account, the economy, jobs, compliance and policing. The questions were misleading, at no point making reference to public houses, which are at the heart of the matter. We would urge you to make reference to the consultation papers when considering these points.

5) The Scottish Executive seems to have underestimated the economic impact of an outright ban on smoking in public places on two levels.

Firstly, it has underestimated the actual financial toll a ban will take on the Scottish economy. New independent research form the Centre for Economics and Business Research (London) reports, amongst other things, that the value of annual turnover in the licensed trade will decline by £105m, that employment in the licensed trade can be expected to decline by at least 2,300 jobs, that 142 average sized licensed premises may close as a result of decreased trade and that the Chancellor of the Exchequer may lose out of £59m in annual tax revenues from Scotland.

Secondly, it seems to have underestimated the importance of the economic impact in the debate on smoking policy. Many hold the view that the economic situation is largely irrelevant when one is consider the health of the nation. However, little recognition seems to have been afforded to the ramifications of a downturn in the Scottish leisure industry and the consequences of lower employment.

6) Creating a divide in smoking policy between Scotland and England will put the nation at a significant competitive disadvantage. There is a strong possibility that tourists will choose English destinations -where one is free to choose between smoking and non-smoking venues, over Scottish destinations -where one is not. Tourism is Scotland's largest business sector; it employees more people than any other industry nationwide. Not to mention the fact that eighty percent of Scotland's visitors are in fact English.

One might also consider the implications this divide in policy may have in policing guidelines. Those on the border will feel legally tom, especially if they, are loosing customers to neighbouring villages in the North of England. We' would be out of step with Westminster which is ridiculous given that it is the same political party that governs.

7) Given the prevalence of already established non-smoking public areas (museums, libraries, modes of transport, cinemas, shops, offices), it would seem that the forthcoming legislation on smoking in public places is almost exclusively directed at the licensed trade. I am therefore slightly angered that the Executive has not tried to work more closely with the publicans, restaurateurs and hoteliers on Part 1 of the Health and Social Care (Scotland) Bill.

The Scottish Licensed Trade Association has in fact been working with the government for many years in developing smoking policing. As an organisation, it was one of the founding members of Voluntary Charter on Smoking. However, in the latest debate its opinions and guidelines seem to
have been marginalized. Perhaps this is because the trade has wrongly been portrayed as opposed to plans to increase restrictions on smoking in public places.

I for one would, and will, welcome tighter smoking laws; however I do not feel that an outright ban is the correct approach and I do not believe the executive has taken the time to fully consider other options which may make a more definitive move for public health.

8) What we have found most surprising in this debate is the apparent assumption that a blanket ban is the best possible option to safeguard public health and benefit the economy. This debate seems to have been dominated by a ban/no ban approach. At no point in the process would it seem that anyone has really sat down and looked for the best solution.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will safeguard the nation's health and avoid the shift in smoking in the home, protect the hospitality and licensed trade industries and will prove enforceable. There has been no Scottish Executive research into the potential consequences of smokers ceasing to visit licensed premises and switching their disposable spends into take home drinking. Approximately six-sevenths of health problems encountered from ETS are derived from domestic situations and it is quite possible that the outright ban approach will result in greater health problems as a consequence.

9) Legislation should only be accepted and introduced when there exists an appropriate and viable strategy with which to enforce and police it. With regards to enforcement, the Executive has created itself a difficult task. It has chosen to impose an outright ban on smoking in public places regardless of the fact a) the public do not support it and b) it is in opposition with our neighbouring States. Do we really expect to be able to form a contingent of "smoking police" that will stretch from Stranraer to Stornaway? Just like Ireland we will end up with one law for the country and another for the city, making a mockery of smoking legislation.

In addition, with smokers forced out into the street to indulge their habit, there is a real risk of increases in social disorder and violence, which at present no organisation is claiming responsibility for. Once they leave the premises, customers of licensed establishments cease to be the responsibility of the licensees. This brings significant issues for local authorities, which the Executive has yet to address.

10) Most of the SLTA members own pubs in small rural villages of approximately 500 people. It is likely that these public houses and communities around them will feel the impact of a smoking ban more acutely than most -and yet the Executive doesn't seem to have afforded them a great deal of thought.

The pubs in question really form the heart of the community, which is often made up of the retired and elderly. They depend on their regular clientele to keep the business afloat -and in turn their customers depend on the local venue for quality of life. To impose a ban in this area just seems ludicrous, you can't expect the elderly smoking population to nip outside in the middle of winter, people are far more likely to choose, or to be forced to stay at home.

11) The government failed to take into consideration that ventilation systems can cut out ETS gases and particles by 85-95% thus greatly reducing exposure to staff and customers. Positive air systems can also stop smoke drifting into areas where it is not wanted or desired thus preventing the need for partitioned smoking areas.

We hope that you will take these points on board and consider taking a little more time to analyse the facts and urge the Committee to afford the issue some greater consideration and thought. I believe we live in a democracy where politician's worked with the people not against them -where the duly elected majority embraced industry rather than destroy it and where freedom of choice was guaranteed.

Donald MacLeod
Managing Director
SUBMISSION BY DIABETES UK SCOTLAND

Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

Diabetes UK Scotland supports any initiative calling for a ban on smoking in closed public places, including the workplace, across Scotland. Smoking is harmful to the estimated 213,000 people with diabetes in Scotland and they should not be subject to the effects of passive smoking.

We support national and local decisions made to ban smoking in closed public places, such as the provision made in the Smoking, Health and Social Care (Scotland) Bill.

Everyone risks damaging their health through smoking but for people with diabetes the risk is even higher. People with diabetes are already at increased risk of heart disease, stroke and circulatory problems. Smoking doubles the risk of these problems again and doubles the chances of developing erectile dysfunction and kidney problems. Cardiovascular disease (CVD) is the main cause of death in people with Type 2 diabetes and is two- to fourfold more frequent than in those who do not have diabetes.

People with diabetes who smoke should be encouraged to stop smoking.

SUBMISSION BY FOREST

FOREST (Freedom Organisation for the Right to Enjoy Smoking Tobacco) is a media and political lobbying group that defends the interests of smokers and voices the opinions of many smokers and tolerant non-smokers.

FOREST does NOT agree with the main objective of the Bill on the general principles that, by removing all freedom of choice and failing to permit reasonable alternatives, it is wholly disproportionate and not justified either by science relating to environmental tobacco smoke (ETS) or public demand.

FOREST’s specific objections to the Bill as introduced are as follows:

1. Definition of a public place
   1.1. The definition as it stands in Part 1 of the Bill provides no certainty on what constitutes ‘no smoking premises’ since it permits Ministers to modify the definition at any time in the future by adding or removing kinds of premises at a later date. It is therefore entirely unclear what scope of premises the legislation is intended to cover.

   1.2. For example, no distinction is made between genuinely ‘public’ premises where the public has automatic right of access (such as railway stations, public transport, hospitals) and those that are destinations of discretionary choice for their patrons and/or private establishments capable of determining their own smoking policies, taking into account the interests of their customers and employees.

   1.3. It is completely unacceptable that businesses and places of work should have to take onerous steps to conform to a vague description of an ‘enclosed public place’ without any accompanying detailed clarification or any guarantee that the definition will not be changed on the whim of Ministers at some time in the future.
2. Private membership clubs
2.1. A notable casualty of the proposed Scottish legislation will be private members’ clubs, which include ex-servicemen and community social clubs. The general public does not, by definition, have access to private membership clubs. These clubs, which are open only to paid-up members, should therefore be exempt from the Bill and permitted to offer smoking facilities to their members if the majority of them so wish. If obliged to become no-smoking, private clubs - many of which are the focal point of community socialising, particularly in rural areas - will lose their smoking members and risk suffering irreparable social and economic harm.

3. Disregard for reasonable alternatives
3.1. Many people (including some smokers) do not want to eat, drink or work in a smoky atmosphere and FOREST supports initiatives that encourage proprietors to (a) introduce substantially more no smoking areas, (b) ban smoking at the bar and (c) improve ventilation.

3.2. The hospitality sector in Scotland has already made significant progress in extending the availability of no-smoking areas and premises. A survey into the voluntary charter on smoking in public places in Scotland (September 2003) showed that the number of businesses that had introduced smoking polices for the public had risen by 26% since 1999. The review, carried out for the Scottish Executive by the market research consultancy MVA, looked at 974 pubs, clubs, hotels and other leisure facilities and revealed that the Scottish hospitality industry had met three out of four of the targets set for it in 2000: 39% allowed smoking throughout, 43% restricted smoking and 18% were completely smoke free.

3.3. FOREST notes that the Scottish Licensed Trade Association is committed to continuing this programme of improvements and has recommended a five point plan of action:

(i) Smoking should be banned at the bar in all licensed premises
(ii) Smoking should not be permitted in any area where and when hot food is being served
(iii) All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be increased to 40% in year 2 and 50% in year 3
(iv) Every licensed premise should have a smoking policy sign at the entrance
(v) Smoking should not be permitted in any area of licensed premises from which the public are excluded (ie back of house)

3.4. Good ventilation, properly maintained, removes the need to ban smoking in indoor public places. Modern ventilation and air cleaning technology is effective in removing smoke particles and keeping gases well within the Health and Safety Executive guidelines. An independent study by the University of Glamorgan, carried out at the Doublet bar in the west end of Glasgow in April 2004, has shown that such systems can ‘clean’ the air of tobacco smoke and give pubs air quality equivalent to a non-smoking public place. The study has been replicated at other outlets elsewhere in the UK.

3.5. In England, the Secretary of State for Health John Reid has proposed a regime that will allow smoking in pubs that do not serve food prepared on the premises (approximately 10-20% of all pubs). Others have called for strict air quality standards that will require pubs and bars to install state-of-the-art ventilation systems as one of the criteria for being granted a ‘smoking licence’ by the local authority.

3.6. The Scottish Executive has totally disregarded these alternative policies which recognise that a combination of more no smoking pubs, more no smoking areas, and premises with good ventilation provides a reasonable alternative to an outright smoking ban.

4. Removal of all choice
4.1. The proposal within the Smoking, Health and Social Care (Scotland) Bill to ban smoking in public places, including pubs, bars and private members clubs, is an unnecessary infringement of individual freedom. It removes entirely the element of choice; it goes far beyond the reasonable scope of what government should and should not regulate; and it assumes that there are no alternatives to an outright ban on smoking in public places, which – as argued above – is manifestly not true.
4.2. FOREST believes that proprietors, publicans and restaurateurs should have the freedom to choose the smoking policy that best suits their business and the preferences of their customers and staff. Reasonable alternatives have been put forward that will increase substantially the availability and choice for non-smokers – both customers and staff – while retaining some choice for those who do smoke.

5. Total ban does not have support of Scottish public
5.1. The Scottish Executive claims that its proposal of an outright ban has the support of the majority of the general public. The Executive’s own consultation documents as well as independent opinion polls show that this is not true.

5.2. A random telephone poll of 10,000 people (including 1,000 in Scotland) conducted by Populus in April 2004 found that only one in five people (22%) in Scotland thought smoking should be banned completely in pubs, clubs and bars. Almost two thirds (63%) said decisions on smoking policies in pubs, clubs and bars should be left to the owners and managers of individual premises, rather than central government (14%) or local councils (21%). Of those not in favour of a ban (77%), the vast majority (95%) said they preferred a choice of separate non-smoking and smoking areas. Other reasons for not supporting a ban were that it infringes people’s rights and would harm the business prospects of pubs, clubs and bars.

5.3. A further Populus poll conducted among a representative sample in Scotland in January 2005 found that a majority (59%) supported the new legislation when offered a ‘yes/no’ answer. However, when offered a variety of choices instead of a simple blanket ban, 66% of Scots said that pubs, bars and clubs should be able to accommodate smokers. Two-thirds of those surveyed believe it should be up to the owners of licensed premises — and not politicians — to determine their own smoking policy. The same proportion believes that the government should not use legislation to dictate the public’s lifestyle choices.

5.4. Support for exemptions is a consistent finding of the Executive’s own consultation feedback. In its Omnibus survey, 66% thought there should be exemptions from the ban on smoking in public places, with 57% spontaneously naming pubs and 21% naming clubs. Other Executive consultation methods were deeply flawed but, even so, 66% of those responding to the youth consultation believed that smoking should continue to be permitted in some places. In focus groups, many people were “not in favour a total ban for a number of reasons” and of the organisations responding to the public consultation, only a minority were favour of an outright ban.

6. Criminalisation of landlords and smokers
6.1. Part 1 (Sections 1 and 4) will make it an offence for a landlord or licensee to allow smoking within their licensed premises. As smoking, in itself, is not an illegal activity, this is an unacceptable intrusion into private property rights. The ‘pub’ is not a public place. It is neither owned by the public nor does any member of the public have an automatic right of access. Entry and service granted to any member of the public is at the landlord or licensee’s discretion entirely. The ‘pub’ is private property and the owner has the right to determine which legal activities take place there. It is the landlord or the licensee who has the right to ban or allow smoking, not the government.

7. Risks of ‘passive smoking’ overstated
7.1. The justification for the bill is based on the alleged health risks from environmental tobacco smoke (ETS). These ‘risks’ are based on inconclusive, disputed and, at times, discredited scientific research which has nonetheless been presented to the Scottish Parliament and the Scottish people as incontrovertible fact.

7.2. The more extreme estimates place the increased risk of a non-smoker - exposed to ETS consistently - acquiring lung cancer as 1.3 in 10,000. The chance of a non-smoker who is not consistently exposed to ETS acquiring lung cancer is estimated to be 1 in 10,000. If there is an increased risk it is so small that it is not statistically significant.

7.3. The Scottish Executive has also claimed that 1,000 people die every year in Scotland from illnesses related directly to passive smoking. This figure, based on a report by Professor David Hole of Glasgow University, is pure guesswork based upon extrapolating from various published studies about relative risk and attempting to relate them to Scotland. Nonetheless the Executive
has presented this figure to the Scottish Parliament and the Scottish people as if it were an established fact.

7.4. Professor Hole acknowledged himself that there were different motivations at work when he said on BBC Radio Scotland: “The point of the ban really is twofold. One is to protect the health of individuals who are working in an environment where they are consistently exposed to other people’s cigarette smoke, so that’s one issue; and secondly, I think there is a more general issue about what Scots people feel they can do about tackling the bigger problem of cigarette smoking, both active and passive.”

7.5. The scientific evidence is too flimsy to prove assertions that environmental tobacco smoke causes diseases and should not be used to justify the Scottish Executive’s draconian legislation. Dr James Le Fanu, writing in the Daily Telegraph on 18 January 2005, summed up the uncomfortable relationship between present scientific knowledge and proposed legislation:

“There may well be reasons for welcoming smoking restrictions in pubs and restaurants, but the specific claim that this will prevent the allegedly injurious health effects of passive smoking is clearly spurious. Or, as one of the protagonists puts it: ‘It is rotten science, but in a worthy cause. It will help us get rid of cigarettes and become a smoke-free society, and that’s all that really matters.’

“The rotten science in question is the proposition that the miniscule exposure to tobacco fumes can cause a significantly increased risk of lung cancer in innocent bystanders. If doctors can persuade government to act on the basis of such absurdities, they can persuade them of anything.”

8. Negative effect of a ban on smoking in public places
8.1. Evidence from Ireland suggests that many pubs and bars have seen takings fall by 15-25% since the introduction of the smoking ban. In Elgin, Scotland, a pub was recently forced to close after a smoking ban proved to be a commercial failure. Many pubs in England have been forced to reverse smoking bans following a severe loss of income.

8.2. From the village style communities of the major cities to the more remote towns, villages and islands of Scotland, the loss of the community pub would be sorely felt by residents and visitors alike. The community pub, social club or bingo hall plays a fundamental role bringing the citizens of a community together, enriching the lives of residents of all ages and cultures. For many, time spent in the pub, social club or bingo hall, is the perfect opportunity to congregate with friends, old and new, to set up a football tournament, participate in the local fishing club, perhaps organise a round of golf amongst friends or plan an away day for the regulars.

8.3. Rural communities rarely have access to theatres, cinemas etc. The only social gathering places, apart from the local church, are hotels and pubs. A total ban on smoking in all leisure venues could destroy a vital part of Scotland’s community life. No more congregating with friends in a leisurely manner as the pubs, social clubs and bingo halls of the community may not survive the loss of the many patrons who like to smoke in a social environment.

8.4. With no leisure venues available for smokers to enjoy their (legal) tobacco products at the same time as enjoying the company of their friends, many will undoubtedly spend more time at home. Not only will children be exposed to more concentrated levels of ETS (with no ventilation systems to remove the gases and particles) but they will be at risk from the much more serious hazards – such as fire, domestic abuse and household accidents – that inevitably arise when people spend more time drinking at home.

8.5. A complete ban on smoking indoors will not appease the more extreme anti-smoking campaigners. In America they refer to “the next logical step”. In California smoking is now banned in many open air parks, on beaches and coastal footpaths. There is now talk of banning smoking in cars. The consequence of such anti-smoking intolerance is clear for all to see: recently an American company sacked seven workers for smoking in their own home. A ban on smoking in all indoor public places represents a significant step towards the type of discrimination that no tolerant, civilized society should be willing to countenance.
9. Conclusions and recommendations
9.1. FOREST urges the Scottish Executive to amend its proposals and adopt the following policies in lieu of a total ban on smoking in public places:

9.2. Offices: non-smoking to be the norm in offices, shops etc. However, employers who wish to accommodate smokers by providing a well-ventilated smoking room indoors should be allowed to do so.

9.3. Pubs, clubs and bars: Scottish Executive to reach a voluntary agreement with the hospitality industry that will allow smoking in pubs, clubs and bars but will also set tough new targets (eg ban on smoking at the bar, substantially more no-smoking areas, better ventilation etc).

9.4. Restaurants: over a three-year period existing restaurants to be given the option of going no-smoking (with the exception of a separate bar area) or installing modern ventilation systems that can remove most of the gases and particles from environmental tobacco smoke; in addition, all new restaurants to be no-smoking unless they can provide a separate (and well-ventilated) smoking area divided from the no-smoking area by a fixed wall.

9.5. Cafes: to be allowed to accommodate smokers if certain conditions (eg agreed standards of ventilation) are met. In practice this will mean that many cafes will go no-smoking but there will still be an element of choice for café owners and the consumer.

9.6. Hospitals: to be allowed designated smoking rooms at the discretion of the management. Likewise community and other civic centres.

9.7. Private clubs: to be exempt from further restrictions on smoking; policies on smoking to be chosen at the discretion of the members.

FOREST

SUBMISSION BY HEALTH ECONOMIC RESEARCH UNIT

Introduction

In April 2004 Health Scotland commissioned Anne Ludbrook (Health Economic Research Unit) and colleagues from the University of Aberdeen to conduct a study of the health and economic impact of the regulation of smoking in public places. The researchers were advised by a reference group that included experts in the field of epidemiology, respiratory medicine, health economics and tobacco control. The draft report was sent for peer review to four referees with international reputations in the fields of tobacco epidemiology, health economics and tobacco control. Reviewers commented on the high quality and robustness of the research and agreed with the overall conclusions. Indeed a consistent view was expressed that the overall estimates of the health and economic benefits were, if anything, rather conservative.

In their evidence the SLTA were critical of the research. The remainder of this submission is the response of the principal researcher Anne Ludbrook and the research commissioner from Health Scotland, Sally Haw to the issues raised by the SLTA.

Comments

These next comments relate to the first two points in the evidence submitted by the SLTA.

(a) Completeness, relevance and timescale of the ‘Financial Impact Study’.

The SLTA claim that the research was incomplete but fail to identify any studies that the evidence review missed.

All of the evidence reviewed related to the health and economic impacts of the regulation of smoking in public places and was entirely relevant. It is true that there was little evidence relating
to impact on bars and this is made clear in the report. We excluded evidence from New York relating to the one year follow up of the comprehensive ban on smoking because it was not published in a peer reviewed source. However, it should be noted that this report showed a positive impact on bars and restaurants but did not show results for the sectors separately. As with all aspects of the research, the authors have been careful not to overstate the case for regulation.

Based on their own research report, the SLTA state that the International Review did not identify evidence that a ban would reduce the number of smokers because the smoking may be displaced elsewhere. However, the review cites specific evidence that both smoking prevalence (number of smokers) and cigarette consumption by continuing smokers are reduced by restrictions and bans and that bans have greater effect than lesser restrictions (such as segregation). Again, this evidence was interpreted cautiously in terms of modelling the results for Scotland.

There is a difference between conducting research efficiently to a short timescale and rushing the research. No evidence is put forward to identify any aspects of the report that were not conducted properly.

(b) CEBR estimates of likely financial impact.

We have not as yet had the opportunity to attempt to replicate the CEBR analysis. However, our examination of the data indicates a number of concerns. The CEBR researchers do not justify the starting date of 1996 and there is no obvious reason to include 8 years data prior to the ban. This start date introduces problems of re-indexing the published data (not discussed by the CEBR researchers). It also takes in a period of growth in the value of the bar sector, relative to the whole retail sector, in the early part of the period, whereas the performance of the bar sector relative to the retail sector has been in decline in the more recent period. This pattern of increase and decline introduces structural problems in the analysis.

Furthermore, the CEBR model does not take into account the impacts of other relevant changes on the bar sector. In particular, restrictions on children being in bars after 9 pm were introduced from September 2003. It is reasonable to hypothesise that these restrictions would have most impact on holiday and tourist business (as this would be the main time at which families might wish to be out together in licensed premises). In this case, there might be an effect in the summer months of 2004, which would confound the analysis of the smoking ban.

The CEBR researchers indicate that the accuracy and reliability of their results are supported by observation of monthly trends. However, extrapolating the seasonally adjusted trend from 2000 (which we believe is a more reasonable starting point) and comparing this with observed monthly data gives a reduction in ratio of the sales value index for bars to the sales value index for all retail business (excluding the motor trade) of 4.4% (rather than 7.3%) and for the ratio of the volume indices of 2.4% (rather than 10.7%). This is without taking into account any possible effect of the restriction on children after 9pm.

Points (c) – (f) are not related to the evidence review.

Comments relating to the Moffat Research Centre Report

Chapter 9 – Review of Aberdeen University Study.

1. The first paragraph states that the Aberdeen study defines its geographic scope by selecting and reviewing studies from other countries. This is incorrect. We reviewed all the studies that met the quality criteria and these happened to be from other countries. We have not excluded evidence from the UK, as this opening paragraph might imply, and the Moffat report does not offer any evidence that has been missed.

2. The Aberdeen study reviewed all of the evidence from all of the sectors. Only one study related to smoking restrictions affecting bars but this reflects the available evidence. We excluded the one-year report from New York City, which has introduced a comprehensive smoking ban, because the report was not a peer reviewed publication. The reported experience in New York of
the Smoke Free Air Act was an increase in tax receipts from bars and restaurants but this was not broken down between the two sectors.

3. The Moffat report attempts to argue that because areas where restrictions have increased incrementally have reported no significant effect on business, an outright ban in bars where smoking restrictions have previously been very limited will necessarily have a more adverse effect. This is a logical fallacy and is not supported by any evidence. Most studies have found no significant effect when restrictions are first introduced. Also, the study cited relates to restaurant restrictions, and the author(s) of the Moffat report maintain a position that evidence relating to restaurants and hotels is not relevant to bars.

4. The comments under 9.3 relating to the study by Glantz and Smith 1997 are erroneous. Although this study was undertaken before a State wide ban on smoking in bars took effect in California, the data in this study were taken from 5 cities and 2 counties which had already enacted bans on smoking in bars.

5. The author(s) of the Moffat report then totally misinterpret the use of the term ‘subjective’ in the Aberdeen University report, despite a clear distinction having been made. Subjective is used to describe the type of information contained in certain reports and papers; i.e. opinion survey results. This is in comparison to objective data, such as sales tax receipts. At no time does the Aberdeen University report refer to self-interest or bias. An overview of the subjective research findings is provided in the Aberdeen University report.

6. The author(s) of the Moffat report assert that there are two weaknesses in the Aberdeen University report relating to a lack of evidence on:
   o reduction in smoking following a ban rather than a displacement of smoking from the workplace; and
   o the impact of a no smoking policy on the hospitality sector, particularly bars.

In relation to the first point, the author(s) have either not read, or not understood, the section of the Aberdeen University report relating to changes in smoking behaviour. This provides a clear overview of evidence of a reduction in smoking prevalence (number of smokers) and a reduction in total number of cigarettes smoked by continuing smokers. The only reservations expressed in the Aberdeen University report related to estimating the precise size of the effect, not its direction, and a cautious interpretation was employed in modelling the results for Scotland.

Regarding the second point, the main argument resorted to by the Moffat report is an attack on the background of the authors of two studies cited in the Aberdeen University report (one of which is referred to by the wrong date and was not included in the evidence review). The study that was used in the review, Glantz and Smith 1997, was published in a leading medical journal and subject to rigorous scientific review. These are appropriate considerations in a serious review of evidence; personal attacks on the authors are not. The Moffat report author(s) neglect to comment on the authors of nine other studies cited in the review, all reporting similar findings, one of which was published in a hospitality sector journal (Cornell Hotel and Restaurant Administration Quarterly). As no ‘economists familiar with the hospitality and tourism industry’ appear to have published any analysis of objective data in peer reviewed publications, it is unclear what additional evidence such individuals could bring to the study.

The remainder of this section of the Moffat report largely consists of repeating the caveats included in the Aberdeen University report. We had considered all the potential weaknesses of both the health and economic impact evidence and drew very careful conclusions taking these into account. The author(s) then indicate that the level of analysis of economic impacts has to be similar to that given to the health argument. However, it is almost impossible to replicate the kind of study designs available in medical research. We recommended that research should be undertaken at the level of individual businesses using objective data, such as tax information, although this could be difficult to achieve for reasons of confidentiality relating to such data.
Chapter 10  The counter argument

This chapter provides no new evidence and repeats the argument that there is no reliable evidence for reduction in active smoking despite the evidence put forward in the Aberdeen University report.

Anne Ludbrook
University of Aberdeen

Sally Haw
NHS Health Scotland

SUBMISSION BY THE HOWARD LEAGUE FOR PENAL REFORM IN SCOTLAND

The Executive Committee of the Howard League Scotland has only recently had an opportunity to consider the terms of Part I the Executive bill: Smoking, Health and Social Care as introduced in to the Parliament. Though the deadline for comment has passed it has a number of comments that it hopes may still to be considered and taken in to account in the Parliament’s consideration of the Bill.

The Howard League Scotland does not wish to offer a view on the health objectives of this proposed measure though it is certainly not opposed to them and regards the reduction of harm caused by secondary smoking as laudable. The HLS does however have sincere doubts about the criminalisation of the behaviour caught by the Bill. It believes that in general the Scottish Executive and the Government are too ready to make use of the criminal law without fully exploring whether other forms of influence and control might be used to achieve the policy objectives. It further believes that in the preparation of this Bill the Executive has paid too little attention to how it might achieve its objectives without resorting to criminalisation of behaviour which may be anti-social but could not be regarded as criminal in the true sense.

It must be supposed that the situation harmful to health which the Executive seeks to avoid is the exposure of the public or employees to smoke filled enclosed places and that it is not the Executive’s present purpose to reduce the amount of [primary] smoking by adults in situations where such smoking cannot harm those who do not smoke. If that is so then the League does not consider that legislation which criminalises smoking per se in defined circumstances is an appropriate manner in which to achieve its policy aims.

It is apparent from the terms of the bill that having geographically defined the enclosed places or parts of places, the legislation would criminalise smoking in these places even at times when they were not open to the public or not in use by employees. For example a lone individual who smoked while cleaning in a public house that was closed would commit an offence. This inclusion could not further the policy objective and it is suggested that the bill should be amended so as to allow the prohibition on smoking to apply only at times when the public or multiple employees had access.

It is noted that the scope for prescribing premises would appear to allow Scottish Ministers to exclude from the application of the provisions a club formed for the purpose (or one of its purposes) of permitting its members to smoke perhaps while eating or drinking. However we understand from public statements that the Scottish Ministers would not choose to exercise their discretion in this way. The League here too feels that the legislation should not be capable of being applied to persons, who choose to smoke, doing so in the company of others who smoke and who have explicitly agreed to share the premises for this purpose. As a general rule the League feels unable to support legislation which seeks to prohibit consenting adults from undertaking higher risk activities provided the risks do not extend to anyone who has not so consented.

Where it is clear that the application of a smoking prohibition to premises in defined circumstances can assist the health objective the use of criminal sanctions may still be inappropriate and unnecessary. The League feels that criminalising smoking in such circumstances is a disproportionate response and that the Executive should instead devise schemes that allow those responsible for these places to discourage and where necessary prevent individuals from smoking.
Management rules, powers to expel and bar individuals and so forth should be explored in preference to criminal sanctions.

Finally, the League notes that the powers of search together with the prohibition should be confined to times when the public or employees have access to the premises and that powers of search going beyond this would be unnecessarily invasive.

Robin MacEwen

SUBMISSION BY LYNNET LEISURE GROUP

I would like to take this opportunity to make a formal written submission to the Health Committee concerning the Health and Social Care (Scotland) Bill. I am the Group Operations Manager for a Glasgow based – family run leisure group. Primarily our interests are focused in the Strathclyde area, but also own 4 bars in and around London. In addition to our retail estate we own and operate to wholesale companies serving the length and breadth of Scotland and Northern England. We are members of the SLTA, BEDA and of the AOB Group.

As a member of the SLTA I have been working with the government for a number of years now in developing smoking policy and as such I am delighted that the government is making proactive steps to safeguard the nation’s health. However, I have been alarmed by the way in which the legislation has been progressed and I am worried that the Executive has not taken enough time to review all the necessary information in making its decisions. I am greatly concerned as to whether the nation’s health is the true objective here, especially when compared to the Westminster Governments proposals for legislative change, or indeed whether the Holyrood government’s actions are serving individuals agendas rather than the nation as a whole.

As a member of the AOB Group, I fully support and endorse their submission to yourselves but also feel that an individual submission on behalf of our directors, staff and customers should be voiced. I would like you to consider the following points:

1. Haste with which the legislation is being progressed
2. Lack of public support
3. Poor preliminary research
4. Flawed consultation process
5. Underestimation of the economic impact
6. Inability to appreciate the need for concordance with UK legislation
7. Lack of communication with the licensed trade which is the public sector at the heart of this legislation
8. Inability of the Executive to consider that an outright ban may not actually be the best approach to safeguarding this nation’s health.
9. Poor appreciation of the policing issues of imposing the legislation
10. Underestimation of the effect this will have on one-pub villages/small communities

We hope that you will take these points on board and consider taking a little more time to analyse the facts and urge the Committee to afford the issue some greater consideration and thought. We urge the Committee to request more time to conduct appropriate research into the financial and health benefits of alternative approaches. We really would recommend that the government opens its mind to more effective ways in which to maximize the health benefits achievable from restricting the use of tobacco in licensed premises.

Craig Amner
Lynnet Leisure Group
Health Committee, 6th Report, 2005 (Session 2) - ANNEX D

SUBMISSION BY MACMILLAN CANCER RELIEF

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

Legislation on smoking is required because voluntary regulation has not worked and a major cultural shift is required towards ensuring non-smoking becomes the norm in Scotland, which only legislation will achieve. The evidence for the harmful effects of second-hand smoking is overwhelming. In November 2004 the Scientific Committee on Tobacco and Health summarised research that had been published since their previous report in 1998, in response to a small number of groups, mainly funded by the tobacco industry, that still denied the health risks associated with second-hand smoke (SHS). The conclusion was that the health hazards were even greater than previously expected overall, with increased relative risk of lung cancer remaining at 24%, the risk of ischaemic heart disease now being in the order of 25% and a strong link between the evidence of exposure to SHS and adverse health effects in children, including serious respiratory illness, asthmatic attacks and Sudden Infant Death Syndrome. There is also an association between SHS and respiratory symptoms, and reduced lung function in adults. The Committee’s conclusion was that SHS is “a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to, and SHS represents a substantial public health hazard”.

The requirements of the proposed content of the Bill of making an offence of permitting others to smoke in No Smoking premises, making it an offence to smoke, the requirement to display warning notices and the clarity of definition are all sound points. There needs to be an incentive to ensure that both those responsible for premises and those using the premises abide by the regulations and clarity is needed to show that any particular area is covered by the regulations.

There are other reasons for agreeing with the objectives of this part of the Bill:

a There is increasing evidence from tobacco industry documents in particular that second-hand smoke is even more harmful, volume for volume than directly inhaled cigarette smoke and evidence of attempts by the tobacco industry to undermine second-hand smoking restrictions by recruiting scientists to criticise the science in second-hand smoke. The only people who continue to challenge whether second-hand smoke causes ill-health are hospitality groups and the tobacco industry.

b The suggestion that ventilation is an alternative, or that small areas at a bar counter should be No Smoking are totally inadequate. Banning smoking in one part of an area is akin to allowing the shallow end of a swimming pool to be used as a public toilet. The addition of ventilation makes a room look less smoky and feel more comfortable, but tobacco contains 4,000 toxins and more than 50 cancer-causing substances, many of which are odourless, invisible gases which cannot be moved by current ventilation systems. There is a wealth of scientific papers from around the world demonstrating that efforts will at best provide partial protection from second-hand smoke and, as there is no safe level of exposure to second-hand smoke, this is an entirely illogical way of proceeding.

Are there any other comments you would like to make? Yes

a For Macmillan Cancer Relief this legislation is partly about the benefits that will be reaped from banning smoking in public places for smokers, non-smokers, staff who have no choice but to be in the area etc. However, it is part of a broader cultural change within society in Scotland that will ensure non-smoking is the norm and the rights and health of the majority of the population that do not smoke are protected. In the Republic of Ireland we know that total sales of cigarettes are estimated to be down over 17½% on 2003, and more than 7,000 extra
smokers have quit than otherwise could have been expected. This mirrors the impact of a ban on smoking in public places in the States and Australia, where this was also associated with a greater awareness of the risks of second-hand smoke and changes in behaviour. In households with children the proportion of homes that had smoking restrictions more than doubled in less than 10 years, and the increase was most dramatic in households where one or more adults smoked. Smoke-free legislation will clearly support the current 70% of smokers who want to quit, and de-normalise smoking in society so that future generations do not become addicted to smoking, or suffer the consequences of other people's second-hand smoke.

b Possible exemptions outlined in the draft Bill: Macmillan Cancer Relief believes that if any exemptions are to be considered they should be justified only on humanitarian grounds and on the existing evidence base with safeguards built in to protect employees who could potentially be put at risk by any such humanitarian action. Specifically there should not be exemption for hotel and bed-and-breakfast rooms or private clubs. This would only serve to undermine what otherwise would be a very effective piece of legislation. It is much easier for the public to understand and for regulatory provision if the same rule applies equally to all premises to which the public has access.

c Macmillan Cancer Relief has noted with interest the attempts by the tobacco and hospitality industries to predict economic meltdown. We have kept abreast of all the published information and, to our knowledge, no objective peer-reviewed study ever conducted has found any significant negative economic impact associated with smoke-free legislation. This seems logical, given that 70% of people do not smoke, and one could confidently expect any ban to increase the number of non-smokers in the population.

A comprehensive smoke-free law is the only way in which to protect the people of Scotland from the health hazards associated with second-hand smoke. Smoke-free legislation will clearly support current smokers attempting to quit and de-normalise smoking in society so that future generations do not become addicted to smoking.

I Gibson
Macmillan Cancer Relief

SUBMISSION BY MACLAY GROUP PLC

I write as Managing Director of Maclay Group plc, a family owned group which owns and operates 21 pubs, bars and inns in Scotland. Maclay employs in excess of 350 people and has annual turnover in excess of £10m.

We are members of the Scottish Beer and Pub Association and supports of the AOB group (Against Outright Ban).

We firmly believe that a ban on smoking in public places is a positive move for Scotland but that this has to be managed carefully to ensure smooth and effective implementation.

The timescale of Spring 2006 and the immediate implementation of a full ban at that time does not, we believe, provide for such time as is necessary to achieve the objectives of the legislation.

We support a phased implementation over a longer time frame such as that supported by the industry in its voluntary charter (which Maclay actively supports).

The reasons for us holding these beliefs are given below:-

1. The consultation process leading to the drafting of the Bill was flawed.
   • The questionnaire was poorly drafted and ambiguous.
   • There was a delay in the issue of sufficient numbers of forms to licensed trade bodies.
   • When eventually issued, the forms were marked to identify the source of the forms.
   • Ministers pre-empted the conclusions of the Consultation process by publicly voicing their views on its outcome.
More consultation is required.

2. Research into the economic impact of the proposed ban have been limited to the limited analysis of a single study on pubs done by Aberdeen University on the Californian experience. The quality and relevance of the source material to Scotland is dubious and this inadequacy was compounded by the quality of the analysis thereafter.

More research is required.

3. The proposed ban will create a business disadvantage. Maclay is a small company endeavouring to grow a sustainable business in Scotland and at the same time provide quality amenities for locals and visitors alike. Such growth requires capital and it is evident to us that investors are reluctant to invest in the Scottish leisure sector because of the increased uncertainty facing the industry here when compared to the English situation.

In order to grow the sector and support Scottish business it is vital that the uncertainty is removed and that a workable framework is phased in over an appropriate period.

4. The costs of implementing and policing the ban by our own staff will result in higher costs to consumers.

It is vital that support is provided to operators in order that we can comply with any new requirements of signage, training etc etc.

5. Based on the Irish experience it is likely that many pubs will experience a fall in profitability, leading to job losses and closures.

It is vital that the non-domestic rating system is reviewed and revised to ensure that rates due are quickly adjusted to reflect the lower levels of trade.

6. It is unclear who will enforce the smoking ban, particularly as the new licensing legislation (and its proposed licence enforcement officers) has yet to be enacted. It is also unclear if a liquor licence could be lost through a customer defying the ban.

It is vital that the uncertainty surrounding such key operational matters is removed quickly.

7. The legislation will create a risk of Civil Disobedience and Social Disorder. There are some reasons for genuine concern about the risk of disobedience of this legislation by the Scottish smoker:

   • Scottish smokers feeling prejudiced because of the English (Westminster) decision to allow choice and to let the public make their own lifestyle decisions. The Scottish Parliament’s approach throughout the process has smacked of high handedness and a desire to move positively towards a nanny state environment.

   • Scottish smokers feeling irritated by the misrepresentation and exaggeration of the health benefits by Scottish Parliamentarians. For example, the First Minister makes reference to 1,000 Scots dying each year through the impact of ETS without informing Parliament that this figure is primarily related to ETS experienced in domestic environments. (November 10th speech to Parliament.)

   • Scottish smokers feeling anger that the Scottish Executive has ignored clear evidence about public opinion on the subject.

   • Scotland has many licensed premises which form part of tenemental buildings and it is not possible for licensees in these landlocked situations to provide external smoking facilities for their clients, due to neighbourhood nuisance and noise issues. The likelihood is therefore that many
Scottish streets will be disrupted by groups of smokers indulging their addiction on pavements outside the front of pubs and clubs. This will in turn bring new problems for the authorities to deal with and it does not seem easy to introduce a law which forbids people to stand and smoke in external public areas. Once they leave the premises, customers of licensed establishments cease to be the responsibility of licensees.

- It is universally agreed that smoking is more prevalent in the less affluent areas of Scotland’s cities and towns. Smoking bans are likely to hit hard in the more deprived communities, driving people to stay at home rather than make their regular visits to their favourite hostleries. As UK Secretary of State for Health Dr John Reid has said on many occasions, one of the few pleasures of the working man is to have a drink and a cigarette with his friends. If this right is denied him, community life will change radically, ripping the heart out of many localities.

I would urge you to ensure that the proposed legislation is phased in a more appropriate timescale in order that the points I raise can be satisfactorily addressed.

Yours sincerely

Stephen G Mallon
Managing Director
MACLAY GROUP PLC

SUBMISSION BY NHS GRAMPIAN

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

Yes

If yes, why?

It is consistent with the response of NHS Grampian to the public consultation on smoking in public places.

The provisions within the Bill are appropriate in order to protect people from breathing environmental tobacco smoke.

This legislation will have a hugely beneficial impact to the health of people in Scotland.

SUBMISSION BY NHS LANARKSHIRE

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

1 It will help reduce the approximately 1200 deaths a year among Lanarkshire residents caused by smoking, and its associated morbidity and human misery.

2 It will gradually enable NHS resources to be used for patients with other health problems.
3 It lends enormous weight to the ongoing efforts of the NHS, individuals, voluntary sector, companies, etc. to reduce smoking among the population.

4 It will greatly reduce the impact of the mixed message given by the lack of legislation which is used by smokers to justify their continuing to smoke.

5 It is more restrictive than the original Prohibition of Smoking in Regulated Areas (Scotland) Bill proposed by Stewart Maxwell.

6 It covers all enclosed places of work thereby forbidding individual employees to smoke in their own offices.

7 It removes the problem of staff abusing their position of seniority in the work place in order that they can continue to smoke.

8 It places responsibility on individuals as well as on organizations for compliance, and there are financial penalties for failure to comply.

If not, why not?

It does not address some important issues.

1 ‘Smoke’ is defined in terms of tobacco. This could result in people smoking cannabis in enclosed premises.

2 Current local requirements in some premises for people not to smoke, e.g. health care premises, educational establishments, shopping centres, mean that:
   i) the area around their entrances is made exceedingly unpleasant by the tobacco smoke and/or smell from smokers outside the entrance which all those entering the building have to walk through;
   ii) patients (some with their intravenous infusion equipment), visitors and staff smoke outside hospital entrances and other health care facilities which results in mixed messages to the public, and the smoke and smell permeating the entrance hall and nearby corridors which are enclosed spaces.

Potential means of improving this situation are:

a) there should be no smoking on any NHS property, thereby including its land and car parks, and as an organization devoted to health would demonstrate the NHS’s commitment to this;

b) there should be no smoking within 50 yards of doorways, windows and ventilation systems of buildings to which the public have access or are places of work, including educational and care service establishments.

3 Section 4(4) addresses employees and public access but is unclear about the facilities used by non employee bosses who may exclude the public from part of their premises in order to ensure the boss(es) can continue to smoke.

Are there any other comments you would like to make?

1 There is a typographical error in Section 4(6)(b) second line: ‘or such’ is repeated.

2 The specification of no-smoking premises is so all encompassing that, rather than have all of them put up signs saying they are no-smoking premises, would it be better to legislate that
smoking is forbidden in all enclosed places unless otherwise indicated, and require the few exempt locations to put up signs saying smoking is permitted there?

This response is made by the Chief Executive and the Director of Public Health for NHS Lanarkashire which is responsible for improving the health of approximately one tenth of the population of Scotland.

David Pigott, OBE        Dr Dorothy C Moir, CBE  
Chief Executive          Director of Public Health

SUBMISSION BY NHS TAYSIDE

NHS Tayside fully supports the section within the Smoking, Health and Social Care (Scotland) Bill which relates to Prohibition of Smoking in certain wholly enclosed public places. In its own Smoking Policy, NHS Tayside has prohibited smoking in all of its enclosed areas – however, for humanitarian reasons, it has given discretion to managers to provide specific designated smoking rooms for three categories of patients – i.e. psychiatric in-patients, patients for whom there is no likelihood of discharge and terminally ill patients. This is done in a way which poses little or no risk to the health of staff. It should be stressed that at Ninewells Hospital and Perth Royal Infirmary, NHS management has decided not to offer any internal designated smoking room to terminally ill patients and thus these hospitals are totally smoke-free.

Paul Ballard  
Consultant in Health Promotion  
NHS Tayside

SUBMISSION BY PHILIP MORRIS INTERNATIONAL LTD

Philip Morris International welcomes this opportunity to provide comments to the Health Committee on the Smoking, Health and Social Care (Scotland) Bill.

Public health authorities have concluded that secondhand smoke causes diseases, including lung cancer and heart disease, in non-smokers. In addition, public health authorities have concluded that environmental tobacco smoke can exacerbate adult asthma and cause eye, throat and nasal irritation.

We believe the public should be guided by the conclusions of public health officials regarding the effects of secondhand smoke in deciding whether to be in places where secondhand smoke is present; or if they are smokers, when and where to smoke around others.

Philip Morris International believes that the conclusions of public health authorities are sufficient to warrant measures that regulate smoking in public places. We believe smoking bans are appropriate in many places including educational establishments, health care facilities, and places providing services to children. In general, people should be able to avoid being around secondhand smoke in places where they must go, such as public buildings, many areas in the workplace and public transportation.

At the same time, government regulations should recognise that some business owners and their customers wish to permit smoking in certain locations. Regulation should provide business owners with the choice to permit or prohibit smoking, and to decide how best to address the preferences of non-smokers and smokers, such as through separation, separate rooms and/or high quality ventilation.
We do not believe a total prohibition on smoking in all premises is necessary or justified. We believe the issue can be addressed more pragmatically by requiring a combination of separation between smoking and non-smoking areas coupled with ventilation and warning signs which state the public health community’s conclusion that secondhand smoke causes diseases in non-smokers.

Addressing the issue in a more flexible way would allow people to choose to visit a restaurant, which permits smoking or one which does not allow any smoking at all.

Philip Morris International wants to work cooperatively and constructively with the Scottish Parliament and other governments throughout the world to achieve effective tobacco regulation and to address issues that are of legitimate concern to both governments and consumers. We look forward to additional opportunities to discuss tobacco related issues with the Committee.

SUBMISSION BY PUNCH TAVERNS PLC

I should like to take this opportunity to make a formal written submission to the Health Committee concerning the Smoking, Health and Social Care (Scotland) Bill.

Punch Taverns plc owns some 450 public houses within Scotland, all of which are owner operated as leases or tenancies. As such, these pubs represent 450 small businesses.

I am delighted that the Government is making proactive steps to safeguard the nation’s health. I am, however, alarmed by the way in which the legislation has been rushed and am worried that the Executive has not taken enough time to review all the necessary information in making its decisions.

As far as I am concerned the most salient arguments in this debate are as follows:-

1. The haste with which the legislation is being progressed
2. Lack of public support
3. Poor preliminary research
4. Flawed consultation process
5. Underestimation of the economic impact
6. Inability to appreciate the need for concordance with UK legislation
7. Lack of communication with the licensed trade which is the public sector at the heart of this legislation
8. Inability of the Executive to consider that an outright ban may not actually be the best approach to safeguarding this nation’s health.
9. Poor appreciation of the policing issues of imposing the legislation
10. Underestimation of the effect this will have on one-pub villages/small communities
11. Lack of appreciation of the industries own approach to self regulation

The Executive is about to impose the most radical piece of health legislation the devolved parliament has seen - based on incomplete economic research and against overwhelming public opinion.

It was with absolute amazement that I witnessed the speed at which the Executive is forcing the Health and Social Care Bill through the Scottish Parliament. As I have said, I am totally in favour of increasing smoking restrictions but surely the Executive should take some more time to truly consider whether an outright ban is the most effective way to tackle the smoking issue. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

I believe that one of the most formidable arguments against the forthcoming legislation is that the public is opposed to it. The Executive’s own MRUK opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in public places. This is not to
say that they would not support increased restrictions on smoking policy - but they do not want, and are not ready, for an all-out ban. You are taking away their freedom of choice.

I could understand the Government making a decision against public opinion if it was absolutely sure that it was in the nation’s best interest, but the Scottish Executive has rushed its research and failed to fully consider the possibility that the gradual introduction of smoking legislation, which would give the general public time to adjust, may make a more definitive move for public health.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will safeguard the nation’s health, avoid the shift in smoking to the home, protect the hospitality and licensed trade industries and which will prove enforceable.

I would also point out that a number of our pubs are in small rural villages of approximately 500 people. It is likely that these public houses and the communities around them will feel the impact of a smoking ban more acutely than most – and yet the Executive doesn’t seem to have afforded them a great deal of thought.

The pubs in question really form the heart of the local community, which is often made up of the retired and elderly. They depend on their regular clientele to keep the business afloat – and in turn their customers depend on the local venue for quality of life. To impose a ban in this area just seems ludicrous, you can’t expect the elderly smoking population to nip outside in the middle of winter, people are far more likely to choose, or to be forced, to stay at home.

I would ask that the Government opens its mind to more effective ways in which to maximize the health benefits achievable from restricting the use of tobacco in licensed premises. As an industry, nationally, we have put in place a plan which gets us to a position of:

- Non smoking at the bar, 45% of trading area non smoking in wet led pubs and 50% in food led pubs by December 2005;
- Non smoking at the bar and 80% of trading area in all pubs non smoking by December 2009

This will be actively monitored and fed back to all parties with a vested interest. I feel this to be a far more pragmatic and achievable approach which will deliver the aim of creating a social climate where smoking is no longer the norm whilst protecting a group of small businesses which provide employment, tax revenue and support for local communities. I also feel that it will have far wider public support.

I would welcome any opportunity to discuss this with you further and hope that my comments will be received in the constructive manner that they are intended

Yours sincerely,

Giles Thorley
Chief Executive

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SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?
Health professionals are united in their belief that reducing smoking levels is the most important public health issue facing decision-makers at present. The RCN has always adopted a proactive approach to public health issues, supporting credible measures aimed at improving health and wellbeing. The issue of smoking in public places was debated at the RCN’s annual congress in 2004 and the overwhelming majority of delegates (86%) voted in favour of a ban in enclosed public places. Following that vote a call for smoking to be banned in public places throughout the UK was made a key public health objective in the RCN UK manifesto for the next UK general election. RCN Scotland also consulted with members prior to Congress at our annual conference with similar results.

The central issue for RCN members in expressing this view has been the impact that they believe a ban will have on the health of people in Scotland. This is both in terms of reducing the exposure to second-hand smoke and additionally the knock-on benefits of a reduction in the number of cigarettes being smoked by those who continue to smoke and in the overall number of smokers. Evidence from other countries where bans have been instituted is now becoming available and we are clear that the desired benefits in health terms are being delivered already by the action taken elsewhere.

With regard to the specific offences that the Bill would create we believe that the measures outlined are necessary to ensure that the ban is clear and effective and support the proposed penalties for offending as reasonable.

If not, why not?

Are there any other comments you would like to make?

RCN Scotland has already submitted evidence previously on both Stewart Maxwell’s Member’s Bill and the Scottish Executive’s public consultation and consequently have restricted our comments here as requested by the Committee.

However, we would like to add that we are particularly supportive of the comprehensive scope of the legislation as drafted and believe that Scotland is acting as a driver for action on this issue throughout the UK.

SUBMISSION BY THE ROY CASTLE LUNG CANCER FOUNDATION

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

Introduction

As the UK’s only charity dedicated to defeating lung cancer, the Roy Castle Lung Cancer Foundation firmly supports the restricting of smoking in public places, which it must be remembered are workplaces. Such a restriction in areas where people can smoke can only be positive – protecting the health of 74% of the population who have chosen not to smoke, encouraging those addicted to tobacco smoke to “give up” and most importantly protecting those exposed to a smoke filled environment in their place of work.

1. The Health Risks of environmental Tobacco Smoke

Tobacco smoke contains 4,000 toxic chemicals and at least 40 known carcinogens. Smoking is the single greatest preventable risk to health and is responsible for 13,000 deaths in Scotland annually.
Smoking is not only a threat to smokers, passive or secondhand smoking (involuntarily breathing in the smoke of others sometimes called exposure to environmental tobacco smoke) is established beyond doubt as a cause of serious disease in non-smokers - including cancer, cardiovascular disease and numerous respiratory conditions. Children, pregnant women and those with established disease processes such as asthma are particularly vulnerable.

Short-term exposure to passive smoking leads to effects ranging from headache, sore throat, dizziness and nausea, increased cough, wheeze and phlegm production, to irritation of the eyes and the nuisance of foul smelling clothes and hair – interestingly many who suffer this ‘inconvenience’ will not ask a smoker to stop for fear of causing offence! Research indicates that 5-minutes exposure to secondhand smoke significantly reduces the coronary blood supply in a fit and healthy adult.

3 million people in the UK are exposed to environmental tobacco smoke in the work place and latest estimates suggest that 12,000 U.K. non-smokers die annually as a result of exposure to secondhand smoke.

2. The Economic Impact of restrictions on smoking in public places

Employers have a legal responsibility to protect the health of their employees. Having a policy can reduce legal liability; create a safer working environment, improve workers’ health, reduce tensions between smokers and non-smokers and demonstrate your commitment to the well being of all your staff and customers.

• A report commissioned by Smoke Free Liverpool earlier this year estimated that the economic cost to employers of smoking amongst the Liverpool workforce is approximately £28.5 million per annum

• In New York since they went smoke-free tax revenues from the hospitality sector have increased by 12% and 10,000 new jobs have been created in this sector.

• The Ring ‘O’ Bells pub on the Wirral went smoke-free in 2003 and has not looked back, seeing a massive increase in their takings including a 50% increase in drink sales and 60% increase in food sales.

• The Lauriston Farm Brewers Fayre in Edinburgh has become a no smoking building after managers decided that a total ban could boost their takings. Staff at the pub, which is part of a chain, say takings have actually gone up after they banned smoking in their adjacent restaurant and they expect the pub ban to have the same effect.

The Rushbrook Arms in Bury St Edmunds went smoke free in June 2004 and has experienced a 33% in sales across the board.

• Failure to act to protect employees from exposure to secondhand tobacco smoke in the workplace could result in legal action against employers.

Smoking could be harming business because…

• An average smoker may take six – 10 minute smoke breaks each day, that’s an hour of work lost for each smoker employed. Five hours per smoker per week!

• Non-smokers may resent the number of additional breaks their smoking colleagues take and take additional breaks themselves

• Due to these tensions staff moral and productivity may suffer

• Smokers are more likely to be ill and take longer to recover placing additional strain on business

• Secondhand smoking may damage the health of non-smokers leading to sickness, loss of productivity and the threat of litigation

• Businesses who don’t provide separate accommodation for smokers and non-smokers maybe be failing to meet their health and safety obligations

• Smoking increases fire risk and so insurance premiums will be higher
• Nicotine stained furnishings curtains and decoration need more frequent cleaning, replacement and refurbishment.
• Many non-smokers avoid places where smoking is allowed. More than 70% of people are non-smokers and generally they have more money to spend – because they don’t smoke.

Therefore having a policy has significant benefits for business:
• Increased on-the-job productivity, just think of the cost of all those ‘smoke breaks’
• Improved working relationships and morale
• Reduced sickness and early retirements due to ill health
• Reduced annual health-care costs and health insurance for smokers
• Fulfillment of health and safety regulations and reduced risk of litigation
• Reduced risk of fire damage, explosions and other accidents related to smoking
• Reduced insurance premiums
• Reduced maintenance and cleaning costs
• Greater appeal to non-smoking customers – the majority of the population
• Increased income – remember all those non-smokers with money to spend.

Attitudes toward smoking, even amongst smokers themselves, are changing:
• Smoking is a minority activity – more than 70% of the population are non-smokers
• 86% of all adults agree there should be restrictions on smoking at work
• 88% of all adults agree there should be restrictions on smoking in restaurants
• 53% of all adults agree there should be restrictions on smoking in pubs
• Smokers are increasingly considerate towards others in their smoking behaviour
• 57% of smokers say they would not smoke at all if they are in a room with children
• 45% of adult smokers say they would not smoke at all in the company of adult non-smokers

3. The Impact of a ban in reducing the prevalence of smoking

A recent BMJ study using data from other countries showed that if all UK workplaces were smoke-free, we could expect smoking rates to fall by 4% and overall tobacco consumption by 7.6%. Around 90% of lung cancers are caused by tobacco smoke; The Roy Castle Lung Cancer Foundation would be delighted to see any measures taken to help the public to quit smoking and eliminate this devastating disease.

4. The effectiveness of extractor Fans and other ventilation equipment to remove tobacco fumes from the atmosphere

This is a statement prepared by the Roy Castle Lung Cancer Foundation and endorsed by ASH and the Chartered Institute of Environmental Health and Asthma UK, July 2004 on the subject of ventilation which appears on the National Clean Air Award Website and in the Chartered Institute of Environmental Health Toolkit for Local Authorities.

The Ventilation Argument

It is often claimed by the tobacco industry that ventilation will remove the effects of secondhand smoke from work and public places. However, it is interesting to note that the tobacco companies who endorse ventilation systems have issued disclaimers about such systems having any ability to address the health effects of secondhand smoking.

Tobacco companies have a vested interest in maintaining and promoting smoking in public places as it has been shown that effective smoke free policies in public places can reduce smoking prevalence by up to 4%.

Secondhand smoke

Everyday at least three million workers in the UK, unwillingly, become secondhand smokers. Secondhand smoke causes or exacerbates a wide range of adverse health effects, including cancer, a range of respiratory diseases, including asthma, and heart disease. Shockingly, it is
estimated that one employee in the hospitality industry dies every week from the effects of secondhand smoke.

There are no safe levels of exposure to secondhand smoke.

Is Ventilation Effective?

No. Tobacco smoke is a toxic mix of over 4,000 chemicals including over 50 cancer-causing agents.

Ventilation may remove the smell of tobacco smoke but it does not eliminate all the cancer-causing particles and gases from the air. Just because the air is not visibly smoky does not mean it is safe.

In the case of separate smoking areas with discrete ventilation systems, pollution levels may be slightly reduced but tobacco smoke drifts and therefore staff and customers will still have no choice but to breathe secondhand smoke.

For ventilation to have any significant effect, it would need to be ‘tornado strength’. The scientific evidence is strong and robust:

Ventilation systems cannot eliminate the risk of disease or death from secondhand tobacco smoke.

Ventilation is very costly

Ventilation systems cost tens of thousands of pounds but do nothing to guard against the real health dangers of secondhand smoke. Furthermore, the cost of maintaining and cleaning systems is such that reports have shown that many proprietors leave their ventilation systems switched off, as they find the running costs too high. Poorly maintained ventilation systems are even less likely to be an effective means of reducing the effects of secondhand smoke.

Recent research in venues in Sydney, Australia, shows that designated “no-smoking” areas in the hospitality industry provide at best partial protection and at worst no protection at all against the damaging effects of secondhand smoke.

As all environmental health practitioners are aware, in any risk reduction hierarchy, ventilation, whether general background or local exhaust ventilation are techniques of last resort.

Who promotes ventilation?

The tobacco industry and its lobby organisations (particularly FOREST) advocate "ventilation solutions" as a "reasonable" alternative to the establishment of smoke free work and public places. They fully understand that smokefree environments reduce the consumption of cigarettes and they therefore have a vested interest in maintaining the smoking status quo. They seek to mislead the public by maintaining that ventilation systems effectively address the issue of secondhand smoke. And yet, Philip Morris the largest tobacco company in the world admits on it’s website that ventilation systems have “…not been shown to address the health effects of secondhand smoke.”

The Public Places Charter on Smoking

This scheme is designed to encourage venues to increase provision for non-smokers and improve overall air quality. The charter advocates ventilation as a means of providing clean air despite the overwhelming evidence to the contrary.

Moreover, the scheme is voluntary and four years after being introduced fewer than 1% of venues in the hospitality trade are totally smoke-free.
The solution?

The only way to eliminate the health risks from secondhand smoke is to implement completely smoke free work and public place policies. This action will protect all staff and customers from the harmful constituents of secondhand smoke. It also has the lowest cost implications for employers.

5. Human rights arguments in respect of smokers and non-smokers

This is not about a persons right to smoke, it is about where and possibly when they smoke. No one should be exposed to harmful substances just to earn a living and this is what is happening in any workplace where smoking is unrestricted. No one can argue that a workers right to clean air should be eroded to accommodate a smoker. In the workplace the rights of the worker to clean air trumps the smokers right to smoke.

6. Enforcement

In common with the legislation in Ireland it is our opinion that inspections should be undertaken by Environmental Health Officers and by Inspectors of the Health and Safety Executive. These two agencies should act in a co-ordinated capacity to help to ensure compliance with the legislation. Proactive enforcement checking for compliance should also be backed up with a quick response to any complaints about non-compliance. It is also essential that a number of proactive inspections are undertaken outside normal office hours.

Fines / breaches of the legislation

A significant fine should be imposed on any person found guilty of breaching the law, as this will act as a significant deterrent. The owner, manager or person in charge of a workplace is legally responsible for ensuring compliance with health and safety requirements and with the introduction of a law banning smoking in the workplace this would include the prohibition on smoking in the workplace.

If not, why not?

Are there any other comments you would like to make?

The Foundation is happy to give oral evidence to the committee.

SUBMISSION BY ROYAL COLLEGE OF GENERAL PRACTITIONERS (SCOTLAND)

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

RCGP Scotland submitted evidence to the Health Committee in response to Stewart Maxwell’s Prohibition of Smoking in Regulation Areas (Scotland) Bill. We refer you to this submission for details of our evidence in support of creating smoke-free public places.

Are there any other comments you would like to make?

We welcome the opportunity to reiterate our support for legislation to create smoke-free public places in Scotland, and congratulate the Scottish Executive for making a commitment to introduce legislation in this area.
The Bill as introduced offers a comprehensive ban on smoking in public places. We feel it is vital that legislation offers protection across the board to all employees and members of the public. Exemptions to the Bill must only be made in exceptional cases which are carefully considered and justified.

This legislation will succeed where voluntary action has failed, and will have a positive effect in reducing the effects of secondhand smoke in Scotland. It is a vital part of the campaign to change public attitudes towards smoking in public places, and a significant step towards our ultimate goal - a smoke free Scotland.

SUBMISSION BY THE ROYAL COLLEGE OF PHYSICIANS EDINBURGH

The Royal College of Physicians of Edinburgh is pleased to respond the Scottish Parliament’s Health Committee on its call for written evidence on the Smoking, Health and Social Care (Scotland) Bill.

The College applauds the vision and determination of the Scottish Executive in introducing this key public health measure for the benefit of Scots in general, and staff working within the hospitality and other service industries in particular. This is in sharp contrast to the position in England and this College, with Fellows and Members across the UK, whole-heartedly supports the Scottish plans to ban on smoking in enclosed public places.

The case for introducing this legislation has been made in the previous responses of the College and other organisations citing the evidence-based dangers of environmental tobacco (secondhand) smoke. The Scottish Parliament now has a clear responsibility to enact this legislation.

Implementation will require further thought and guidance to support managers, employees and service users in all sectors to deliver full compliance and agree controlled exemptions only. The College believes that it is in the interest of the health of Scots that exemptions are restricted to situations where the individual might reasonably regard the location as being their own long-term home. In these situations, the employees must be carefully protected from the detrimental effects of second-hand smoke.

Specific guidance would be helpful for NHS premises in Scotland and the College recommends:

1. All hospital grounds and NHS premises should be smoke-free.
2. Outdoor smoking shelters on NHS premises should be considered for a transitional period only and located away from the main entrance and exit doors.
3. In general hospitals, a single indoor smoking area, fully enclosed and effectively ventilated, should be provided for the genuine addicts among patients. Such an area should ideally be near to A&E Departments, for the avoidance of conflict/violence to staff. Such an area should be for patients only. Similar areas will also be required in short stay in-patient psychiatric facilities. In addition, all patients should have access to smoking cessation support while in hospital. However, the direction of travel must be towards a complete smoke-free environment within NHS premises in a defined short time.
4. Smoking for visitors and staff should be totally prohibited in hospitals and other NHS premises and property immediately, with any transitional shelters removed after 2 years.
5. Smoking in long-term care facilities is a significant challenge, and the main principles should include:
   - recognition of a person’s right to do as they wish in private
   - recognition of the need to protect staff from second-hand smoke

Inevitably, there is tension between these two key principles and solutions could include:
providing a communal and enclosed smoking room that is ventilated by an efficient extractor system and empty for 30 minutes before cleaning etc. undertaken

prohibiting smoking in any other communal area

allowing people to smoke in single rooms in long-stay facilities, with a 30 minute non-smoking period before regular staff attendances for care and other needs such as meals and cleaning

The College would be pleased to provide oral evidence if required at a later date.

All College responses are published on the College website www.rcpe.ac.uk.

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk)

SUBMISSION BY SCOTLAND CAN!

This submission is on behalf of Scotland CAN! (Cleaner Air Now), a broad-based coalition of organisations that lobby for smoke-free enclosed public places in Scotland. The submission does not necessarily reflect the views of individual member organisations (see end of response form for full list). The SCOT (Scottish Coalition on Tobacco) Steering Group, which oversees the work of Scotland CAN!, consists of representatives from the following organisations: ASH Scotland, Asthma UK Scotland, Beatson Oncology Centre, Cancer Research UK, Health at Work, Macmillan Cancer Relief, NHS Greater Glasgow, NHS Health Scotland, Royal College of Nursing, Royal College of Physicians in Edinburgh, and the Royal Institute of Environmental Health in Scotland.

We understand that the Health Committee has access to, and will be taking account of, evidence submitted to the Scottish Executive as part of their public consultation on smoking in public places last year. On this basis, the current submission makes reference largely to research that has been accessed and/or published since 30th September 2004.

We ask to be called to give oral evidence to the Health committee.

Part of Bill: Part 1

Main Objective: Prohibiting Smoking in Enclosed Public Places

Do you agree with the main objective of this part of the bill? YES

Do you have any other comments? YES

The Health Risks associated with Second-Hand Smoke

There is a wealth of robust medical and scientific evidence that documents the health risks associated with second-hand smoke (SHS). SHS has been labelled “carcinogenic to humans” by the WHO’s International Agency for Research on Cancer (IARC). It has also been labelled a “class A human carcinogen” by the US Environmental Protection Agency, along with asbestos,

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142 US Environmental Protection Agency. Respiratory health effects of passive smoking: Lung cancer and other disorders. Smoking and tobacco control monographs No. 4 (NIH Publication No 93-3605). Bethesda,
arsenic, benzene and radon gas. The IARC Monograph Working Group on Tobacco Smoke and Involuntary Smoking has recently published their long awaited 1,500-page review of all published evidence related to passive tobacco smoking and cancer. The scientific Group was convened by the World Health Organisation, and consists of 29 experts from 12 countries. They too have concluded that that second-hand smoke is carcinogenic to humans.143

In 1998, The UK Government’s Scientific Committee on Tobacco and Health (SCOTH) issued a report which concluded that exposure to second-hand smoke causes lung cancer and heart disease in adult non-smokers, and a variety of conditions in children, including respiratory disease, cot death and middle ear disease.144 In November 2004, the Committee summarised additional research that had been published since 1998, to examine whether any further revisions to SCOTH’s conclusions were required. This was in response to the tobacco industry and their allies who still deny the health risks associated with SHS. In their additional report, SCOTH concludes that knowledge of the health hazards associated with exposure to SHS has consolidated over the past five years; that more recent evidence strengthens earlier estimates of the size of health risks. The evidence continues to point to a causal effect of exposure to SHS on risk of lung cancer – estimated increased relative risk remains at 24%. The evidence pointing to a causal effect of exposure to SHS on risk of ischaemic heart disease is now stronger, and now estimated to be in the order of 25%. Published evidence continues to point to a strong link between exposure to SHS and adverse health effects in children – SCOTH concludes that smoking in the presence of children is a cause of serious respiratory illness and asthma attacks. Sudden infant death syndrome is also associated with exposure to SHS, and this association is now judged to be one of cause and effect. The evidence published since 1998 also points to an association between SHS and respiratory symptoms and reduced lung function in adults. The Committee conclude that SHS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to; and that SHS represents a substantial public health hazard.145

Since the close of the Scottish Executive’s consultation in September 2004, a number of additional research findings have been published that add further weight to concerns regarding the health risks associated with second-hand smoke. For example, in one of the most comprehensive Europe-wide studies into the health effects of second-hand smoke of its kind, researchers have recently found that children exposed to SHS on a daily basis, and for many hours, face three times the risk of lung cancer than those who grow up in smoke-free environments.146 The study also demonstrated that former smokers (who had stopped for at least 10 years) exposed to SHS at home and/or at work have higher risks for developing respiratory diseases, specifically lung cancer, than those who have never smoked.6 SHS exposure in pregnant women has recently been shown to adversely affect pregnancy by increasing foetal mortality and preterm delivery at higher exposure levels, and slowing foetal growth across all levels of SHS exposure.147 Severity of the condition bronchiolitis is increased in babies and young children who are exposed to SHS.148


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links between SHS and asthma are well documented. In addition a recent report has demonstrated that children with asthma whose parents smoke at home are at least twice as likely to have asthma symptoms all year compared to children of non-smokers.\(^{149}\) Recent research has also suggested that exposure to SHS may lead to abnormal tissue repair; delaying wound repair, preventing the formation of the healing tissue, and increasing the possibility of fibrosis and excess scarring.\(^{150}\)

Recently discovered tobacco industry documents suggest that second-hand smoke may be even more harmful, volume for volume, than directly inhaled cigarette smoke.\(^{151}\) Yet the tobacco industry continues to place the highest priority on preventing the introduction of restrictions on smoking in public places. There are now a number of published reports that document tobacco industry projects to recruit scientists in developed countries around the world who would criticise the science on second-hand smoke, cast doubt on whether SHS harms people and “prolong the controversy” about the effects of health effects of SHS.\(^{152, 153, 154}\)

As early as 1993, the Philip Morris Tobacco Company made preparations to mount a strenuous and well-funded effort to subvert the IARC monograph and associated IARC studies, as they feared that their findings would lead to increased smoke-free restrictions in Europe.\(^{155}\) Their attempts to discredit IARC’s work via industry-directed research, mass media and public communication campaigns, and prevent increased smoking restrictions, failed.

Without exception, the ‘evidence’ presented by hospitality groups and the tobacco industry suggesting no association between SHS and ill-health is flawed, weak, and lacking in scientific credibility. The WHO International Agency for Research on Cancer’s (IARC) classification of SHS as a human carcinogen\(^1\) is based on the full scope of evidence; observational studies, carcinogenic components of SHS, experimental models, and biomarker studies. The issue of whether exposure to SHS causes ill-health and death has been resolved scientifically. It is only hospitality groups and the tobacco industry that continue to “debate”.

Possible Exemptions

The possible exemptions under consideration may include police and prison cells, secure hospitals, hotel and bed-and-breakfast rooms, and hospices. Scotland CAN! strongly believes that if any exemptions are to be considered, they should be justified only on humanitarian grounds and on the existing evidence base, not on economic grounds.

Exemptions may lead to the marginalisation of some sectors of society and parts of the workforce, effectively implying that their health is less important. In making decisions regarding exemptions, it is crucial to remember that a dwelling place for some is a workplace for others. On this basis, Scotland CAN! believes that the only exemptions that should be considered are those in exceptional cases, such as hospices and long stay wards, in order to accommodate people who would be regarded as ‘dwelling’ in these places. In the Republic of Ireland, even though exempt institutions are not obliged to enforce the legislation, all employers still have the right to enforce the legislation, and are free to do so if they wish. Scotland CAN! suggests that the Scottish Parliament

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\(^{154}\) \url{http://tobaccodocuments.org/profiles/whitecoat.html}

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considers a similar model. In the event that these exemptions were introduced on humanitarian grounds, employers and service providers should provide all reasonable means for employers and other service users to avoid exposure to SHS.

Exemptions for hotel and bed and breakfast rooms, and private clubs are not workable. If they were introduced, some establishments would undoubtedly exploit the exemption loophole, as has been demonstrated in shared experience of other countries that have already introduced legislation. Exemptions for hotel and bed and breakfast rooms, and private clubs are not workable. If they were introduced, some establishments would undoubtedly exploit the exemption loophole, as has been demonstrated in shared experience of other countries that have already introduced legislation.156 This would only serve to undermine, and potentially contribute to the demise of what would otherwise be an effective piece of legislation in Scotland. As far as possible, consistency is required in protecting all workers from the harmful effects of second-hand smoke. It is much easier for the public to understand a ‘one rule applies to all’ smoke-free provision. A level playing field is considered fairer and easier. Even organisations with strong links to the tobacco industry, such as the Empire State Tavern Association, and the SLTA (who recently teamed up with the big tobacco companies like Imperial Tobacco to present health evidence opposing legislation157) state that smoke-free legislation should be applied even-handedly, to bars, pubs and private clubs. Legislation which applies equally to all enclosed public places has the additional advantage of requiring minimal lead time, since no building alterations need to be made nor equipment installed. This is clearly the most effective and fairest way to reduce the health risks caused by tobacco and exposure to SHS.

There is an additional advantage related to legislation that requires minimal lead-time. As evidence from other countries has indicated, the option of extending or postponing introduction of new law provides the hospitality trade and tobacco industry with increased ammunition, giving them time to step up attempts to scupper the introduction of legislation. The tobacco industry has a vested interest in opposing legislation and, as previously experienced in New York and Ireland, they actively support groups attempting to derail smoke-free laws before they are introduced.158 Restaurant and bar owners continue to argue that custom will fall and the law will be difficult to enforce. Opponents continue to advocate for compromises such as ventilated rooms or designated smoking areas, which we already know to be wholly ineffective measures. An Aberdeen License Trade Official has reportedly recently called on pubs to consider introducing a voluntary smoking ban, in order to help stop Scotland-wide legislation being introduced in 2006.160 FOREST, the tobacco industry funded front group, has recently appointed a Scottish spokesman, in order to try and persuade MSPs to introduce a system that offers greater choice to smokers.161 Both the Scottish Licensed Trade Association, and the Tobacco Manufacturer's Association, have recently indicated they are examining the possibility of mounting legal challenges against the legislation.162 The threat of legal action is a delaying tactic, intended to overturn the introduction of smoke-free enclosed public places in Scotland.

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160 A valuable resource exposing the tobacco industry’s tactics to attempt to undermine the introduction of smoke-free legislation in other countries is available online at: http://www.tobaccoscam.ucsf.edu/index.cfm (Accessed 09/02/05).
161 ‘Pubs urged to consider voluntary smoking ban.’ This is North Scotland news report (07/01/05). Available online at: http://www.thisisnorthscotland.co.uk/displayNode.jsp?nodeId=149235&command=displayContent&sourceNode=149218&contentPK=11613474&moduleName=InternalSearch&keyword=smoke&formname=sidebarsearch (Accessed 07/01/05).
Economic Impacts

The tobacco industry and their allies remain active in spreading misinformation about the effects of legislation that has already been introduced successfully in other countries. The tobacco industry and hospitality trade groups systematically issue predictions of a serious decline in business in every country where legislation has been, or is currently being, introduced. In the Republic of Ireland, The Licensed Vintners Association (LVA) have published research concluding that the economic impact of smoke-free legislation is unfavourable for the licensed trade, resulting in a decline in the Irish bar trade. The LVA has also claimed that the introduction of smoke-free legislation in the Republic of Ireland has led directly to the loss of 2,000 jobs in Dublin. These research findings are based on subjective estimates and subjective interviews with publicans, and not on objective economic information. Interestingly, the publicans’ estimates of their sales figures are significantly different to the hard data available, such as the drink sale figures produced by the Central Statistics Office (CSO) as well as the drinks manufacturers themselves. According to the latest figures from the CSO, bar sales are reported to have picked up sharply, with sales figures rising by 2.3% between September and November 2004. This rise marks a turnaround after two months of declining volumes. Whilst bar sales continued to be down on 2003, falling by around 5.1%, this is dramatically less than the 29% fall in volumes claimed by the LVA, whose figures do not take account of seasonal changes to drinking purchases.

The decline in Irish bar trade began more than three years ago, before legislation was introduced. Sales reportedly hit their peak in May 2001, and since then, the volume of drink sold in Irish bars has fallen by approximately 15%. Many other factors have contributed to this climate, including changing demographics, the price of drink, increased price competition from supermarkets and off-licences, and changing working patterns and lifestyles. Yet the LVA report attributes all of the alleged downturn in the trade to smoke-free legislation. Furthermore, records of Mandate Trade Union, which represents almost two thousand bar workers, mainly based in Dublin, indicate that job losses in the greater Dublin area have been in the order of a couple of hundred, not the thousands claimed. Grim forecasts were also provided concerning widespread bankruptcies in the pub, bar and restaurant sectors after Norway introduced smoke-free workplace legislation last year. Legislation was in place for seven months in 2004, and, on the contrary, the number of bankruptcies in the hospitality industry declined.

Anecdotal reports, polls or interviews with business owners concerning economic impacts of smoke-free legislation should be treated with great scepticism. The Scottish Licensed Trade Association has recently estimated that “cost of compliance with the Bill will be in the region of £85m, suggesting that “costs may be well in excess of that, depending on the views of the local regulatory authorities on matters such as the provision of fire escapes and facilities for the disabled”. However, a recently published international review has modelled the likely impacts of moving from the current voluntary code to comprehensive legislation on smoking in public places in Scotland. Modelling procedures utilise existing evidence on the economic impacts that have been measured in other countries with comprehensive smoke-free legislation. The report concludes that conservative estimates of savings in the workplace exceed the ‘worst case scenarios’ for losses in the hospitality industry. The effect on the hotel, restaurant and bar sectors in Scotland is centrally estimated at +£110 million (range –£63 million to +£281 million). The study also suggests that the

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165 Ireland implements Europe’s toughest smoking ban’. Online at http://www.able2know.com/forums/about21568.html

166 ‘Retail sales rise of 2.8% marks turnaround – CSO’. Press article in the Irish Times, 22nd January 2005.


170 ‘Fewer businesses bust after smoking ban’. Press article in the Aftenposten (01 February 2005). Available online at: http://www.aftenposten.no/english/local/article959680.ece (Accessed 01/02/05)

171 SLTA response to Stewart Maxwell Bill, page 3, para. 1
most sizeable economic impact is a net gain for society in resource terms, which are centrally estimated at £115 million five years post legislation.172

Smoke-free legislation has been passed in every conceivable type of community, from small towns and rural areas to a number of states, and economists have studied the impacts on communities across the spectrum. No objective, peer reviewed study ever conducted has found a significant negative economic impact associated with smoke-free legislation.173 The reliable evidence, that measures hard numbers from independent sources, remains clear. Legislation on smoke-free enclosed public places will not harm the economy, and will improve Scotland's appalling rates of cancer, heart and lung disease, both by cutting smoking rates and by reducing people's exposure to unwanted smoke.

*Increased Health Benefits: Reduced Tobacco Consumption*

Recent research has documented that health improvements can occur within months of smoke-free policy implementation. Employees in workplaces with no smoking restrictions are thought on average to smoke three more cigarettes daily than those whose workplaces are completely smoke-free.174 In the Republic of Ireland, smoking rates have plummeted from 31% to 25% in just four years. In the six months after their legislation was introduced, an estimated 7000 Irish smokers had given up smoking.175 These figures have not been matched in the North, where smoking rates remain static.176 Some one billion fewer cigarettes were sold in the Republic of Ireland last year, a 15% decrease on 2003. The Department of Finance acknowledges it is to early to say whether all of this decrease can be attributed to smoke-free legislation, but state that it smoke-free workplaces and enclosed public places play a significant role.177 Similarly, although smoke-free legislation in Italy was only introduced on January 10th 2005, Italian cigarette sales have already fallen by 23%.178

Recently published figures show that Scotland now has the highest proportion of smokers in the UK. 31% of Scots are smokers compared to 27% in Wales and 25% in England.179 It should be recognised that there is a substantial benefit to be gained from smoke-free legislation in terms of the impact it will have on active smoking rates. A review of smoke-free workplaces in the USA, Australia and Canada estimates that smoke-free legislation reduces smoking prevalence by 4% and overall tobacco consumption by 30%.32 A modest reduction in active smoking rates would have major benefits in terms of reducing numbers of deaths among the Scottish population generally.

The hospitality and tobacco industry continue to voice concerns regarding a ‘dramatic escalation in a possible rise in smoking in the home’ as an immediate consequence of the introduction of smoke-free enclosed public places.180 However, evidence from countries such as the USA, Canada and Australia suggests that the introduction of legislation for smoke-free workplaces and enclosed public places may have the effect of enhancing protection from SHS in the home. In Australia, the introduction of legislation for smoke-free workplaces during the 1990’s was accompanied by a steep increase in the proportion of adults who avoided exposing children to tobacco smoke at

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home. Among households with children, the proportion with smoking restrictions more than doubled, from 25% in 1989 to 59% in 1997. The increase among households where parents smoked was even more dramatic: among homes where one adult smoked, the proportion with smoking restrictions rose from 17% to 53%; among those where all adults smoked, it increased from 2% to 32%.181

Young children are thought to face highest levels of exposure to SHS in the home.182 A recent US survey demonstrated that most US parents still do not have a clear understanding of the adverse health effects of exposure to second-hand smoke on children, despite what has been established in published scientific research literature.42 Smoke-free gains are when smoke-free is part of a wider tobacco control strategy. For example, media campaigns are required to increase adults’ awareness of the dangers of secondhand smoke, and they should be used in conjunction with smoke-free legislation to ensure the greatest protection for young people from the adverse health effects of secondhand smoke exposure. Smoke-free legislation will clearly support current smokers attempting to quit, and denormalise smoking in society, so that future generations do not get addicted to smoking.

The Scottish Licensed Trade - Proposed Alternative to Legislation
The licensed trade umbrella group, Against an Outright Ban (AOB) represents the SLTA, the Scottish Beer and Pub Association, and other pub groups based in Scotland. In May 2004 they outlined proposals for implementation of a 5-point plan, across a 3-year period, as an alternative to the comprehensive legislation that the First Minister outlined in November 2004. The SLTA’s Chief Executive, Paul Waterson, believes that the 5-point plan would provide a “major contribution to improve health prospects in Scotland”.183 This alternative approach proposes that:

6. Smoking be banned at the bar counter in all licensed premises.
7. Smoking be banned in any area where and when hot food is served.
8. Smoking be banned in any area from which the public is excluded
9. Licensed premises must allocate
   a. 30% of total floor space to a non-smoking area in year one
   b. 40% in year two, and
   c. 50% in year three.
   This would be followed by a further review
10. Licensed premises must display a smoking policy at the entrance in order that customers can see the facilities available before they enter.

As the current Scottish Voluntary Charter on Smoking in Public Places has demonstrated, designated smoking areas continue to expose people in the vicinity to SHS, and increase the exposure to smoke by concentrating smokers in the one place. Like the Voluntary Charter, the proposed 5-point plan put forward by the licensed trade is not based on evidence of how to protect health, either for staff in the workplace, or for the public who use these facilities.

Inherent in the licensed trade proposals is the assumption that ventilation in bars could protect the public from the harmful effects of SHS. Although good ventilation systems can help reduce the irritability of smoke, there is a wealth of published scientific evidence that demonstrates there is no ventilation system that fully removes harmful gases that are present in second-hand smoke.184 185

184 British Medical Association (2002). Towards smoke-free public places.
Only 15% of second-hand smoke is in the form of particles that are visible to the eye. Ventilation filters trap these particles, making a room look less smoky and feel more comfortable to be in. However, tobacco smoke contains 4,000 toxins and more than 50 cancer-causing substances. Many of these are odourless, invisible gases, which cannot be removed by ventilation systems. It has recently been suggested “You can do what you like with ventilation so long as you are prepared to spend the money”. Many businesses end up installing expensive ventilation systems in the mistaken belief that they are protecting staff and the public from the ill effects of SHS. However, any efforts to provide partial protection from SHS remain flawed, as there is no safe level of exposure to second-hand smoke.

Those individuals who continue to advocate ventilation as an appropriate solution to the health hazards of SHS have argued that indoor air pollution could be further reduced by introducing higher air exchange ventilation rates. However, higher ventilation rates do not lead to a measurable improvement of indoor air quality, as increased ventilation rates have no significant influence on the air concentration of tobacco components. It has already been demonstrated that in excess of 10,000 air changes per hour would be required to produce levels of risk acceptable to bar staff from SHS. This would be equivalent to a tornado-like gale, and this is clearly unachievable.

Recent controlled experiments have shown that the air pollution emitted by cigarettes is 10 times greater than diesel exhaust. These experiments have also demonstrated that comparative pollution levels for the tiniest particles – the most dangerous to health, are even greater. Yet improvements in air quality can also be observed within weeks of smoke-free policy implementation. Averaged levels of respirable suspended particles (RSPs – an accepted marker for SHS levels that are known to increase risk of respiratory disease, cancer, heart disease and stroke) have been shown to decrease by up to 84% in smoke-free venues within the first 4 months after legislation takes place. Similarly effects have also been demonstrated just two months post-introduction of smoke-free legislation.

The Scottish Licensed Trade’s 5-point plan represents a backward step. Hospitality workers, children and other members of the public would not be adequately protected from the harmful health-effects of SHS. A recent Scottish study demonstrated that non-smokers exposed to SHS in the workplace may have their lung function reduced by up to 10%. It has also been estimated that SHS in the workplace poses 200 times the acceptable risk for lung cancer and 2000 times the acceptable risk for heart disease. Second-hand smoke kills up to 1,000 people every year in the UK, and some studies suggest that the figure is even higher than this. Scotland. Ventilation does not protect employees and customers from the harmful effects of SHS. The Scottish Executive has made their decision regarding legislation on a wealth of robust scientific and medical evidence. The new laws will benefit everyone. A comprehensive smoke free law is the only way to protect the people of Scotland from the health hazards associated with SHS.

Scotland CAN! involves the following member organisations:

ASH Scotland  
Asthma UK Scotland  
Beatson Oncology Centre  
British Lung Foundation  
British Medical Association  
Cancer BACUP  
Cancer Research UK Scotland  
Centre for Social Marketing  
Chest, Heart and Stroke Scotland  
Children in Scotland  
Fast Forward  
Health at Work  
Macmillan Cancer Relief  
Marie Curie Cancer Care  
NHS Greater Glasgow  
NHS Health Scotland  
Path House Medical Practice  
Roy Castle Lung Cancer Foundation  
Royal College of Nursing  
Royal College of Physicians in Edinburgh  
Royal College of Physicians and Surgeons in Glasgow  
Royal College of Surgeons in Edinburgh  
Royal Environmental Health Institute Scotland  
Scottish Trade Unions Congress  
West Lothian Drug & Alcohol Service

SUBMISSION BY THE SCOTTISH BEER AND PUB ASSOCIATION (SBPA)

About the Scottish Beer and Pub Association (SBPA)

The Scottish Beer and Pub Association was originally formed in 1906. Our members are made up of brewing and large pub companies representing the licensed trade industry in Scotland. The

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main aim of the Association is to contribute to the economic and social wellbeing of Scotland through employment, investment and training.

The Scottish Beer and Pub Association’s members include Scottish Brewers Ltd, Tennent Caledonian Breweries Ltd, Carlsberg U.K. (Scotland) Ltd, Belhaven Group plc, Caledonian Brewery Ltd, Diageo Ltd, Broughton Ales, Scottish and Newcastle Pub Enterprises, Mitchell and Butlers, Spirit Group, Punch Taverns plc & Maclay Group plc.

Our members account for 1,500 of the 5,100 licensed public houses in Scotland.

A total of 150,511 people are employed in the licensed trade in Scotland and in the manufacture of alcohol products, including beer. 10,573 people are employed in manufacturing alcoholic beverages in Scotland, including beer.

If further information is required please contact:

Patrick Browne
Chief Executive

Summary

SBPA is fully supportive of the objective of providing more smoke free areas in Scotland’s pubs and clubs. Moreover, we are committed to providing more comfort and choice for non-smokers within the hospitality environment and to provide a more healthy work environment for our staff.

However, we are opposed to the legislation relating to smoking in the Smoking, Health and Social Care (Scotland) Bill.

There are a number of reasons for this:

Firstly, in May 2004, the licensed trade in Scotland put forward a proposal to the Scottish Executive, outlining a five-point plan which we believe would have achieved the Executive’s objective of creating more smoke free areas in Scotland without the potential damage to the industry of an outright smoking ban. We believe the Scottish Parliament should legislative for additional anti-smoking measures as outlined in the industry’s five-point plan which we believe will maximise both the health and the financial benefits of tobacco restrictions.

Secondly, we oppose the legislation because we do not believe the proposals for a total smoking ban in all premises as outlined in the Bill are supported by Scottish public opinion. This is borne out by the results of a public opinion survey commissioned by the Scottish Executive on this issue and by the Scottish Executive’s own consultation which showed mixed support for the proposal.

Thirdly, we believe the economic and financial research on which the decision to proceed with a total smoking ban in Scotland is fundamentally flawed and we fear that the Bill if implemented would have a detrimental impact on the licensed sector in Scotland, our staff, and our customers. Indeed, studies commissioned by the Against and Outright Ban (AOB) Group, of which we are a member, bear this out.

For the reasons as above we would ask the Scottish Parliament to reject the clauses relating to smoking as outlined in the Smoking, Health and Social Care (Scotland) Bill.

The Industry’s Preferred Approach

Over the last few years, we realise that there has been tremendous pressure to take positive action by way of legislation for smoke free areas. It is clear to the industry, as well as everyone else, that the status quo is not an option. Whilst significant progress was made on this issue through the Voluntary Charter in providing more smoke free areas and much better ventilation for pub goers, we recognise that voluntary action does not provide a level playing field as individual licensees are naturally reluctant to take steps to restrict smoking if these steps place them at a competitive disadvantage.
In recognition of this in May 2004, the licensed trade asked the Scottish Executive, through the then Health Minister, to legislate for smoke free areas and introduce five measures which would have been compulsory for all licensed premises ranging from pubs, hotels, restaurants, sports clubs, and social clubs, to entertainment venues. The points were:

- Smoking should be banned at the bar counter in all licensed premises.
- Smoking should not be permitted in any area where and when hot food is being served.
- All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be ratcheted upwards to 40% in year 2 and 50% in year 3.
- Every licensed premise should have a smoking policy sign at the entrance.
- Smoking should not be permitted in any area of licensed premises from which the public are excluded (i.e., back of house).

At the end of year three a review of progress would be made and appropriate further steps taken. This was very similar to the Norwegian model which has moved to a total ban over a period of years.

The licensed trade did not underestimate the difficulties in introducing these measures but we believed that if these measures were introduced, Scotland would have made a huge stride forward in improving choice for non-smokers and protecting their health as well as the health of employees in the industry. A firm message would be conveyed to the Scottish public in general and smokers in particular and, over a period of time, we would anticipate a significant increase in the presence of non-smokers in licensed premises.

We strongly oppose the introduction of a total smoking ban believing instead that a stepped approach as outlined above is preferable.

Scottish Public Opinion

Responses to the Consultation on Smoking in Public Places

The Scottish Executive undertook its “Consultation on Smoking in Public Places” before arriving at its decision to introduce a smoking ban.

The Scottish Executive’s own consultation, although showing that 80% of respondents favoured a ban on smoking in enclosed public spaces, also showed that a bare majority, just 56% of respondents, favoured a total ban on smoking without any exemptions for any sector which is the proposal contained in the Bill.

mruk Research Findings

mruk research were commissioned by the Scottish Executive to undertake a research exercise with a sample of the Scottish population, regarding smoking in public places and addressing aspects of the smoking in public places consultation exercise itself.

A key finding of the opinion survey was that: “Views were mixed with respect to the level of support for a law that would make enclosed public places smoke free, with just over half expressing support for such a law and around a third indicating that they were unsupportive.

“Overall, two thirds of those who would support such a law were also of the opinion that should such a law be introduced, exemptions should be considered, with pubs and clubs the most commonly suggested exemptions (57% and 21% respectively).”

This suggests that although a majority of those surveyed supported a ban on smoking in enclosed public places, two thirds of those also believed that exemptions should be considered, meaning that just one in five, or 18%, of those surveyed supported a total smoking ban.
It is evident from the findings of the Scottish Executive’s own consultation exercise that a bare majority of respondents want a total smoking ban in Scotland and that less than one in five respondents to a Scottish Executive commissioned survey support the proposed total smoking ban. These findings have been borne out by other surveys including research commissioned by the UK Department of Health in 2003.

**Flawed Scottish Executive Research**

The Scottish Executive based its decision to proceed with a total smoking ban on a range of research which we believe to be fundamentally flawed. This research included the “International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places” undertaken by the University of Aberdeen.

There were a number of comments in the Summary version of the report which illustrated the weakness of this piece of research.

The Aberdeen Study considered the “specific effects on the hospitality sector” of a smoking ban and used a number of studies. 11 of these related to restaurants, four to hotels. Significantly only one related to the experience of bars in California. The report indicated that “this was the only study available to model results for Scotland.”

In relation to the “quality and relevance of the literature,” the Aberdeen Study indicates “There are a number of valid criticisms relating to the studies carried out in this area and these reflect the difficulties of conducting research into policy impacts. The problems include: the inadequacy of sales tax data to capture all the effects, the timing of the intervention in relation to the data periods; limitations to the smoking restrictions; compliance with the smoking restrictions; selection bias; and the transferability of the results to other settings. The failure to find any significant impact on revenues in the sectors analysed does not rule out the possibility of a small negative effect on business … However, it is also the case that there has been no analysis of impacts within sectors and no analysis based on measures such as sales volume or profits.”

The Study also makes no attempt to analyse the macroeconomic impact of any smoking ban on the Scottish economy, instead the report relies on the statement that “the net effect on the Scottish economy of any impact on the hospitality sector will be reduced as any change in spending is redistributed to or from other sectors of the economy. Expenditure that is diverted from or gained by the hospitality sector will be taken up in or lost from other sectors.” However, the study also stated that “it was outwith the scope of this study to provide a full macroeconomic model of the net economic effects.”

Given the lack of robustness within the research produced by the University of Aberdeen on which the Scottish Executive based its decision and on the incompleteness and non-transferability of the international studies analysed, we do not believe that the Executive has justified its assertion that a smoking ban will cause minimal impact to the hospitality sector, and specifically pubs in Scotland.

**Economic Impact of a Smoking Ban**

Tobacco is not a banned substance and research shows that 67% of Scottish pub goers are also smokers who are addicted to nicotine. The dictionary definition of addiction is “something, usually a narcotic drug, upon which people are dependent.” So it is hardly surprising that we fear the impact of a total smoking ban as it could greatly reduce turnover in all licensed establishments with the possible exception of those which specialise in the provision of food.

A reduction in turnover would result in a much higher reduction in operating profit in most licensed businesses, further exacerbating the impact of a downturn in trade.

Recent reports from Ireland suggest that volume sales of beer have fallen by 10% in the first five months of the smoking ban, with sales in Dublin down 14% (Figures from AC Nielsen.) Industry trade bodies in Ireland have estimated that so far some 2,000 jobs have been lost within the industry.
It is impossible for us to quantify the precise economic impact in Scotland of a total ban but we take the view that it would have a significant effect on both large and small businesses many of which would become unsustainable.

Research commissioned by the Against and Outright Ban (AOB) Group, of which we are a member, from the Centre for Economics and Business Research (CEBR), suggests that as a result of a smoking ban in Scotland:

• The value of annual turnover in the licensed trade will decline by £105m
• Annual profits in licensed premises may decline by £86m
• Employment in the licensed trade can be expected to decline by 2,300 jobs initially
• About 142 average sized licensed premises may close as a result of decreased trade

It should be stressed that these figures are based on the reduction in the volume and value of bar sales which has already been experienced in the Republic of Ireland and suggest that a total and immediate smoking ban introduced in Scotland would cost jobs and result in the closure of a significant number of licensed premises.

Conclusion

As we have already stated, SBPA is fully supportive of the objective of providing more smoke free areas in Scotland’s pubs and clubs. Moreover, we are committed to providing more comfort and choice for non-smokers within the hospitality environment and to provide a more healthy work environment for our staff.

However, we are opposed to the legislation relating to smoking in the Smoking, Health and Social Care (Scotland) Bill.

We would propose that the Scottish Executive and the Scottish Parliament delay the implementation of its proposals for total smoking ban in enclosed public spaces until the impact of the ban in the Republic of Ireland over a period of twelve months has been fully assessed.

As we have indicated if the impact of the smoking ban on the value and volume of beer sales already experienced in Ireland were replicated in Scotland we would possibly be faced with:

• The value of annual turnover in the licensed trade declining by £105m
• Annual profits in licensed premises declining by £86m
• Employment in the licensed trade can be expected to decline by 2,300 jobs initially
• About 142 average sized licensed premises closing as a result of decreased trade

We would ask the Scottish Executive and Parliament to:

• Adopt the industry five-point plan as put forward last May to the Scottish Executive. Similar solutions have worked well in Norway and Australia and our proposal would not be materially damaging to the Scottish economy.

• At the very minimum research should be undertaken on the economic impact of the workplace tobacco ban introduced in Ireland at the end of March 2004 and the outcome of that research should be carefully studied before any further action if taken on the smoking aspects of the Smoking, Health and Social Care (Scotland) Bill.

The licensed trade in Scotland and the membership of the Scottish Beer and Pub Association will of course continue to work in partnership with the Scottish Executive in furthering its objectives of promoting health and tackling smoking. We would however urge the Scottish Executive and the Scottish Parliament to think again before proceeding with the current proposals and to instead work with the industry to introduce the change we all want to see in a considered way.
SUBMISSION BY SCOTTISH WHOLESALE ASSOCIATION

I would like to take this opportunity to make a formal written submission to the Health Committee concerning the Health and Social Care (Scotland) Bill. I am writing in my capacity as Convenor of the Scottish Wholesale Association. The Association represents the interests of suppliers to the on and off licensed trades, and our members employ in excess of 8000 people.

I understand the Government’s desire to protect the public from passive smoking, and to support smokers in their attempts to quit. However, I am concerned that the Executive has not taken enough time to review all the necessary information in making its decisions, and in particular would like to bring the following points to your attention:

1. Haste with which the legislation is being progressed
2. Lack of public support
3. Poor preliminary research
4. Flawed consultation process
5. Underestimation of the economic impact
6. Inability to appreciate the need for concordance with UK legislation
7. Lack of communication with the licensed trade which is the public sector at the heart of this legislation
8. Inability of the Executive to consider that an outright ban may not actually be the best approach to safeguarding this nation’s health.
9. Poor appreciation of the policing issues of imposing the legislation
10. Underestimation of the effect this will have on one-pub villages/small communities

Expanded Arguments
1) The Executive is about to impose the most radical piece of health legislation the devolved parliament has seen - based on incomplete economic research; against overwhelming public opinion; with no idea of how to police the legislation; and no real guarantee that it will improve the nation’s health.

It is with absolute incredulity that I witness the speed at which the Executive has forced the Health and Social Care Bill through the Scottish Parliament. As I have said, I am totally in favour of increasing smoking restrictions but surely the Executive should take some more time to truly consider whether an outright ban is the most effective way to tackle the smoking issue. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

2) I believe that one of the most formidable arguments against the forthcoming legislation is that the public is opposed to it. The Executive’s own mruk opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in public places. This is not to say that they would not support increased restrictions on smoking policy - but they do not want, and are not ready, for an all-out ban.

In my opinion the government has wholly underestimated the importance of public support as part of the legal system. One of the vital assumptions made when imposing new laws is that the majority of individuals will comply. If there is evidence to suggest that the law will be rejected you create extreme policing difficulties and threaten to make a mockery of the legislation.

I could understand the government making a decision against public opinion if it was absolutely sure that it was in the nation’s best interest, but the Scottish Executive has rushed its research and failed to fully consider the possibility that the gradual introduction of smoking legislation, which would give the general public time to adjust, may make a more definitive move for public health.

3) As an interested party, naturally we have read through the economic research and health reviews used to guide the Executive’s decision. We were astounded to note the following points. Firstly, as far as the economic impact of a ban on smoking is concerned, the International Review conducted by the University of Aberdeen acknowledged that studies undertaken did not actually include an analysis of a total ban situation. Therefore, the conclusions drawn from smoking policy in foreign countries were non-transferable.
Secondly, the Executive did not take the time to properly assess the Irish situation, which is the closest benchmark we have – and even if it did it would have to assume that any negative impact would be felt more greatly in Scotland, which has a much less stable licensed trade industry.

4) I was extremely disappointed by the Scottish Executive’s management of the consultation process. This is the most important stage in the introduction of new legislation, where individuals and organisations can offer valuable advice and opinions on government proposals. There are certain guidelines that should be followed during any consultation to ensure a degree of scientific integrity. Consultation documents should present all the facts, should be simple, wholly unbiased, without presumption or implication. They should allow any individual to make an informed and objective judgement.

The document presented as part of the Executive’s consultation was a far cry from these guidelines. Both the First Minister and the Deputy First Minister pre-empted the consultation process by indicating firmly and clearly their preference for a total ban. The preface of the questionnaire was extremely heavily weighted towards the health issue and makes no attempt to introduce all necessary factors that need to be taken into account – the economy, jobs, compliance, policing. The questions were misleading, at no point making reference to public houses, which are at the heart of the matter. We would urge you to make reference to the consultation papers when considering these points.

5) The Scottish Executive seems to have underestimated the economic impact of an outright ban on smoking in public places on two levels. Firstly, it has underestimated the actual financial toll a ban will take on the Scottish economy. New independent research from the Centre for Economics and Business Research (London) reports, amongst other things, that the value of annual turnover in the licensed trade will decline by £105m, that employment in the licensed trade can be expected to decline by at least 2,300 jobs, that 142 average sized licensed premises may close as a result of decreased trade) and that the Chancellor of the Exchequer may lose out on a total of £59m in annual tax revenues from Scotland.

Secondly, it seems to have underestimated the importance of the economic impact in the debate on smoking policy. Many hold the view that the economic situation is largely irrelevant when one is considering the health of the nation. However, little recognition seems to have been afforded to the ramifications of a downturn in the Scottish leisure industry and the consequences of lower employment.

6) Creating a divide in smoking policy between Scotland and England will put the nation at a significant competitive disadvantage. There is a strong possibility that tourists will choose English destinations - where one is free to choose between smoking and non-smoking venues, over Scottish destinations – where one is not. Our membership views this risk to the Scottish Tourism industry, both from a financial and geographic standpoint as being a significant threat to the future economic prosperity of the country.

One might also consider the implications this divide in policy may have on policing guidelines. Those on the border will feel legally torn, especially if they are loosing customers to neighbouring villages in the North of England.

7) The Scottish Licensed Trade Association has in fact been working with the government for many years in developing smoking policing. As an organisation, it was one of the founding members of the Voluntary Charter on Smoking. However, in this latest debate its opinions and guidance seem to have been marginalised. Perhaps this is because the trade has wrongly been portrayed as opposed to plans to increase restrictions on smoking in public places.

8) What we have found most surprising in this debate is the apparent assumption that a blanket ban is the best possible option to safeguard public health and benefit the economy. This debate seems to have been dominated by a ban / no-ban approach. At no point in the process would it seem that anyone has really sat down and looked for the best solution.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will
safeguard the nation’s health, avoid the shift in smoking to the home, protect the hospitality and licensed trade industries and will prove enforceable.

There has been no Scottish Executive research into the potential consequence of smokers ceasing to visit licensed premises and switching their disposable spends into take home drinking. Approximately six-sevenths of health problems encountered from ETS are derived from domestic situations and it is quite possible that the outright ban approach will result in greater health problems as a consequence.

9) Legislation should only be accepted and introduced when there exists an appropriate and viable strategy with which to enforce and police it. With regards to enforcement, the Executive has created itself a difficult task. It has chosen to impose an outright ban on smoking in public places regardless of the fact a) the public do not support it and b) it is in opposition with our neighbouring States. Do we really expect to be able to form a contingent of ‘smoking police’ that will stretch from Stranraer to Stornaway? Just like Ireland we will end up with one law for the country and another for the city, making a mockery of smoking legislation.

In addition, with smokers forced out into the street to indulge their habit, there is a real risk of increases in social disorder and violence which at present no organisation is claiming responsibility for. Once they leave the premises, customers of licensed establishments cease to be the responsibility of licensees. This brings significant issues for local authorities which the Executive has yet to address.

10) Many of our members’ customers own pubs in small rural villages of approximately 500 people. It is likely that these public houses and the communities around them will feel the impact of a smoking ban more acutely than most – and yet the Executive doesn’t seem to have afforded them a great deal of thought.

The pubs in question really form the heart of the local community, which is often made up of the retired and elderly. They depend on their regular clientele to keep the business afloat – and in turn their customers depend on the local venue for quality of life. To impose a ban in this area just seems ludicrous, you can’t expect the elderly smoking population to nip outside in the middle of winter, people are far more likely to choose, or to be forced, to stay at home

We hope that you will take these points on board and consider taking a little more time to analyse the facts.

Yours sincerely,

Donald Campbell, Convener, Scottish Wholesale Association.

SUBMISSION BY SMOKEFREE LIVERPOOL

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes
If yes, why?

Introduction

SmokeFree Liverpool is a partnership which comprises Central, North and South Primary Care Trusts, Liverpool City Council, the Roy Castle Lung Cancer Foundation, Liverpool Chamber of
Our aim is to restrict smoking in all enclosed workplaces in Liverpool – for the benefit of all who live and work in Liverpool. As you may know, Liverpool City Councillors voted in October by an overwhelming cross-party majority to seek the powers to restrict smoking in enclosed workplaces, by a local Act of Parliament. This cross-party majority vote was confirmed by a further vote on the 26th January.

1. The Health Risks of Environmental Tobacco Smoke

Evidence of the health risks from smoking and of exposure to secondhand smoke demonstrate that working or living with smokers can increase the risk of lung cancer by between 20 to 30 per cent and heart disease by between 20 and thirty per cent.

Within the workplace bar workers and hospitality staff are a high-risk group because they are often exposed to high levels of secondhand smoke.

2. The Economic Impact of restrictions on smoking in public places

In 2002 an ONS Survey found that over 80% of people support the prohibition of smoking in shops, offices and factories. 83% support the prohibition of smoking in restaurants, and 49% in pubs.

Many studies have indicated neutral or positive impacts on revenues for restaurants or bars where cities have introduced smoke free regulations. Studies which demonstrate a negative effect tend to be funded by the tobacco industry.

The experience of New York, where tax revenues from the hospitality trade were significantly higher in the year following the legislation to prohibit smoking in the workplace.

The report of the Scientific Committee on Tobacco and Health, identified bar workers as the occupational group at most risk from other people's smoke.

3. The Impact of a ban in reducing the prevalence of smoking

It has been demonstrated that smoke free workplaces have an impact on smoking prevalence. A BMJ study recently found that if all UK workplaces were to be smoke free, this would result in a reduction in prevalence rate of 4 per cent and a reduction in overall tobacco consumption of 7.6 per cent.

Paragraphs 8 and 9 of the Regulatory Impact Assessment, published with the Government Public Health White Paper, estimate that ending smoking in all workplaces and enclosed public places would reduce overall smoking prevalence rates by 1.7%. 0.7% of this effect is estimated to result from the direct effect of ending smoking in employees’ own place of work, and 1% from more places outside smokers’ own place of work going smoke free.

4. The effectiveness of extractor fans and other ventilation equipment to remove tobacco fumes from the atmosphere

Studies have found that ventilation systems do not reduce the levels of the compounds in secondhand smoke. A report produced in Ireland concluded that ventilation is not a viable control option for secondhand smoke.

To use ventilation to attempt to address the problem of secondhand smoke is not only ineffective, but would also place an unnecessary financial burden on businesses.

5. Human rights arguments in respect of smokers and non-smokers
SmokeFree Liverpool believe that this is not about a person’s right to smoke, but about where and possibly when they smoke. It is the firm belief of smoke free Liverpool that no one should have to be exposed to harmful substances unnecessarily in order to earn a living and in workplaces where smoking is unrestricted this is exactly what is happening. No one should be allowed to argue that a worker’s right to clean air should be overridden to accommodate a smoker.

6. Enforcement
It is our opinion that, inspections should be undertaken by Environmental Health Officers and by Inspectors of the Health and Safety Executive, as is the case in Ireland. These two agencies should act in a co-ordinated way to help to ensure compliance with the legislation. Checking for compliance in proactive inspections should be backed up with a quick response to any complaints about non-compliance. It is also important to ensure that a number of proactive inspections take place outside normal office hours.

Evidence from Ireland is that there is an extremely high level of compliance (97%) with legislation there.

Fines / breaches of the legislation
A deterrent to breaking the law would be the imposition of a significant fine on any person found guilty of breaching the law. The owner, manager or person in charge of a workplace is legally responsible for ensuring compliance with health and safety and this is no different when enforcing legislation prohibiting smoking in the workplace. This means that owners, managers and people in charge would also be liable to significant fines for breaches of the law in the premises under their control. This might include non-compliance with the requirement to display signs or the allowing of smoking in the premises.

If not, why not?

Are there any other comments you would like to make?

If required, Smoke Free Liverpool will be happy to provide oral evidence to the committee.

SUBMISSION BY TENNENT CALEDONIAN BREWERIES

As the market leading drinks supplier, I felt it appropriate that Tennent Caledonian Breweries submit a response, as requested, to the aforementioned Bill.

Our main concern regarding the introduction of an outright smoking ban in pubs and clubs is the economic impact. There is little doubt that an eventual smoking ban will have a positive impact on the nation’s health, but there has been no regard for the economic health of those that rely on the drinks business to make a living.

To date, there has been no convincing argument from Government about why an instant and immediate ban is preferable to a phased approach.

Our organisation is an active member of the Scottish Beer & Pub Association, and I know they have sent in lots of statistics and facts about the potential impact of the proposed ban. I will not therefore regurgitate them, but would instead hope that the Scottish Executive and appropriate Ministers have taken the time to familiarise themselves with some very compelling arguments against an immediate and outright ban.

The Scottish Executive, Ministers and the Scottish Parliament as a whole would deserve full marks and all plaudits if successful in bringing about the death of smoking in Scotland – but not if it signed the death warrant for the licensed trade as well.

In addition, I think it is important for the Scottish economy that there is alignment with the rest of the UK on this issue leading to more consistency, less confusion and ultimately more time for publicans and consumers to get used to, and prepare, for the ban.
The fact is there is no evidence that the people of Scotland want this ban, but we also recognise why it is needed in the longer term. Work with and not against the industry for phased implementation, and I guarantee that all parties - including the people of Scotland - will be happier with the approach.

I now look forward to hearing the views of the First Minister and others after receiving all the submissions.

Yours sincerely

Mike Lees
Managing Director, Tennent Caledonian Breweries

SUBMISSION BY TOBACCO WORKERS’ ALLIANCE

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? No

If not, why not?

The TWA has already made clear its views on this policy area in submissions to Stewart Maxwell’s Prohibition of Smoking in Regulated Areas (Scotland) Bill and to the Executive’s consultation on Smoking in Public Places. The TWA opposes a total ban in public places. We believe that more needs to be done but that smoking can effectively be managed through restrictions and ventilation rather than draconian measures such as those in the Bill.

The TWA is concerned that many of the points raised in our previous submissions have not been taken on board. Arguments concerning the impact on jobs and the effectiveness of ventilation appear to have been dismissed entirely in the drafting of the Bill.

The TWA maintains that an outright ban on smoking in public places will have a negative impact on jobs, particularly in the hospitality industry.

More recent figures released by the Irish Government’s Central Statistical Office show a fall in hospitality trade employment of 6.0% in the six months following the ban. In the six months prior to the ban sector employment had increased by 3.2%. This represents a loss of some 7,600 jobs.

The TWA has little to add to the points made previously but would urge the Committee to revisit the submissions to seriously consider the arguments therein.
**PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES - INDIVIDUALS**

SUBMISSION BY ANONYMOUS

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? no

If yes, why?

If not, why not?

I do not support a total ban, I would prefer people to be allowed to smoke in some pubs.

As an individual non-smoking member of the public I think that it is a little unfair to present this as an issue of public health versus big business. There are business interests on both sides of the debate, but there are also interested individuals such as myself who genuinely believe that this is also an issue of striking a balance between public health gains and the restriction of personal freedoms. It is perfectly reasonable to restrict personal freedoms to improve public health, but the restrictions should be proportionate to the health gains. I do not believe that an all-out ban is a proportionate, and I don’t think that the majority of Scottish people do either if the recent polls are to be believed.

Executive proposal

In its policy memorandum for the Bill the Executive states that:

“Although there is much support for an approach that would create separate smoking or non-smoking areas within leisure and hospitality premises, such an approach is difficult to justify on public health grounds given that there is no defined safe level of exposure to second hand smoke. A complete ban on smoking in all enclosed public places would provide the most comprehensive protection to public health and also has the advantage of being simpler to implement.”

I believe that a compromise would effectively protect public health, and would not be much harder to implement.

Before I go on to make this case, a note on the expression “safe level of exposure”:

This expression can be misleading as it creates the impression that any level of exposure to a substance will automatically cause harm. This is not true. A safe level of exposure to a substance is a level of exposure which can be proven to be safe. There is no safe level of exposure for carcinogens, and as tobacco smoke contains carcinogens there is no safe level of exposure to it.

Equally then, there is no safe level of exposure to the city air which contains carcinogens from exhaust fumes, or from the smoke given off by barbeques and other fires.

What is true, and is stated in Executive-commissioned reports on smoking as part of the pre-bill work, is that there is a link between the level of exposure to carcinogens and the health risks associated with them. The greater the exposure the higher the risks, the lower the exposure the lower the risks.

Once exposure is reduced to a low enough level the risks become low enough to be acceptable, or negligible. A former employee of ASH admitted to me that the occasional cigarette was not likely to do someone harm, but it was persistent and long-term exposure that was of real concern.
Even if the full ban goes ahead, customers at pubs will inevitably walk past smokers on their way into and out of the pub, children will be exposed to smoke in pub gardens, and members of the public walking past pub entrances will be exposed to smoke too. Both common sense and statistical evidence leads one to conclude that this small level of exposure to tobacco smoke is not a particular health concern.

I believe that the legislation should therefore seek to reduce passive smoking to acceptably low levels (this is all it can do – it will fail to fully eliminate exposure), and suggest that this can be achieved without going as far as a full ban.

Compromise proposal

I believe that some pubs should be permitted to allow smoking.

I propose that there should be a presumption of non-smoking in all pubs, but where landlords are able to provide a separate smoking room away from the bar area, they should be allowed to apply for a licence to do so. In order to keep the balance in favour of non-smoking, legislation could require this area to be smaller in size than the non-smoking area.

Further regulations requiring ventilation of smoking rooms might be a good idea too.

The benefits of this partial ban would be almost exactly the same for non-smoking customers as they would be with a total ban – any member of the public would be able to go to any pub safe in the knowledge that they would not have to breathe in second hand smoke (probably not even on the way in to the pub as will happen under the legislation as it is currently drafted).

The impact on staff would be similar to that of a total ban – there would be no smoking at bars, and the only exposure to second hand smoke that a member of staff might have to face would be to go into the smoking room to collect empties, wipe tables etc. This would only be occasional and short-lived exposure, which would not pose a real health risk to the staff involved (especially if there were proper ventilation in smoking rooms).

The major difference would be for smoking members of the public. They would still be able to go to some pubs and smoke, just as they can do now.

Enforcement

It has been stated that a partial ban would be difficult to enforce. I disagree; the partial ban would be enforced in much the same way as a complete ban.

I believe that in Ireland the ban is enforced by way of inspection, and pubs can be fined if they do not comply. Someone inspecting a pub could just as easily check that the main (non smoking) area of the pub is smoke free as check the whole pub.

There is also a hotline that people can call to report smoking in Ireland – this could be run in the same way in Scotland, and so long as the smoking and no-smoking areas were clearly marked there would be no confusion.

There would also be an additional sanction under this system – pubs that allowed smoking to cross over from the smoking room to the non-smoking areas could have their smoking licences revoked. It would therefore be in the interests of pub owners who wished to allow smoking in their premises to ensure that their smoke free areas stayed smoke free.

Proportionate response

The Executive commissioned report estimates that a total ban would decrease overall smoking prevalence by 1-3%. In health terms clearly this small reduction in smoking is welcome, nevertheless it is small, especially in the context of the declining year on year tobacco sales that are already happening without a ban. It does indicate that the imposition of a total ban is perhaps a
disproportionate restriction on personal freedoms relative to the Scottish Executive’s own estimation of the likely benefit.

In any case, by allowing smoking to take place in a minority of pubs and ensuring that all pubs are either entirely or mainly smoke free, most of this 1-3% reduction would still take place, as the overwhelming majority of public places, including most pubs would be smoke free.

Changing Culture

My belief is that this move is about more than just the risk of passive smoking or reducing smoking by 1-3% in the short term, but is part of an attempt to change social attitudes to smoking. A major part of this is sending out the message to children and young people that smoking is not (or need not be) a normal part of social life. This will then hopefully discourage people from starting up in the first place and will encourage more people to give up over the medium-long term.

I do not believe that a partial ban would undermine the attempts to change Scottish cultural attitudes towards smoking. Children should not be allowed in smoking rooms, even in pubs which have licences to allow children in. Allowing smokers to go to a room away from young children may in fact be preferable to having them smoking just outside pubs or in pub gardens where children are playing.

The vast majority of pubs, and all other public places would still be completely non-smoking. And even in pubs with smoking rooms, the main areas would be completely smoke free.

Are there any other comments you would like to make?

Please treat my personal information in confidence, I am happy for you to make my response publicly available, but not my name or contact details etc.

SUBMISSION BY ANONYMOUS

Do you agree with the main objective of this part of the bill? yes/no
If yes, why?
Yes in broad terms it is an attempt to improve the present situation.
If not, why not?
Are there any other comments you would like to make? Yes, why are parents or anyone else not banned as part of this bill from smoking in the same enclosed space as their children. Seems spineless of the executive to stop an adult from entering a smoky pub of their own free will but allow adults to expose children who have no choice, to the dangers of passive smoking. Is the executive afraid to protect the most vulnerable in society as some parents might be a bit upset? If the argument is sound for a public ban why is it not sound for a ban in the same enclosed space eg. The home for children.

SUBMISSION BY ANONYMOUS

Do you agree with the main objective of this part of the bill? No
If yes, why?
I not, why not?
It is purely a question of property rights. Yes, public health is important, but the right of a property owner to allow a perfectly legal activity on his/her premises – even if it damages the health of
customers or employees – is more important. It is no more absurd to suggest banning loud music in discos due to the risk of hearing loss. Even if it cut down the number of smokers, the end does not justify the means. Not to mention the cost to this country: Job losses, fall in tobacco and alcohol tax revenue, closure of licensed premises, enforcing the draconian legislation, increase in children’s exposure to smoke due to more people smoking in the home (although the right of families to allow smoking in their private home must, of course, be defended).

Are there any other comments you would like to make?

The scientific community is divided over the risk of passive smoking. Some have branded it a “major public health hazard” whilst others have called it “statistically insignificant”. Why is the government biased towards the former viewpoint? Pubs, clubs and restaurants are places of adult entertainment. There cannot be a single, sane adult left in Scotland who is not aware of the supposed risks of passive smoking. Given that, it should be the responsibility of these informed adults to make the decision and not for the government – who seem to want to save people from themselves. This is what makes Dame Ellen MacArthur’s feat even more remarkable – she has exposed herself to incredible danger in an increasingly safety-conscious society. She is a true role-model for today’s namby-pambied population.

I also think the government have been “economical with the truth” by not mentioning the smoking ban during the election, as late as September 2003 saying “there are no plans to introduce a smoking ban” and then doing a U-turn. A sly trick to keep smokers’ votes during the 2003 Election? I wouldn’t dream of accusing them of it

SUBMISSION BY MARK CADLE

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill?

NO

If yes, why?
If not, why not?
The ban extends to far and removes people rights to choose, It should be limited to areas serving food and smoking at the bar where people are working, however an all out ban, due to the clear lack of true public consultation I strongly feel that this is an unjust approach.

SUBMISSION BY DAVID CATTANACH

As a long term smoker I feel I must submit my concerns about your proposals for an outright ban in all public places.

“For the sake of future generations who’ll be able to breath clean air” ….. Excuse me, but does this mean you will have to ban all cars….stop all planes from flying because they carpet bomb us with their spend fuel … close all nuclear reactors?
The list of killers on this Planet is endless… including Mother natures contributions. I find it hard to forget that our Government can foster exclusivity with such red herrings…..Join our caring club of subservient moralists and we will save the future for our children? This might be a valid argument in some fantasy novel; however we live in a world that sanctions bombs being dropped on Mothers and innocent children. The disappointing thing about the parliaments decision is that it merely distracts from more important issues… Where is the balance?

To conclude……If by some miracle everyone stops smoking, who are you going to tax next? What are you going to ban next?
I think you should have learned by now that it is not banning things that works but managing them.

SUBMISSION BY MARGARET ELLAM

Can I ask how many cases have come to the notice of the Police where someone who has had too many CIGARETTES has assaulted another person? I am disgusted with the Parliament's suggestion that smoking in public should be banned. "PRIORITIES". We are shown the amount of time and money spent by the Police, the Courts, the Hospitals, and other Emergency Services is down to alcohol related crime. Why don't we ban the intake of ALCOHOL in all public places and then we could cut all the related costs drastically. I might add that I smoke and drink, both in moderation, and I do not go out socialising very often, so the ban will not affect me very much, but I am sometimes terrified in my own house in the evenings when listening to the drunken ramblings of packs of revellers who have been drinking to excess. Maybe if the Police were able to get enough cash (or enough interest) we would feel safer in our homes. How many murders and assaults are committed by alcohol fuelled minds?

I really think it time the Parliament got the priorities sorted out and tackled the issues that your constituents are most concerned about - and I am sure that smoking in public places would be way down most people's list. Most of your constituents would, I am sure, be happier if our elected representatives carried out OUR wishes rather than your own. Is this not what an elected representative is supposed to do?

I live in a village in North Lanarkshire where every Friday and Saturday evening (without exception) between 20 and 40 drink fuelled youths roam, shouting and fighting and generally scaring all the residents sitting in their homes hoping that no one is killed or badly injured. I am also sure that this is not the only area where this is the case.

The Police do turn up when telephoned, but by that time the fracas is over and the youths have dispersed. If they do come immediately and the youths are still around, I have yet to see the officers get out of their vehicles and try to sort them out on foot. I can understand they might fear for their own safety, but that goes for everyone in the vicinity. Maybe if you gave the Police more resources, instead of wasting the cash on a smoking ban, there would be enough of them to make a significant difference to your constituents and the Police.

Please take what I have said seriously, as the incidents are now seriously affecting all law-abiding people!!

SUBMISSION BY JOHN HEATHERILL

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

If yes, why?

I have just come back from Dublin and I must say it was an absolute pleasure to go basically anywhere without ending up smelling stale and end up with a dry and irritated throat – food tasted better also. This is the best ever Bill to be put in place - congratulations.

My father died of lung cancer and it was a long painful process for him - I think anyone smoking in what should be our right for non polluted air, should give a thought for others. The strain on the health service due to smoking related problems is astronomic so it makes economical sense as well as from a societal health perspective.
Smoking at work is most annoying and difficult to control – nobody really makes up for smoke breaks and those who don’t smoke are then not treated the same i.e. non smokers are discriminated against as they have to keep working.

If not, why not?

Are there any other comments you would like to make?

Do not give in, in any way, shape or form – it will be difficult at first but through time, it will be fully accepted and nobody will look back on smoking days being “the good old days”

Great

SUBMISSION BY JOHN AND WINIFRED HUGHES

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

NO.

If not, why not?

The imposition of enforced bans - against the wishes of the people who have elected MP’s to represent their views - is completely undemocratic, and is an infringement of our basic rights to exercise freedom of personal choice.

Removal of those rights is a significant step towards the establishment of a dictatorship, and as such cannot and will not be tolerated by the British people.

Are there any other comments you would like to make?

The terms of the anti-smoking campaign, and those of the Bill itself, are based entirely upon severely flawed and biased evidence which is spurious at best, and indeed while many of the counter arguments are mentioned in the supporting documents, they are also completely ignored as if they are of no consequence.

The scientific “evidence” which is being used by the government, the media, and even healthcare professionals, has been selectively manipulated, and we are being assailed daily by propaganda which quite certainly – and demonstrably – does not reflect the true situation.

As a simple example, the public are being informed by our self-styled experts that “75% of the UK population do not smoke. Smokers are a minority group and so the ban is fully justified”.

This is so insulting to our intelligence, it defies belief. In terms of using these “statistics” to justify a ban, here is the reality of the position: (All figures are approximate, but fairly accurate according to government sources).

Approximately 21 million are children under the ages of 16 and 18. The former group cannot legally buy cigarettes, and neither group can legally even BE in a pub, other than family pubs of course.

6 million are over the age of 70 – few from this group are still pub-goers at that age.

6 million are registered disabled – many of course do visit pubs like everyone else; however a significant number are in full-time care, and many either dislike, or are physically unable, to go out to pubs.
Over 2 million are forbidden by their religion to enter premises where alcohol is being sold.

Ignoring the many tens of thousands of other groups (such as long-term prisoners, etc), this yields a minimum figure of at least 23 million – from a population of under 59 million – who by definition cannot be classed as either smokers or pub-goers.

With 14 million smokers in the UK, this leaves only 22 million people who potentially “might” be non-smokers who object to smoking in pubs.

However, according to the polls, approximately 27% of non-smokers (roughly 5.9 million) would prefer to continue to have segregated smoking areas and improved ventilation. Even if we ignore any percentage at all from the 12 million disabled and over-70 groups, and others, this still clearly shows that the true figures are more in the order of 16 million non-smokers “versus” 14 million smokers.

The obvious ‘flaw’ here is that not all of these people will actually be pub-goers themselves; however it would be stretching our imagination to think that any smoker would vote for a ban whether they personally go to pubs or not. Of course some will, simply due to the overwhelming avalanche of misinformation which may have persuaded them that they really are in a socially unacceptable minority.

There is a wealth of scientific research which has shown repeatedly and consistently that the health implications of smoking have been vastly exaggerated and overstated, and yet this evidence is continually denied, disputed, and even ridiculed because it fails to accommodate political agendas.

Having said that, few people would suggest that smoking is actually good for you, and while the health risks are infinitely smaller and vastly less significant than with other environmental factors – such as car and industrial pollution – this debate actually has very little at all to do with smoking, or public health.

Non-smokers are already very well catered for indeed in terms of no-smoking pubs, restaurants, taxis, buses, trains, airports, and other public places and buildings, and it is only fair, right, reasonable, and proper that they should continue to enjoy the right to smoke-free facilities. Nobody is disputing this right.

To deny those of us who choose to smoke a similar degree of choice however – and even in completely segregated areas – is again, simply a first step towards the imposition of a dictatorship which will subsequently move on to intrude in other areas of our lives.

People who are overweight should have particular cause for alarm, and yet (without wishing to wander off-topic, as this is also a very relevant point), the World Health Organisation have only just discovered that part of the reason we are currently seeing record levels of obesity, is because doctors have been using weight/growth charts for the last 40 years which are completely inaccurate.

They were constructed using government-approved data which, it turns out, were based on the wrong information, as they used statistics from groups of bottle-fed newborn babies instead of breast-fed children as we now know they should have been.

Smoking is in steady decline in most Western countries, and there is no evidence to suggest that it will not continue to do so. Hence there is no viable reason whatsoever for our elected representatives to be adopting such a draconian stance on an issue which will further alienate and penalise the most vulnerable and deprived sectors of our society.

It is certainly the remit of our government and public bodies to continue to advise and caution the public against the possible risks associated with smoking {and also drinking, and other far more socially debilitating activities}; however – as will be clearly demonstrated in future elections, where our support will be given to any party who offer more democratic policies – this so-called initiative is crossing a line which has hugely wider implications for all of us.
All the darkness in the universe is not enough to extinguish the light from one small candle, or the
glow of a smoker’s cigarette, for that matter!

Please wield your political power wisely, and lastly – here is an analogy which I think is particularly
relevant:

“Most of us cannot imagine or visualise what “one million” of anything is. Let’s imagine then, what a
million Oxo cubes might look like – they’d probably completely fill a good-sized living room, yes?

In terms of the smoking debate, if ALL the smokers in North America were to continue to smoke for
20 years, they would produce one million tonnes of “toxic” waste substances, or – put another way
– one million Oxo cubes weighing one tonne each.

Meantime, cars in North America are producing 3.7 BILLION tonnes of exactly the same “toxic”

waste not merely every 20 years, but EVERY SINGLE YEAR!!

That equates to 74 thousand million Oxo cubes, or 74 THOUSAND times as many cubes as
smokers produce in the same time period.

In reality then, our government is seriously proposing that by forcibly removing just ONE roomful of
Oxo cubes from a collection of 74 thousand, they will significantly improve public health.

Think about this for a moment – people who smoke 20 to 60 cigarettes per day may, or may not,
live well into their 40’s, 50’s, 60’s, or beyond.

People who run a hose from their car exhaust pipe into the passenger compartment and switch on
the ignition will be unconscious in under 90 seconds, and dead within minutes. So which is infinitely
the more lethal? But because car fumes are less visible than cigarette smoke, we delude ourselves
that car drivers are really OK – it’s not a big problem.

We’ll complain vehemently about someone who lights a cigarette in a bar, but are happy to inhale
traffic fumes, aerosols which smell nice, and ingest massive quantities of the SAME “toxic”
chemicals which are present in our food, water, milk, and bread as in cigarette smoke.

And while alcohol causes infinitely more social problems than cigarettes – for example violence,
vandalism, road accidents and traffic deaths, suicide, depression, personality disorders, physical
abuse of spouses and children and loss of employment, etc, not to mention liver, brain, and kidney
damage or the chronic burden on hospital and social services, somehow none of this is as big an
issue as smoking – even if smoking is strictly controlled by segregation and ventilation.

And yet are they similarly doing anything to restrict our drinking habits, or reduce the uncontrolled
growth of traffic on our roads? Or penalising industries which pollute the atmosphere to the order of
hundreds of thousands times more than smokers?

No, they’re not, and yet the overall result of all this collective pollution is that globally we are
irreversibly damaging the earth’s ozone layer – the one thing which protects us from the most
powerful carcinogenic agent in the universe, sunlight.

Priorities? You can count on your government to get it 100% wrong every single time”.

SUBMISSION BY LAURA LAMB

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no
If yes, why?

Absolutely yes. I am appalled that in my day to day life I am forced to put my life at risk on a daily basis from dangerous side stream smoke. It is almost unthinkable that there are no legal protections for non-smokers when the dangers of this are well known. There are countless pieces of research illustrating the dangers of passive smoking on people who can do very little to avoid inhaling it. It is not only cancer which is a problem, heart disease can also be caused by passive smoking in people who have never even had a cigarette in their mouth. How can any government let this happen? I also have a close friend who had an asthma attack last week while we sat in a café after someone started smoking beside her. What should non-smokers do? Stay at home? It is unacceptable. In view of Scotland’s ghastly state of health, which I have viewed first hand, as I am a registered nurse, please do the decent thing and make sure this bill is passed. There will be massive opposition to it, mainly from smokers! However, to protect people who choose not to smoke and who have no choice at the moment as regards inhaling smoke, it is the only option.


If not, why not?

Are there any other comments you would like to make?

To be honest, I don’t think that the proposals go far enough. I think that smoking should be banned in ALL public places. If people want to endanger their health in such a foolhardy way, they should do it out of the way of people who don’t so that they can’t be affected by it.

SUBMISSION BY COLLETTE LANDER

Main Objective: Prohibiting smoking in enclosed public places o you agree with the main objective of this part of the bill? NO If yes, why? If not, why not?

Total prohibition of smoking in enclosed spaces is unfair to those who have always enjoyed their freedom to smoke in places like bars and clubs.

Separate, enclosed, ventilated rooms would cater for those wishing to smoke, and would also afford a smoke free environment for those who do not smoke.

You work on the premise that all smokers wish to give up the habit but cannot, but this is simply not true.

There are many, like myself, who have smoked 10 cigarettes or less for all of their adult lives, and enjoy the habit, much as drinkers enjoy their drinks, but that does not automatically define them as alcoholics.

People who have had their smoking habits spiral out of control, or have health issues may wish to give up, just as an alcoholic might wish to, and of course they must be helped, but not at the expense of smokers like myself.

Would you ban drinking because some drinkers will inevitably become alcoholic?...

I feel that there is excessive spin at this point in time on smoking and health, when much of today's poor health is due to environmental factors and sedantry lifestyles.
In the 60s and 70s when huge amounts of the population were smokers, there were fewer instances of asthma than there are now. Why should that be I wonder...

Perhaps blaming it all on smoking will divert peoples’ attentions away from the other, more pertinent causes?

If you carry on regardless of the smoking publics’ opinion, what will be blamed next, when in 10 years time, you find that public health hasn’t become significantly better?

People argue that as a smoker I may use up NHS resources as a result of my habit. Cigarettes carry a very high tax burden, so when you consider how much tax I have paid into government coffers, I’m sure you’ll agree that my medical care will have been paid for in advance many times over.

Smoking, like drinking, can be very harmful when not taken in moderation, and especially when combined with a bad diet and lack of excercise.

Smokers also have the right to vote, and I am sure that an outright ban in Scotland will be reflect badly on Labour at the polling booths, but I guess the current government know this, which is why the prohibition is not scheduled until 2006.

If smoking is permitted in establishments with suitably equipped rooms, this would be to the benefit of public health, because the alternative under your proposals would be to smoke at home with friends, some of whom may be non-smokers. There would be little-to-no ventilation at home, so where do you imagine the non-smoking people would be better off socialising - at the well ventilated club, or their friend's home?

I have no objections to the creation of smoke-free environments, but lets use some common sense and logic, and improve conditions for everyone.

Not all smokers wish to give up. Help those who do wish to give up, but do not punish those who do not.

As adults we make our own lifestyle choices and take responsibility for the consequences.

I urge to consider less draconian legislation, and consider people like myself who wish to be able to enjoy a cigarette on a night out. If I can't smoke in a club, then I would rather stay at home than be forced to endure the ravages of the Scottish weather outside.

I can only hope that my feedback to your proposals will be considered with impartiality, when I suspect that my arguments are falling on deaf ears, but you asked for opinions and these are mine.

Regards,
Collette.

SUBMISSION BY KENNETH MACARTHUR

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? yes
If yes, why?
Smoking is an antisocial habit, which has both superficial and serious consequences for those exposed to it. People should only be allowed to do it in private areas.
SUBMISSION BY CHARLES MCCANN

Part of Bill: Part 1  
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? NO

If yes, why?

If not, why not? I
It is an infringement on my civil rights to make my own choices. As I thought we live in a democracy. It should be the landlord’s choice to whether or not they have smoking within there own premises. The government has taxed smokers heavily over the years. What is next? You have moved on to alcohol now trying to ban happy hours and to eradicate cheap alcohol. Will there be any choices we make on our own in the future. This is how dictatorships begin.

SUBMISSION BY SHEILA MCQUEEN

Part of Bill: Part 1  
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

I’ve just given up smoking – 3 weeks now, thanks to the help of my local medical centre. I’m enjoying the advantages of having my senses of taste and smell returned, of not smelling like an old ash tray, being able to breathe better, not being concerned as to when the next fag break is due, not being a nuisance to other people, and all of this whilst saving money!!

I don’t want to go into pubs and restaurants – or anywhere – so that I can breathe someone else’s fumes.

You have my full support.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY WENDY NGANASURIAN

Can I add my personal contribution to the mass of evidence that the committee will receive on this issue. My childhood asthma was possibly re-kindled in adulthood through working in an extremely smoke-filled environment as a nurse in the 1970s: namely, a psychiatric hospital where most of the patients and many of the staff smoked almost continuously. I have found it impossible to eat in certain places where the policy has either been to allow smoking or to allow it in so-called designated areas which are as good as useless for preventing smoke moving throughout the area. I never go into pubs which is a shame since although I’m not a big drinker it would be nice to have the option of going in with friends when we are out for the day. Hotels, stations, airports all present the same problem to an asthmatic who is hypersensitive to smoke since the smokers may be confined but their smoke isn’t!
SUBMISSION BY ANDREW PEARSON

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

If yes, why?

I believe it is the right of every person to breathe air which is as fresh and unpolluted as possible and in the context of enclosed public spaces this must include the absence of tobacco smoke.

In my experience areas of public spaces which are designated non smoking can still be affected by smoke from adjacent smoking areas even with ventilation systems in place. Therefore a total ban is what I would expect to be implemented.

Making it harder for people to smoke all the time may eventually lead to improved health for the Scottish population as more people quit.

If not, why not?

Are there any other comments you would like to make?

I do not trust any “evidence” supplied by the Tobacco industry. As the experience in the United States has proved they rely on misinformation to promote their case. Please visit this site: http://www.tobaccoscam.ucsf.edu/fake/index.cfm

I believe there are 3 groups who will have an effect on viability of commercial venues:
1. Pub & restaurant goers who are smokers
2. Pub & restaurant goers who are non-smokers
3. Non-smokers who currently avoid premises which allow smoking

Group 2 will continue to go to pubs etc, group 3 numbers will increase enormously as has been shown in the US. Group 1 may reduce in numbers but some, if not most, will still go and may smoke outside.

SUBMISSION BY ANDREW ROSE

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

I welcome this part of the bill on a number of grounds.

• As a non-smoker, I don’t enjoy the smell or taste of second-hand smoke and as an asthma sufferer, I find the smoky environments cause me difficulty. The result is that I feel excluded from pubs and restaurants where smoking is permitted. Therefore, I welcome Part 1 of the bill as it will open up these places to me.
• I am fortunate to work in a smoke free environment. However, I don’t think it is reasonable for any employee to be subjected to a smoky environment. I welcome Part 1 because it will address this problem, at least in part.
• I am well aware of the negative impact that smoking has on the lives of many people in Scotland. I welcome Part 1 of the bill for the positive health implications that it has for Scotland.
Are there any other comments you would like to make?

I am disappointed that that the bill only makes it possible for vehicles, vessels, trains, etc. to be covered. I would like to see 4 (6) (b) reworded and moved to 4 (4) (e) so that such places are covered by default.

SUBMISSION BY MIKE THISTLE

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? NO
If yes, why?
If not, why not?
No objections to smoking bans in offices etc. but places of public entertainment should have both smoking and no smoking areas. Otherwise smokers are being effectively banned which is unfair. Alternatively, 50% of public houses could be smoking, or non-smoking, providing choice.

Are there any other comments you would like to make

SUBMISSION BY LOUISE WILSON

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? yes
If yes, why?
Dangers of inhaling passive smoke are now well documented. Action needs to be taken to prevent passive smoking related health problems

PART 2 : GENERAL DENTAL SERVICES, GENERAL OPHTHALMIC SERVICES AND PERSONAL DENTAL SERVICES

SUBMISSION BY MDDUS

I wish to make the following observations on the Dental Implications of the above Bill:
Dental Lists
1. The intention to expand the Dental Lists held by Health Boards to include the following is noted and endorsed.
Non-Principal Assistants.

Dental Bodies Corporate.

2. With regard to Dental Bodies Corporate, it is suggested that the Health Board record details of a "lead" dentist for the purposes of liaison at a local level.

Entry to Control of and ODeration of the Lists

1. The principle is accepted that the same jurisdiction in relation to Discipline Committees and the NHS Tribunal should include non-principals, but there is merit in giving further consideration to the implication of these proposals on the Vocational Dental Practitioner undergoing training in the Vocational Training Scheme.

Vocational Dental Practitioners are not truly independent Assistants and they are in fact employed by NHS Education Scotland. There is a high level of supervision and monitoring of clinical care and patient contact and it would therefore not be appropriate for such young and inexperienced practitioners to be deemed solely responsible for their clinical acts and omissions. Vocational Dental Practitioners should either be exempted from this process or alternatively special arrangements made to carry out a review within the Vocational Training Scheme.

2. With regard to the nature of the information to be provided by an applicant for inclusion on the Dental List, it is recommended that:

- Specific guidance be given on the nature of the conviction and (particularly) non-conviction information to be provided.
- That the relevance of this information be considered against stated criteria.
- That all such information is circulated to the minimum number of people and is dealt with at the highest levels of confidentiality, particularly with regard to non-conviction information.

Discipline

1. Referral to NHS Tribunal

The NHS Tribunal no longer exists in England and Wales. No case has been made to justify the continued existence of the NHS Tribunal in Scotland.

2. Suspension by a Health Board (Local Suspension)

It may be appropriate, in certain unusual and rare circumstances, for a Health Board to have the power of local suspension, it would not be appropriate to suspend without good cause. The example quoted in the Policy Memorandum states that one circumstance for suspension would be "where there was suspicion of fraud being committed". Simple. "suspicion" is not in itself grounds for suspension, particularly with regard to allegations of fraud.

It is recommended that consideration be given to providing guidelines or criteria to govern the power of suspension by Health Boards. There is an equal obligation to protect the interests of the dental practitioner and the public and we have grave reservations about any power to suspend based upon "suspicion" or upon inadequate and incomplete information. Also there are no clear criteria establishing the mechanism by which this suspension can be undertaken. Before any such decision is made there must be a properly constituted review process from Non-Health Board sources.

The same conditions of entitlement to payment whilst suspended by the NHS Tribunal should apply to suspension by a Health Board.

Hugh Harvie
SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 2, sections 9-10
Main Objective: Free dental and eye tests
Do you agree with the main objective of this part of the bill? yes
If yes, why?
Given the rising incidence of oral cancer and Scotland’s poor dental health record we support Section 9 of the bill as a progressive means of improving oral and dental health in Scotland.

We also believe that the introduction of free eye examinations and sight tests will help to identify visual problems earlier which should help to reduce the number of serious sight problems experienced by people in Scotland in the long term.

If not, why not?
Are there any other comments you would like to make?
There are clearly workload and workforce planning issues to contend with in relation to this objective which we know the Committee is already well aware of following its recent Workforce Planning in NHS Scotland inquiry. While the problems relating to dental services are well documented, there are also nursing workforce issues connected to these sections. For example the number of clinical nurse specialists whose main area of work is ophthalmology in NHS Scotland currently stands at just 11.

Part of Bill: Part 2, sections 11-17
Main Objective: Changes to dental and ophthalmic services
Do you agree with the main objective of this part of the bill? yes
If yes, why?
We believe that the changes proposed in these sections will assist in developing access to appropriate dental and ophthalmic services in NHS Scotland. This is particularly important given the problems experienced by people in many parts of Scotland in accessing NHS dental services at present.

If not, why not?
Are there any other comments you would like to make?

SUBMISSION BY WHICH?

Part of Bill: Part 2, sections 9-10
Main Objective: Free dental and eye tests
Do you agree with the main objective of this part of the bill? Yes
If yes, why?
We strongly support general moves to encourage preventive dentistry, which will be crucial to improving oral and dental health in Scotland. We welcome the Scottish Executive’s commitment to introduce free NHS dental checks by 2007 for all consumers. This will be important to encouraging
consumers to have regular dental check ups and seek on-going registration with a dentist, which is an essential part of a more preventive approach to dentistry and improving dental health.

We do however wish to express concern that the dental examination will be thorough enough to provide a meaningful oral health check.

If not, why not?
Are there any other comments you would like to make?

Part of Bill: Part 2, sections 11-17
Main Objective: Changes to dental and ophthalmic services

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

We consider significant reform is needed of the way dentistry is funded and paid for to promote improved access to NHS care and to ensure high quality care. Current arrangements do not support a modern approach to dental care and treatment, and act as disincentives for dentists to provide NHS care. Furthermore, the current system of patient dental charges act as a significant barrier to improving dental health in Scotland and ensuring that consumers get appropriate care and treatment.

New ways of remunerating dentists are needed that guarantee a minimum commitment to provide NHS care, using either sessional or block contract payments. We also consider that the remuneration system should provide incentives for preventative and high quality care and focus resources in areas of greatest need.

We also suggest that reform is needed to ensure that the NHS is able to adopt more rapidly new techniques and treatments of proven efficacy. We consider that any limits to the types of dental treatment available on the NHS should be determined by a systematic evaluation of the clinical efficacy of treatments that also incorporates consumers’ views as part of the process. This should be based on more than a rigid definition of what is needed to maintain oral health and dental fitness, and as such any treatments that have both clinical and cosmetic benefits are allowed if the dentist believes that they are necessary.

Urgent reform of the current system of patient charges for NHS dental care is needed. A simpler, more transparent and fairer charge regime is required to ensure that the cost of NHS dentistry (or the perception of its cost) does not act as a barrier to consumers, particularly those in greatest needs, seeking dental care. We suggest a simple three-band system of charges, with a much lower maximum charge than the current level, which should help to make dentistry more affordable.

We also recommend a systematic review of the current groups of consumers that are exempt from dental charges.

Extent and nature of NHS dental services

Which? supports moves to adopt a more cohesive and integrated approach to primary care dental service provision. This is crucial to delivering high quality NHS dental services to all consumers that want and need them and to improving dental health across Scotland. We welcome moves to strengthen the local NHS Boards’ role in ensuring provision of dental services that meet local needs.

We recognise that new technology is bringing many changes to dentistry that can deliver significantly better outcomes for consumers. However, we are concerned that the NHS is often slow to adopt these changes and so the benefits of new treatments are often only available to those who are able or willing to pay for them privately. Abandoning the rigid fee for item of service remuneration for dentists should help to ensure that the NHS is able to adopt new treatments of proven efficacy more rapidly.

We accept that a balance has to be struck between allowing unrestricted adoption of new technologies and treatments, and ensuring that the costs of NHS dentistry do not escalate wildly. We support the systematic evaluation of new technologies in dentistry, as in other areas of health care, to ensure that treatments of proven efficacy are available on the NHS. However, we are concerned that this process can be slow and result in a significant time-lag in the adoption of new technologies by the NHS. Consideration should be given to how this process can be speeded up, and we strongly advocate that consumer views are an integral part of this process.
We acknowledge the debate about the availability of dental treatments which deliver primarily a cosmetic rather than therapeutic benefit. Some orthodontic care and treatments, such as crowns and bridges, may sometimes be judged as not strictly necessary to achieve oral health and dental fitness. However, Which? is concerned that a rigid approach that only allows the NHS to cover dental care and treatment to maintain oral health and dental fitness is overly restrictive and is a retrograde step. It treats dentistry differently from other types of health care, and ignores the important relationship between oral health and other elements of consumers’ health. Additionally, oral health and dental fitness are not states that can be rigidly and objectively defined, so such an approach is likely to result in significant differences of approach between dentists and therefore inequalities for consumers.

We are particularly concerned that too restrictive a definition of oral health and dental fitness may be used to justify exclusion of some treatments such as orthodontics, crowns and bridges. While these may have greater impact on the appearance of someone’s teeth rather than functionality or dental fitness, this can be a significant factor affecting their mental health and general well-being. Which? suggests that to exclude these treatments on the basis that they exceed what is needed to achieve oral health and dental fitness, is to treat dentistry differently from other aspects of health care such as treatment following accidents. It is also in danger of putting the quality of dental care available on the NHS back several decades and is significantly out of step with consumers’ expectations for modern dentistry.

Which? agrees that treatments which are of purely cosmetic value, such as tooth whitening, veneers etc, or are of unproven clinical efficacy should not be available on the NHS. However, there are many treatments that have both cosmetic and clinical benefits (not just dental health) that should be available on the NHS and open to dentists to prescribe them where they judge them necessary. We suggest that consumers should be actively involved in any definition of what treatments should be available on the NHS, particularly if it is to exclude treatments that are currently available.

On the balance between preventive and repair services, we suggest that the introduction of the Oral Health Assessment will help shift the balance towards a more preventative approach as will the introduction of free dental check ups. A key part of the regular dental check up should be advice on dental hygiene, tooth-brushing techniques etc. We advocate a much more proactive approach to encouraging better dental self-care through public information and education programmes aimed at children and adults, which should reap future benefits in terms of improved dental health. We also suggest that preventive treatments such as fissure sealing and topical fluoride that have clinical benefits should be offered as routine treatments on the NHS.

The delivery of NHS services

The current fee for item of service remuneration for dentists has been shown to be both complex and lacking in transparency. Consumers rarely know what treatment they can get under the NHS, and are often vulnerable to pressure from dentists to undertake treatment privately.

Dentists also cite this system as a major reason for switching from providing NHS to private care, which has resulted in thousands of consumers not having access to NHS dentistry when they want and need it. Moving away from this approach will not only prove popular with dentists, it should also lead to consumers having greater access to NHS dentistry and a clearer understanding of what treatment they are entitled to. Which? would therefore support the introduction of alternative ways of remunerating dentists for providing NHS care.

On balance, our preferred option for funding NHS dental services is sessional or block contract payments for dentists rather than item of service payments or capitation only. This should provide greater clarity and certainty for dentists about their levels of income from NHS dentistry, and encourage greater commitment to provision of NHS care, as well as greater focus on preventative dentistry.

While there are some merits in funding services on the basis of capitation, we do not support adoption of this on its own. If adopted, a capitation system would operate best combined with a simplified scale of fees related to the level and type of treatment provided.
Which? supports introduction of payments to promote better quality care, improved facilities and equipment, and to encourage dentists to provide services in areas of greatest need or which face the greatest shortages of NHS dental care. This is a key part of bringing dentistry into the twenty-first century. The future focus of funding should be on the dental practice rather than the individual dentist, which would support a more team-based approach to dentistry and recognise that in individual practices, certain dentists may specialise in providing particular types of treatment. Whatever methods of funding are introduced, we strongly suggest that these should be related to a minimum level of commitment to provide NHS care that is properly audited to prevent abuses of the system.

**Patient Charges**

The current regime for patient dental charges is extremely complex and grossly opaque for consumers. The actual level of charges that patients pay can be very high (80% of the cost of treatment up to a maximum of £378 for a course of treatment). Research from Citizen’s Advice (formerly NACAB) shows that dental charges act as a major barrier to many consumers receiving care and treatment.

The burden of charges falls hardest on those with the greatest needs, and for those on low incomes, the current charge regime represents a very real burden and disincentive to seeking treatment. This is particularly concerning given the close correlation between poor dental health and socio-economic status. Which? has argued previously that there is no real rationale why charges exist for dental care but not for other types of health care. There is very little difference for the consumer between the pain and health implications of an ear infection and those of a dental infection, but for one there is no charge to see the health care professional but for the other there is.

The discrepancy between dentistry and other aspects of health care in the NHS is further illustrated by the differences in the categories of patient that are exempt from charges. Some groups, such as children and women who are pregnant or within a year of having had a baby, are exempt from charges for both dentistry and prescriptions, but others, such as older people, are exempt from prescription but not dental charges. Additionally, for dental charges there are no categories of exemption that relate to clinical need or risk.

Additionally, the low income rules are complex and opaque, such that many consumers do not know whether or not they are exempt from charges. Which? recommends that there should be a systematic review of the exemption categories for dental charges to ensure that charges do not act as a barrier to consumers with low incomes or significant dental health needs.

There is some merit in completely abolishing patient charges for NHS dental care, but we recognise that the cost of this must be considered in the wider framework of all health priorities and needs. However, Which? considers that the basis for considering future systems of patient charges is that they should continue to generate a comparable level of income as is raised currently by patient charges. However, there is considerable uncertainty about the future levels of demand for and provision of NHS dental services, what it will cost and at what levels charges should be set. It is crucial that the Executive undertakes some modelling to establish the cost implications of the different scenarios for patient charges and assesses that benefits and costs that may accrue not only in terms of the costs to the Executive but also their likely impact on dental health in Scotland. Which? suggests that any new system of charges should be based on the following principles:

**Transparency and simplicity, particularly to clarify the distinction between NHS and private care**

**Consistent and fair**

**Affordability, particularly for those on low incomes and with the greatest clinical need, such that charges do not act as a barrier to care**

**Supportive of preventive care**

**Easy to administer, including arrangements for paying for emergency treatment**

**Easy for patients to understand.**

A major objective of the review of dental charges should also be to radically reduce the maximum amount that anyone has to pay for a course of treatment. Although only a few people pay the maximum charge, it acts as a major psychological barrier to consumers seeking treatment because of concerns about what treatment might cost. Which? suggests that it should be possible to
achieve a significant reduction in the maximum level of dental patient charges with a minor redistribution of charges at the lower levels.

Which? finds little merit in other suggestions for a new system of patient charges. A system of single, simple charges for specific procedures will be easy to understand and administer, but it will still mean that those with the greatest needs will pay the most charges. A fixed charge related to the length of time in the practice, will favour those who have been able to secure on-going registration with an NHS dentist and penalise those who are mobile or only seek dental care on an occasional basis, for whatever reason. Similarly, changes to the percentage or type of treatment depending on the nature of the service or the patient’s characteristics, will not bring greater clarity and transparency for consumers but will make the system more complex for dentists to administer. Which? considers that there should not be separate payment arrangements for dental appliances as these should be regarded as an integral part of the treatment plan. For people with particularly poor dental health, dentures are essential to enabling them to function as ordinary members of society. This would result in a major discrepancy between consumers needing this type of care and those requiring other prostheses for other types of health care.

While an insurance type system will enable consumers to make small regular payments to cover the cost of dental treatment, this will not work well for consumers who do not regularly seek dental care or who are unable to register with a dentist for on-going care. There may also be problems for consumers transferring between dentists, or who have to have emergency treatment. Which? is also very concerned that under this approach, what consumers would be expected to pay should be based on their status or dental health. We suggest that this would be complex to administer, lack transparency for consumers and potentially penalise those with the greatest needs or the most marginal groups.

Which? suggests that a simple banding system for dental charges which is related to the level of intervention and the complexity of treatment undertaken would most closely accord with the principles we have outlined above. A system of three or four bands would provide consumers with a clear indication of what they would have to pay. Much will depend on how the bands are determined and at what levels they are set. However, through detailed analysis of the charges consumers currently pay and modelling of different band levels, it will be possible to ensure bands are set at levels where some consumers continue to pay similar levels of charges to those they pay at present, but those with the greatest needs pay significantly less. We understand that the Department of Health has undertaken such modelling as part of their consideration of the new charge regime for England. We commend this approach to the Executive.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY ANDREW ROSE

Part of Bill: Part 2, sections 9-10

Main Objective: Free dental and eye tests

Do you agree with the main objective of this part of the bill? yes

If yes, why?

Dental and eye tests have significant preventative value in terms of related health problems. Particularly in the case of dentistry, those who cannot afford regular check-ups are often those who most need them. By making dental and eye tests free, this bill will help to alleviate suffering and may prevent the need for expensive treatment for more developed problems by early intervention.
Are there any other comments you would like to make?

As a tax payer I suspect this will have financial implications. However, I remain in favour of these sections of the bill despite any such implications.

In some (many?) areas, it is already difficult to find dental practises that are willing to take on NHS patients. Section 9 is likely to increase the number of dental appointments required, thus stretching the existing services even further. Without legislation to limit private dental practise or to recruit more dentists, it would seem difficult to implement section 9.

**PART 3 : PHARMACEUTICAL CARE SERVICES ETC**

**SUBMISSION BY BMA**

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

Introduction

The BMA supports the introduction of modern contracts for NHS professions to ensure the evolution of the provision of health services to meet the changing needs of the people of Scotland. However under proposals outlined in Part 3 – Pharmaceutical Care Services, the BMA is concerned about the impact this may have on dispensing doctors in Scotland.

Background - Dispensing Doctors

Dispensing doctors are a small group of doctors who provide pharmacy dispensing services within the practice in small communities who would not otherwise have access to a local community pharmacy.

There are currently 276 dispensing doctors in Scotland, an increase on previous years. This group of doctors dispense to 176,000 patients and provide care for 275,000 patients in total. Dispensing doctor practices exist in those areas of Scotland where the population density is too low to support a pharmacy. Therefore they are prevalent in more remote and rural communities.

However, it is also the case that in these small communities, the provision of medical services is only economically viable because of the dispensing income generated for GP practices.

Pharmaceutical Care Services

Section 2CB places a responsibility on Health Boards to secure pharmaceutical care services for their local communities based on local need. This seems to suggest that NHS Boards would be able to subsidise pharmacists in order to secure pharmaceutical services in areas that are currently serviced by a dispensing doctor.

The BMA does not oppose this principle and recognises the advantages of improving access to pharmaceutical care services, but this should not be at the expense of the provision of general medical services in these communities.

NHS Boards are required to provide for a range of primary care services to their local populations. Under the current drafting of this legislation, it would seem to conclude that when a plan for pharmaceutical care services is under consideration, a pharmacy contract should be entered into in any area where pharmaceutical care services are not provided if there is a contractor willing to provide it. There is a very real concern amongst dispensing doctors that the impact on the provision of medical services will not be considered when NHS Boards are considering entering into new contracts for pharmaceutical care services.
It is essential that drafting of this primary legislation reflects the requirement for NHS Boards to consider the impact that entering into a pharmaceutical care contract in these communities will have on the provision of general medical services to the local population.

For More Information Contact:
Gail Grant

SUBMISSION BY LLOYDSPHARMACY

Part of Bill: Part 3
Main Objective: Giving health boards responsibility and powers to provide pharmacy services

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

• Lloydspharmacy supports the proposed legislative changes giving Health Boards new powers and responsibilities for pharmacy services, as it will set a framework for the implementation of a new contract for providers of pharmaceutical care services.

• Lloydspharmacy supports a more proactive strategic approach to service planning and delivery by Health Boards for the provision of appropriate pharmaceutical care services. We trust the strong opposition to “Holding Contract” expressed during the consultation has been reflected, as we believe this would lead to instability of the community pharmacy network.

• We agree with the principle of extending the Pharmaceutical list to include non principals as this will strengthen clinical governance and quality assurance of service delivery. We support and understand the need for pharmacists to be on Health Board’s list to provide pharmaceutical services. We are concerned that the mechanism for maintaining accurate lists works effectively, especially across Health Board boundaries.

• Lloydspharmacy understand and support the need for pharmaceutical care services contracts to be negotiated and agreed locally, but strongly supports the Scottish Executive’s intention to have a degree of uniformity across all health boards to reflect the fact that the new contract has been agreed at a national level.

If not, why not?

Are there any other comments you would like to make?

• Lloydspharmacy would welcome the opportunity to contribute further to the draft Bill as it progresses through the legislative process.

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 3
Main Objective: Giving health boards responsibility and powers to provide pharmacy services

Do you agree with the main objective of this part of the bill? yes

If yes, why?
Because we believe that pharmacy services are an essential community health service and should be properly provide for locally and this new power and responsibility will help to ensure that this happens.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY ELIZABETH CALDER

The Ileostomy Association has drawn my attention to certain proposals in the above Bill and I would like to comment as follows.

1 Appliances are to be delivered exclusively by community pharmacists. Will this outlaw specialist firms like Allardyce in York Place. What happens where there is no community pharmacy or the community pharmacist does not want this new role?

2. NHS Boards are expected to ensure that the existing patients continue with their current appliance. Could I therefore be forced to change from my present, suitable appliance? Will I still be able to receive the appliances I need, or will limits be placed on frequency of prescriptions and/or the number of appliance which can be prescribed at one time?

3 NHS Boards will be free to transfer to NHS employment stoma care nurses currently on contract sponsored by appliance makers. These nurses are sponsored by appliance makers because the NHS could not afford them. Will this service therefore disappear.

I hope you will bear these questions in mind when this Bill is debated, so that patients are not disadvantaged.

SUBMISSION BY FRANCIS FLYNN

APPLIANCE CONTRACTORS -FUTURE ARRANGEMENTS

I have received a copy of a letter written by Hamish Wilson, Head of Primary Care, concerning proposed changes in the way that ostomy equipment will be made available to those requiring it. Apparently the Executive hope to implement the new arrangements from April 2006, This is dependent on the progress of the new Pharmaceutical Care Service provision within the Smoking, Health and Social Care (Scotland) Bill.

As far as I can ascertain the proposed changes will involve the outlawing of agency arrangements, i.e. Appliance Contractors will no longer be allowed to supply ostomy equipment directly to a patient on presentation of a prescription. Instead, ostomists will be required to get their equipment from either community pharmacists who might be willing to provide the service or from a locally contracted service which would be staffed by NHS Board employees. As an ileostomist I find the proposed changes, within such a short timescale, most alarming. I, like many other ostomists, do not use off-the-shelf equipment. The appliance supplier that I use tailor-makes the flange part of my ileostomy bag to fit my stoma size. This involves cutting part of the flange so that it fits neatly around my stoma and so help to cut down problems associated with leakage and excoriated skin. A badly fitting appliance can be the cause of both leakage of faeces and excoriation of the skin. Apart from being both unpleasant and embarrassing these conditions can cause patients to develop psychological problems such as low self esteem and cause them to be effectively housebound out of fear of leakage from their appliance. In extreme cases a badly fitting appliance can result in the patient requiring further surgery. In addition to the above, many older ostomists suffer from arthritic and/or rheumatic conditions that mean they are unable to cut their flanges themselves and depend on this service being provided by the equipment supplier. Also, most
suppliers of ostomy equipment provide a free delivery service - a service that is extremely beneficial to the elderly and infirm.

I have spoken to our local community pharmacists and community nurses regarding the proposed changes. Neither was aware of these proposed changes and they expressed some concern about being able to provide a service comparable to the one that we enjoy at present.

Apparently one of the reasons for introducing the proposed changes is due to concern over the impartiality of the company-sponsored stoma nurses who work in hospital. I have checked with a number of the NHS funded stoma care nurses who work alongside the company-sponsored nurses and they all claim that the company nurses show no bias towards their own equipment - they all supply the best appliance for the particular patient. There is also the suggestion from the Executive that these sponsored nurses may be offered employment by the NHS. I find this very hard to believe - these nurses are in post because the NHS cannot afford to employ them and, as far as I am aware, most Health Boards spend over their budget at present.

All in all, I fear that the proposed changes to the Pharmaceutical Care Service provision within the Smoking, Health and Social Care (Scotland) Bill will result in a deterioration of the service that we ostomists enjoy at the present. I hope that you will be able to oppose these particular changes.

Francis P Flynn

**PART 4 : DISCIPLINE**

**SUBMISSION BY SCOTTISH NHS CONFEDERATION**

Smoking, Health and Social Care Bill: Part 4 – Discipline

I am grateful for the Committee’s invitation to the Scottish NHS Confederation to give oral evidence on part 4 of the Smoking, Health and Social Care Bill. On this occasion, however, we have indicated to the clerks that we felt that, as our evidence would be likely to be very brief, it would be more appropriate for us to provide it to you and the committee’s members in written form, rather than take up time that could be used by witnesses with more to contribute. We would of course be more than willing to elaborate further on the points that we outline below if any of the committee’s members wish us to do so. We have taken up the Committee’s invitation to give oral evidence on part 5, section 31 of the bill, on Joint Ventures, as this is a more complex issue.

The Scottish NHS Confederation is the independent representative body for Scotland’s NHS boards and special health boards. We fully support the bill’s provisions to strengthen the grounds and procedures for the discipline of Family Health Service Practitioners (FHSPs). We believe that these are sensible and logical changes which are necessary both to strengthen the protection of patients across Scotland and to meet the expectations of the public. The need for these changes has obviously been particularly highlighted by the Shipman case, but we believe that they are also necessary and useful in their own right. We believe that they provide clarity and fairness for practitioners and will strengthen the ability of NHS organisations both to ensure patient safety and protect the public purse.

Although there is an expectation that the annual number of local suspensions and/or referrals to the NHS Tribunal may rise slightly, mainly on the grounds of fraud, we do not believe that this rise will be so great that it will cause any significant administrative or financial burden to NHS boards. We accept that the wording of the new grounds for disqualification (“professional or personal conduct”) and suspension (“otherwise in the public interest”) may appear, on the face of the legislation, to be broad and potentially open to interpretation. However, we believe that this can easily be remedied through guidance and regulations, to ensure that these terms are understood and applied consistently by all NHS Scotland organisations.
Finally, we would point out that, although we fully support the requirement for FHSPs to provide additional information in order to be entered on to NHS board lists, this will require efficient cooperation with and timely action by Disclosure Scotland to ensure that the ability of FHSPs to practice is not delayed or hampered in any way.

Once again, we would be happy to clarify or add to any of these points or others which committee members may wish to ask us.

Susan Aitken
Policy Manager

PART 5: MISCELLANEOUS

Section 24: Payment to certain persons infected with hepatitis C as a result of NHS Treatment

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 24

Main Objective: Providing legal basis for making payments to Hepatitis C sufferers

Do you agree with the main objective of this part of the bill? yes

If yes, why?

An RCN Scotland representative was a member of the Expert Group chaired by Lord Ross which considered this issue. RCN Scotland is very supportive of such a scheme being introduced. However, we share the frustration of those people infected with Hepatitis C and their families at the delays and injustices which continue in their fight for the truth and adequate compensatory payments.

If not, why not?

Are there any other comments you would like to make?
RCN Scotland believes that the scheme should pay out at least as much as (allowing for inflation) the compensation paid to those who took proceedings under the Sale of Goods Act. We are also concerned that the Committee consider, and take evidence on the Clause 24 (1) (c) "did not die before 29th August 2003," and whether this cut off date disadvantages families and partners who have had no access to compensatory payments from any fund or legal process.

Independent health care service

Section 25: Amendment of Regulation of Care (Scotland) Act

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, sections 25-26

Main Objective: Restricting definition of independent health care services + representations and right of appeal to Care Commission

Do you agree with the main objective of this part of the bill?

If yes, why?

If not, why not?

Are there any other comments you would like to make?
Section 25 provides that Ministers can except from the regulatory regime of the Care Commission those providers of independent health services by way of secondary legislation. This would mean that at the discretion of Ministers, they can remove certain providers of independent health services from the standards, inspection, and licensing of the Care Commission. The policy reason for this is set out in the policy memorandum at para 121.

The scope of the legislation currently goes further than the original policy intention. As it stands, once section 2(5) of the 2001 Act is fully commenced, the Care Commission’s regulatory powers would encompass a wider area of the independent health care sector than that originally envisaged. For example, the Care Commission would be responsible for regulating services from a doctor or dentist provided under arrangements by a third party such as occupational health services or medical consultations and examinations for insurance companies. Any private services being provided by NHS general practitioners would also be covered by the current definition.

The changes to the 2001 Act are all technical and consultation was not considered to be necessary. The Care Commission and the Council are aware of, and support, the proposed changes to the 2001 Act. In relation to the change to section 2(5) of the 2001 Act the policy intention is that, prior to making regulations, consultation will be carried out on which, if any, services should be excepted from the definition of an independent healthcare service before these provisions are commenced. RCN Scotland would wish to be part of any consultation process.

RCN Scotland is unclear of the impact of these legislative changes and the accompanying policy memorandum gives little supportive information. It is unclear why the Care Commission, in implementing the broad principles of the original Act, would wish not to regulate indirect medical service provision. RCN Scotland would want to see that the public was safeguarded via a regulation process for the services outlined. The policy memorandum describes more about the desire of the Commission not to do something that the protection of the public duty for which they were established.

We have no comment to make on Section 26.

Section 27: Provision of information to the Scottish Social Services

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 27

Main Objective: Notifying Social Services Council of social workers misconduct

Do you agree with the main objective of this part of the bill? yes

If yes, why?

If not, why not?

Are there any other comments you would like to make?

Again, while acknowledging the need for this additional duty it is not clear what will happen to individuals not regulated by the Scottish Social Services Council (SSSC) but working within a registered service and thereby a social service worker. For example will a registered nurse or AHP be notified to the SSSC and if so for what reason? Would reciprocal arrangements not be needed within the Nursing and Midwifery Council (NMC), General Medical Council (GMC) and Health Professionals Council (HPC) etc? How would those who have been the subject of such a notification themselves be notified and have their rights protected? Again any notification to the NMC would need to be on the basis of a complaint which is shared with the individual and subject to statutory processes and rights of appeal. Equally notification onto the Vulnerable Adults List or similar for the protection of children includes rights and appeal mechanisms for the individual.
In short para 57A would require employers to notify the Council in circumstances where misconduct may have taken place but may not, and has not been investigated. Further the links to other regulatory bodies is not set out.

We believe that para 57B appears to be a reasonable duty.

**Section 30: Authorisation of medical treatment**

**SUBMISSION BY BRITISH DENTAL ASSOCIATION**

Part of Bill: Part 5, section 30

Main Objective: Easing authorisation of medical treatment for adults with mental incapacities.

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

The legislation to allow a dental practitioner to sign and issue a certificate under Section 47 of the Adults with Incapacity (Scotland) Act 2000 within his or her own professional area will facilitate the care of adults with incapacity, particularly when emergency relief of dental and oral pain and discomfort is required. Under the existing act, delays often occur in the treatment of patients suffering from dental pain whilst a Certificate of Incapacity is being sought.

In addition, the dental practitioner skilled and experienced in the care of patients with special needs may well have more understanding of the procedures and the ability to assess a patient’s capacity for consenting to specifically dental treatment than a medical practitioner.

If not, why not?

Not applicable

Are there any other comments you would like to make?

No

**SUBMISSION BY BMA SCOTLAND**

Part 5: Authorisation of medical treatment

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

The BMA would only wish to comment on the section of Part 5 of the Smoking, Health and Social Care (Scotland) Bill which relates to the authorisation of medical treatment (section 30) under the Adults with Incapacity (Scotland) Act 2000.

Authorisation of medical treatment

The BMA welcomes the protection afforded to the rights of vulnerable adults as outlined in the Adults with Incapacity (Scotland) Act 2000 and we continue to support the principles underpinning this legislation.

However, since the implementation of Part 5 (medical treatment) of the Act in 2002, the BMA has held concerns over certain practical aspects of the Act. Our concerns centred on the additional administrative burden and workload which have arisen as a result of the legislation and the constraints of the Act which, in our view, has not been to the overall benefit of patients.
The BMA welcomes proposals in the Bill to extend authority to grant a certificate under section 47(1) to health professionals who have relevant qualifications and training to assess the capacity of adults. Currently the Adults with Incapacity Act limits responsibility for the assessment of incapacity to medical practitioners only. The BMA believes this to be inappropriate as it includes all registered medical practitioners regardless of the nature of their professional experience and training, while excluding others such as appropriately trained specialist nurses and clinical psychologists.

The BMA is concerned about issues raised by the Health Committee during its early discussions on this Bill (11 January 2005). Extending the ability for other health professionals to issue certificates will not remove overall responsibility for the care of patients from the general practitioner or other doctor, rather it is intended that this amendment would prevent unnecessary delay and discomfort for patients requiring treatment. GPs would continue to issue certificates of incapacity for general authority to treat, but it would no longer be necessary for doctors to issue certificates for treatments provided by independent health professionals.

Many healthcare professionals, other than medical practitioners, have specific training and expertise in dealing with incapable adults and are in a position to judge an adult’s capacity for making decisions regarding treatment. In addition, doctors may not understand specific (e.g. dental) treatments in any detail and would therefore not be best placed to judge the capacity needed in those circumstances.

The broad definition of ‘medical treatment’ in the Adults with Incapacity Act potentially limits the access of incapacitated adults to routine treatment without formal assessment. Subsection (2)(b) lists those persons who will be able to issue a certificate, but only in respect of their own area of clinical practice. Care must be taken to ensure that terms such as dental treatment or nursing treatment are not interpreted narrowly. The essential requirement is that the practitioner doing the assessment is capable of assessing capacity and forming a view on the likely benefit to the adult of the treatment proposed.

The BMA acknowledges that the list of those persons who will be able to issue a certificate can be amended by regulations subject to consultation. The BMA would recommend that clinical psychologists be added to this list.

Duration of certificates

Certificates of incapacity giving the general authority to treat under section 47 of the Adults with Incapacity Act are currently valid for a maximum of one year. However, certificates issued for the purposes of other parts of the Act are valid for up to three years. The code of practice explicitly states that should the adult’s condition improve so that they regain capacity, a certificate should be annulled, regardless of its duration. There will be patients, for example those with severe learning disabilities and progressive dementia, for whom recovery is presently impossible. For these adults, an annual assessment, for the purposes of issuing a certificate is a solely bureaucratic exercise. Extension of the certificate for up to three years would be a sensible measure and reduce unnecessary bureaucracy.

Summary

The BMA welcomes the changes proposed in Part 5 of the Smoking, Health and Social Care (Scotland) Bill that amend the Adults with Incapacity (Scotland) Act 2000.

These changes will improve access to appropriate health care for incapacitated and will remove some of the bureaucracy that has resulted from the introduction of the legislation.

**SUBMISSION FROM CHARTERED SOCIETY OF PHYSIOTHERAPY SCOTLAND**

The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body representing physiotherapists, physiotherapy students and assistants. More than 98% of all
Physiotherapists in Scotland are members of CSP Scotland and physiotherapy is the fourth largest health care profession in the UK, and the largest of the allied health professions.

CSP Scotland has around 4,000 members in Scotland. Approximately sixty percent of chartered physiotherapists work in the NHS. The remainder are in education (including students), independent practice, the voluntary sector and with other employers, such as sports clubs or large businesses. Three Scottish universities offer degrees in physiotherapy. These are among the most over-subscribed university courses in the country. Approximately 150 newly qualified physiotherapists graduate in Scotland each year.

Physiotherapy involves the skilled use of physical interventions to promote, maintain and restore physical, psychological and social well being. Using problem solving and clinical reasoning, physiotherapists work to restore functional movement or reduce impairment utilising movement, exercise and the application of electro-physical modalities.

Part 5 Miscellaneous
Authorisation of medical treatment
30 Amendment of Adults with Incapacity Act (Scotland) 2000
The ‘Adults with Incapacity Act’ Part - Medical Treatment balances the need for timely intervention of treatment or therapy with the need to ensure that consent for any procedure is obtained. The Act is governed by regulations which determine this balance.

CSP Scotland has contributed to the Scottish Executive review of this part of the Act and is not opposed to the proposed amendments to the legislation. Nevertheless, CSP Scotland would make the following points concerning future regulations regarding treatment.
CSP Scotland would urge the importance of chartered physiotherapists to be included in the group of other health professionals to be prescribed by Scottish Ministers who should have access to training to assess the capacity of patients. The success of this extension to other health professionals in addition to ‘registered medical practitioners’ will depend greatly on the level and nature of qualifications and training envisaged.

Physiotherapists treat patients within the definition of adults with incapacity in both acute and primary care settings, and in the private sector. Working autonomously with patients of all ages and with a wide spectrum of conditions across physical and mental health. Physiotherapy may involve various procedures, including electrotherapy in the treatment of pain relief, respiratory care and restoration of function.

Some physiotherapists, in particular those working in rural isolation, may seek to access training to assess the capacity of patients. These professionals should not be excluded by omission from exclusive regulations. CSP Scotland would urge the Health Committee to impress on the Scottish Executive the need to ensure that future regulations do not prevent physiotherapists from gaining the necessary qualifications for those that wish to train in assessment of capacity.

The issue of appropriate qualifications and training is crucial to protecting the interests of patients and CSP Scotland would qualify its support until more information is available on the provision of training. In particular, who will provide training, what will be the level and nature of training and how professionals will access training are crucial to the success of this change.

CSP Scotland would broadly support the increase in the maximum duration of a certificate of incapacity to three years, dependent on the nature of incapacity. However this should be restricted to cases where there is little or no prospect of capacity being regained.

Conclusion
Chartered Society of Physiotherapy Scotland takes an active interest in the above legislative measures. Health promotion and safe effective practice are essential to the physiotherapy profession, and CSP Scotland is committed to patient centred services and continual measures to improve patient care.

CSP Scotland is also interested to learn more detail on the nature of training to be offered to health professionals to assess the capacity of patients.
SUBMISSION FROM THE LAW SOCIETY OF SCOTLAND

Section 30 Amendment of Adults with Incapacity (Scotland) Act 2000

The Mental Health and Disability Sub-Committee of the Law Society of Scotland welcomes the opportunity to submit written evidence on this Bill and has the following comments to offer:

The Sub-Committee agrees that it should be possible for healthcare professionals, other than doctors, to issue certificates of capacity. However, in the view of the Sub-Committee, it is essential that anyone certifying should demonstrably have appropriate expertise in the assessment of capacity as well as expertise in relation to the proposed medical treatment. Accordingly, the Sub-Committee suggests that the professional must obtain a qualification in such assessments. The Bill should therefore include this requirement.

The Sub-Committee has also been sent a copy of the additional briefings sent to the Health Committee by the Scottish Executive and notes that the briefings do not acknowledge the authority that the Adults with Incapacity (Scotland) Act 2000 gives to attorneys, guardians and persons authorised under intervention orders. For example, an attorney or a guardian may have the power to consent to medical treatment. If the scope of certification is to be widened, then it is important that the relevant professionals are advised of this authority. This must be on the basis that appropriate and accurate guidance will be issued.

I hope the foregoing comments are useful to the Committee.

Yours sincerely

Stuart Drummond
LAW REFORM OFFICER

Section 31: Joint Ventures

SUBMISSION BY PARTNERSHIPS UK

Joint Ventures and Investment in Scotland's Primary Health and Social Care Estate

1. Public Bodies and Joint Ventures

Joint ventures (JVs) between the public and private sector are becoming increasingly common. Typically, they are seen as an appropriate way for two or more parties to work together where each has complementary (but not necessarily identical) objectives and where each party has a contribution to make, but where that contribution is likely to be more effectively deployed if pooled. Equally, a JV may provide a more effective way of sharing the risks and rewards of certain actions where these are initially difficult to determine.

JVs are often seen in circumstances where change is unavoidable and where required outcomes are easy to determine, but the way in which the outcomes are best achieved is uncertain. By contrast, if the way in which two or more parties can make distinct contributions to the achievement of required outcomes is quite certain, then more straightforward contractual arrangements are preferable. Most of the commercial dealings between the public and private sector fall into this second category.

The Lift initiative in England has proceeded on the basis of a corporate JV model. JVs are introduced at both the national level (i.e. PfH is itself a JV between the Department of Health (DoH) and PUK) and at the local level (the "local LiftCo" is a JV between local public bodies, PfH and the private sector). The principal reasons that the JV model was adopted for Lift were:
At a national level, the DoH and PUK possessed different but complementary skills both of which were judged necessary to make the Lift initiative work but the product of this joint endeavour was impossible to predict for some time and required investment by both to ascertain;

At a local level, the outcomes being pursued are being achieved over an elongated period of time, they are likely to change over this period of time, they will require parties to respond flexibly and these circumstances will inevitably mean that the risks and rewards of the partners are impossible to define precisely at the outset.

A JV itself can take two principal forms. Perhaps the most common is the corporate JV. In this arrangement, the parties to the JV set up a separate company (JV Co) in which they own pre-agreed proportions of shares. As a company, JV Co is not set up for a pre-set period of time. Once JV Co is judged to have completed its work, shareholders simply implement well-understood winding-up procedures.

The relationship of the parties to JV Co is regulated principally by a Shareholders' Agreement. JV Co has a separate legal personality to and runs independently of its shareholders, although obviously significant influence can be brought to bear through rights and obligations (for example, to appoint directors to the Board of JV Co) established in the Shareholders Agreement and in the Companies Acts.

JV Co can own and deal in assets and it can employ people and enter into other contracts in its own right. A skilled independent management team can be put in place, staff can be incentivised to succeed and administrative processes that reflect the size and complexity of the business can be introduced. JV Co can therefore, be extremely flexible. However, this flexibility needs to be balanced against issues such as directors' liabilities, insolvency legislation and wider implications for public sector bodies such as public accountability, ministerial responsibilities and audit requirements.

Although they need to be dealt with properly and professionally, such matters have not proved to be a major impediment to public bodies establishing JVs. The Lift initiative has required public servants to recognise when their responsibilities qua public servant or qua PFH company director (with fiduciary duties to shareholders) take precedence. At a local level where, in the Lift initiative, the public sector shareholding is in a minority, certain matters have been dealt with as special rights accruing only to public sector shareholders. Directors' personal liabilities that may arise under the Companies Acts are typically covered by professional indemnity insurance and insolvency law acts both to police and to protect the actions of directors of troubled enterprises.

Although rarer, it is also possible to establish a contractual rather than a corporate JV. Contractual JVs confer defined rights and obligations on the contracting parties. The contracting parties exercise their rights through direct participation in the activities of the JV (typically through membership of a JV Project Board).

The contractual JV tends to deal less efficiently first, with conflicts between the contracting parties (contract termination being the typical solution) and second, with issues that arise from time to time upon which one or both JV parties are unsighted. As such, they tend to be used a) where there is more certainty over the roles and contributions of the different parties, b) where the environment within which the JV operates is more predictable or c) where the period over which mutual benefit is to be derived is relatively short.

Over the years, PUK has entered into a number of both corporate and contractual JVs. Typically, PUK's contractual JVs represent short-term (perhaps two to three year) arrangements where it deploys its resources to support those of the public sector to achieve a clearly defined end.

Some of the critical factors that determine whether a corporate or a contractual JV is likely to be more suitable to any particular set of circumstances include:

1. The intended longevity and activities of the JV;
2. The level of certainty about the commercial issues that will be dealt with by the JV;
3. The importance of high quality, efficient and timely decision-making by the JV to achieve the JV's objectives;
The familiarity of the organisational proposal to potential JV partners.

The Lift Initiative in England

The NHS Plan in England, published in July 2000, signalled the start of a major investment programme in the primary care estate in England. The Plan sought to avoid ad hoc premises development which had fostered a disjointed and anachronistic pattern of service provision. The Plan also recognised the need to add to traditional methods of investing with a more systematic approach which, when the two combined, would deliver the volume of investment required at the pace demanded.

Private capital already provides the bedrock for funding GP premises in England. However, this has been achieved in a piecemeal fashion, with little or no risk of asset performance being retained by the private sector and with punitive exit costs falling, in particular, to GPs. These have occasionally acted to obstruct the introduction of new models of primary care delivery. It is also clear that GPs acting alone or in partnership are less likely to accept the burden of property ownership of larger health centres now being planned to house multi-disciplinary and multi-institutional teams.

2.1 Factors Determining the Design of NHS Lift in England

The Lift initiative seeks to present the investment opportunity arising in primary health and social care in such a way that it is attractive to private capital on a systematic basis. Fundamental to the design of the Lift model is the presentation of a "pipeline" investment opportunity to the private sector. Lift creates a vehicle that is capable of delivering today’s and tomorrow’s investment needs, even where such needs cannot currently be defined in any detail.

Lift makes systematic investment of private capital in the primary and social care estate attractive by:

Presenting larger investment opportunities, by bundling together individual requirements into larger packages;

Establishing common (and therefore, easily recognisable) procurement processes and contractual terms by which the public and private sectors can do business;

Introducing a single point of contact in the public sector through which investment opportunities can be pursued (the local LiftCo).

The Lift initiative in England has been pursued and operated at two levels, nationally and locally. The national vehicle, PfH, was created as a centralised procurement resource with the following main tasks:
To develop standard procurement processes and contractual terms and thereby, to create a new market of private sector players interested in owning and operating England’s primary health and social care infrastructure;
To work as part of local procuring teams, providing procurement and negotiating expertise;
To ensure that the standard tools developed were effectively applied at the local level;
To collect, collate and apply best practice emerging and to ensure that experiences in other areas of the country were taken into account.
To act as the direct interface with the DoH tracking progress on the delivery of policy objectives;
To demonstrate commitment and drive on the part of Government.
In addition to procurement support, PfH also became an investor in the local JV companies (called "local LiftCos") which are established once the local procurement processes had been completed. Through its investment, PfH retains an enduring economic interest (set at 20% in England) in all local LiftCos and exercises its influence through its right to nominate one director to each board.

PfH was itself established as a corporate JV (owned 50:50 by the DoH and PUK). This was because both the DoH and PUK judged that the ongoing success of the Lift initiative would depend on their being an enduring (but light-touch) role in local LiftCos for non-local bodies. It also provided comfort to private sector partners that dysfunction and/or breakdown in the local LiftCo would register very rapidly at a national level. 'Three waves of local LiftCos have now been procured. The success of the initiative has encouraged the DoH to sponsor a fourth wave, the first procurements of which commenced in December 2004. All competitions have, so far, attracted at least three credible bids from the private sector and contracts are currently being signed at a rate of about one per week. The competitions for LiftCo partners are now starting and finishing in around 18 months.

The public sector parties involved in a local Lift are known as Strategic Development Partners who enter into a Strategic Partnering Agreement to create, inter alia, a Strategic Partnering Board. Prior to the procurement of a private sector partner, the Strategic Development Partners and PfH create a project team, combining local (for example, clinical and managerial) and national (experts employed by PfH) resources, along with external advisers.

The competition is run effectively to find the private sector company that is most capable of acting as co-shareholder with the Strategic Development Partners and PfH in the local LiftCo and, through this shareholding, to provide long-term partnering services to the local primary health and social care system. In addition, the successful private sector partner is obliged to procure that the local LiftCo enters into contracts, either with it or with a quality-assured supply chain, that will complete investments endorsed by the local LiftCo. The first tranche of these investments will have been identified as part of the original competition but future investments will emerge and be implemented over time.

Continuing value for money must be demonstrated by LiftCo in order to secure the approval of the Strategic Partnering Board for each new project. This is achieved by demonstrating a reduction in rents (in real terms) over time for new investments, which reflect LiftCo capturing the efficiencies of the long-term partnering arrangements. LiftCo can use either benchmarking and/or market-testing techniques to demonstrate value for money. If benchmarking is used, the cost elements making up the rents must be measured against those being achieved, not only in the local area, but also in other cohort groups up and down the country. In addition, every five years, the entire supply chain of each LiftCo is subject to a formal market test to ensure that the price benefits of competition continue to be harnessed.

2.2 What Has Been Achieved

Like Scotland, primary legislation needed to be enacted in England to allow JV arrangements to be entered into. This was completed in May 2001. First generation procurement processes and contractual documentation were developed during 2001 and procurement of the first wave started in March 2002. Local Lifts were identified and prioritised into waves in Spring 2001. 1st wave Strategic Development Partners were identified, Strategic Partnering Agreements entered into and Strategic Service Development Plans (SSDPs - these set out the nature and size of local investment requirements looking forward a number of years) completed over the next nine to twelve months.

In summary, since the launch of the Lift initiative:

- 33 local LiftCos have been established in three waves with nine more still in procurement - a substantial number include Local Authorities, either as full Strategic Development Partners or as (Lease Plus) tenants;
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- Over £400 million of immediate and near term investment is now contracted for as part of the three waves, of which around £30 million is up and running and the remainder currently in various stages of construction.
- Five LiftCos have identified their 2nd tranche of primary health and social care investment;
- The 4th wave commenced work in December 2004 which will bring the total number of local LiftCos to 51;
- The four waves will mean that 50% of all PCTs are now involved in Lift, covering over 75% of the population of England.

PfH continues to sponsor developments designed to make the process more efficient. Standard documentation has now reached a fourth generation (which, in particular, calibrates them for Local Authority requirements) and template supply chain and facilities agreements are being worked up. PfH is also increasingly involved in supporting organisational development aimed at cementing the new partnering relationships that arise at the local LiftCo level.

3. A JV Approach for Scotland's Investment in its Primary Health and Social Care Estate?

A small number of critical factors determined the introduction of the Lift initiative in England and, subsequently, its shape and structure. Given that Scotland is seeking a systematic improvement in its primary health and social care estate, it would be prudent to consider whether the same factors obtain and in the same way.

Prima facie, the challenge to improving the primary health and social care estate in Scotland shares many of the features presenting in England. In neither country, is modernising facilities an end in itself, nor is the mechanism by which investment is delivered. In 2003, the Scottish Executive's Short Life Working Group, comprising representatives of health providers, local authorities and the Scottish Executive, which looked at jointly occupied premises, concluded that the absence of good quality facilities from which services are provided was becoming a major obstacle to achieving service improvements in Scotland. The Short Life Working Group also recognised that the need to rapidly improve the quality of these key public services made tried and tested delivery mechanisms particularly attractive. The action to seek additional statutory powers for public bodies to enter into JV arrangements is prompted by the need to ensure that ways of achieving the desired end by means that are recognisable to the public and private sectors are readily available to Scotland's service providers.

The Lift initiative can be considered in terms of a) its architectural framework and b) its detailed design. Its worth noting that the overall architecture of the initiative has proved resilient both over time and when transplanted across to the schools investment programme. Detailed design within this architectural framework though, is necessarily something that has been tailored to local and sectoral circumstances. Such design work is expected to be required if the framework is adopted in Scotland.

3.1 Architectural Framework

In England, the JV approach was adopted at the national level because the need for a central procurement resource to support local project teams was judged essential. It was recognised that the core competencies required by this central resource could only be found by pooling the capabilities of PUK and the DoH. The corporate JV model was recommended because first, the risks and rewards of the joint endeavor were genuinely unknown and second, it was recognised that PfH would continue to enjoy a proactive and enduring role in the activities of local LiftCos well after their creation.

In Scotland, different conclusions could be drawn about, for example, the need for and complexion of a central procurement resource and the activities and lifespan envisaged for the central support body. The Scottish Executive has expressed its preference for short, medium and long-term involvement, direction and support from an expert central procurement and investment resource. This resource will provide a broad and stable platform of capabilities that can be drawn upon by
project teams establishing and implementing local investment plans. It will also give confidence to the private sector that local decision-making will be supported by standard structural and contractual approaches, prosecuted through a central support resource. This blend of local and central capabilities was important to the success of the initiative in England.

Again, in England, the local LiftCo has been designed as a corporate JV. The need to pool the respective expertise of the public and private sector argued heavily in favour of a JV solution. The main factor dictating the development of a corporate JV model though, was the decision to construct the opportunity presented to the private sector on a population basis and not as an asset bundle.

The asset bundle provides a more certain (but constrained) set of requirements. This enables a clearer delineation of responsibilities between the public sector client and the private sector provider. The population-based opportunity presents less certainty but can accommodate new, changing, and elongated requirements. The corporate JV model is a more flexible mechanism than the contractual JV, relying on the coincidence of commercial interests to incentivise behaviour and performance rather than defining detailed requirements at the outset.

In England, meeting the challenge of improving primary health and social care involves a prolonged campaign of recruitment, training, and cultural change. Capital investment in new infrastructure is a supporting and enabling tool that is being used, time and again, to catalyse the change needed. Its contribution is being determined locally and over time but its availability is proving critical in removing obstacles that would otherwise be used to impede progress.

If the challenge in Scotland is not one that will be addressed by a single, one-off injection of investment, but is one that will be dealt with by carefully co-ordinating the role that investment plays in transacting change with other development tools (such as recruitment), then the architectural framework of Lift should be equally effective here as it has been in England.

3.2 Detailed Structural Design

Detailed structural design will determine such matters as the average size of a local investment area, the scope of services that are to be required from the private sector and the degree of influence that the public sector wishes to exercise over the running of the local delivery bodies. These factors determine, amongst other things, the number of investment areas to be supported by the central procurement resource, the number and nature of the Strategic Development Partners involved and the shareholding required in each local JV Co.

The main factors that have determined the detailed design of local LiftCos in England are:

- The population size served by each local LiftCo (300,000 to 500,000) and, linked to this, the scale and nature of the immediate, near and long term investment opportunity available in each Lift area;
- The scope of the opportunity presented to the private sector over which the local LiftCo will preside, including some or all of primary health and social care premises, facilities and operational management, and information systems;
- The level of investment supportable by public sector capital, both at the outset and on an ongoing basis;
- The nature and level of co-ordinated working achieved or achievable by the Strategic Development Partners;
- The capacity and capability of public sector shareholders to act effectively as parties to the long term JV and, in particular, to play their part in translating their SSDPs into investment requirements.

There is every reason to believe that the detailed design of local investment areas would be different in Scotland to England. The population of Scotland is around 5 million and is served by 15 Health Boards. The population of each Health Board though varies considerably, with the smallest being 19,000 and the largest 635,000.
Prima facie, this suggests that, for a small number, the Health Board may represent too large a planning and contracting unit and for many others, it is certainly too small. 46 Community Health Partnerships work alongside the 15 Health Boards and the 32 Local Authority bodies in Scotland and together, they define and provide a wide range of primary health and social care services.

The detailed design of local investment areas in Scotland would need to be influenced by, inter alia;

- The scale of investment required in each Health Board;
- The state of readiness of the Health Board and its partnering agencies to become Strategic Development Partners and to embark on and support the "procurement of a private sector partner;
- The capabilities of the Strategic Development Partners to identify a rolling programme of investments arising from local service developments;
- The appetite of the Strategic Development Partners to have an enduring involvement in the management and governance of a corporate JV.

As in England, federated arrangements between different Health Boards and other public sector partnering bodies in Scotland would probably be determined by a mix of historic relationships and service inter-dependencies. The pace at which different federations came together and proceeded with the Lift initiative in England varied, but the flexibility of the Lift model to cope with this was judged one of its great strengths.

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 31

Main Objective: Allowing Scottish Executive to participate in joint ventures to provide services and to exploit intellectual property.

Do you agree with the main objective of this part of the bill?

If yes, why?

If not, why not?

Are there any other comments you would like to make?

The Committee may wish to ask for evidence from England on the uptake and outcome of such schemes and whether policy realisation flows from this funding model. RCN Scotland is not convinced.

SUBMISSION BY UNIVERSITIES SCOTLAND

Comment on Joint Ventures

Universities Scotland is the representative body of Scotland’s 21 universities and colleges of higher education. Many of our members are involved in areas of academic research which are directly relevant to the National Health Service in Scotland. The sector also has strong experience in the successful exploitation of academic research for real-world purposes. Every institution will be involved in joint ventures with other partners to aid this knowledge transfer process, and some are directly involved in partnerships with NHS bodies.

Section 31 of the Smoking, Health and Social Care (Scotland) Bill gives Scottish Executive Ministers the ability to take equity in spin-out companies formed on the basis of intellectual property developed in the NHS in Scotland. This enables them to become partners in any joint ventures established to further the use of any such intellectual property. The law in England was changed
some time ago but was not modified in the same way in Scotland. Westminster Ministers can already take equity stakes in joint ventures so this is largely a catching-up exercise.

The aim – to enable, or rather remove the potential restriction on, the NHS in commercialising inventions arising from its research base – is one that we fully support. The ability of Ministers to take equity in science parks and other similar initiatives is also welcomed.

The only circumstance in which this provision would give the higher education sector any concerns would be if it granted the Scottish Executive any new or additional powers over intellectual property right and their ownership. However, as it clearly does not do this, this section of the Bill has the support of Universities Scotland.

Section 32: Scottish Hospital Endowment Research Trust

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 32

Main Objective: Converting Scottish Hospital Endowments Research Trust from a Non-Departmental Public Body to an independent charity

Do you agree with the main objective of this part of the bill? yes

If yes, why?
We agree in principle with the policy intention of converting SHERT from an NDPB to an independent charity but have some questions about the detail of the way in which the charity will function.

If not, why not?

Are there any other comments you would like to make?
RCN Scotland notes that this organisation has funds of around £26.5 million yet only awards around £1m per annum. We note that despite the funds being accrued from the public and endowments the criteria are very restricted to medical research and the treatment of diseases (named on its website).

This is despite there being considerable numbers of medical research funding bodies, but very few for nursing and multidisciplinary or routes other than disease treatment to improve health.

RCN Scotland would ask the Committee to question the Minister on widening the remit of the research areas from the current 8 disease specific areas to a wider range of health criteria.