The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 16 June 2015

Session 4

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HEALTH AND SPORT COMMITTEE
20th Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Brian Auld (Royal Environmental Health Institute of Scotland)
Professor Alison Britton (Law Society of Scotland)
Dr Catherine Calderwood (Scottish Government)
Simon Clark (Freedom Organisation for the Right to Enjoy Smoking Tobacco)
John Connaghan (Scottish Government)
Paul Gray (Scottish Government)
William Hamilton (Glasgow City Council)
Assistant Chief Constable Bernard Higgins (Police Scotland)
John Matheson (Scottish Government)
Chief Superintendent Iain Murray (Police Scotland)
Margaret Wallace (Stirling Council)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 16 June 2015

[The Convener opened the meeting at 09:18]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 20th meeting in 2015 of the Health and Sport Committee. As usual, I ask everyone in the room to turn off their mobile phones, as they can often interfere with the sound system. I and others will be using tablet devices instead of hard copies of committee papers. We have received an apology from Rhoda Grant, who is attending the Justice Committee on other business.

The first item on the agenda is a decision on whether to take in private at future meetings consideration of our approach to the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill, the Transplantation (Authorisation of Removal of Organs etc) (Scotland) Bill and our inquiry into palliative care. Are we happy to do that?

Members *indicated agreement.*

Subordinate Legislation

Community Care (Provision of Residential Accommodation Outwith Scotland) (Scotland) Regulations 2015 (SSI 2015/202)

09:19

The Convener: Agenda item 2 is subordinate legislation. We have four negative instruments before us today. The first is the Community Care (Provision of Residential Accommodation Outwith Scotland) (Scotland) Regulations 2015. There has been no motion to annul the instrument, and the Delegated Powers and Law Reform Committee has not made any comments on it. As members have no comments to make, is the committee agreed to make no recommendation on the instrument?

Members *indicated agreement.*

Honey (Scotland) Regulations 2015 (SSI 2015/208)

The Convener: The second instrument is the Honey (Scotland) Regulations 2015. There has been no motion to annul the instrument, and the Delegated Powers and Law Reform Committee has made no comments on it. As members have no comments to make, is the committee agreed to make no recommendation on the instrument?

Members *indicated agreement.*

National Health Service (Optical Charges and Payments and General Ophthalmic Services) (Scotland) Amendment Regulations 2015 (SSI 2015/219)

The Convener: The third and final instrument before us is the National Health Service (Optical Charges and Payments and General Ophthalmic Services) (Scotland) Amendment Regulations 2015. There has been no motion to annul the instrument and the Delegated Powers and Law Reform Committee has not made any comments on it. As members have no comments to make, is the committee agreed to make no recommendation on the instrument?

Members *indicated agreement.*

Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment Order 2015 (SSI 2015/222)

The Convener: Oh! There is a fourth instrument. I am sorry—there were five originally, and now there are four. The fourth instrument—and the very last before us this morning—is the Public Bodies (Joint Working) (Integration Joint

Board Establishment) (Scotland) Amendment Order 2015. There has been no motion to annul the instrument, and the Delegated Powers and Law Reform Committee has not made any comments on it. As there are no comments from members, is the committee agreed to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: Before we move to agenda item 3, I suspend the meeting to allow the panel of witnesses to take their places.

09:22

Meeting suspended.

09:23

On resuming—

NHS Boards Budget Scrutiny

The Convener: The third item on the agenda is a second evidence session on national health service board budget scrutiny. Last week, we took evidence from the directors of finance at NHS Greater Glasgow and Clyde, NHS Ayrshire and Arran, NHS Tayside, NHS Dumfries and Galloway and NHS Western Isles. Today, we welcome Paul Gray, the chief executive of NHS Scotland and the director general of health and social care at the Scottish Government. He is accompanied by Dr Catherine Calderwood, the chief medical officer; John Connaghan, the NHS Scotland chief operating officer; and John Matheson, the director of health finance, e-health and analytics at the Scottish Government. I welcome you all.

I understand that Paul Gray wants to make a short opening statement. After that, we will move directly to questions.

Paul Gray (Scottish Government): I thank the committee again for the opportunity to discuss the budgets. We have just concluded the financial year 2014-15 and, subject to audit, we can report that health boards have delivered services within financial plans for the seventh consecutive year. In doing so, delivery of efficiency savings has been a key part of maintaining financial balance. In 2014-15, boards achieved savings of £284.9 million, which is 3.1 per cent.

We start from a strong base in NHS Scotland budgets. We plan for the long term and the short term, and we have clear financial planning assumptions. I assure the committee that budgets are not developed in isolation. They form part of health boards' planning for service delivery and workforce.

Our methods of funding are designed to provide equity as well as stability, and to incentivise the right behaviours on efficiency and planning. Boards' plans for 2015-16 will deliver a balanced position. However, we recognise that it is becoming increasingly challenging to do so, and that challenge will continue. That is why we have a strong focus on improvement and efficiency, and it is why we are continuing the very important work on the integration of health and social care.

As always, convener, if there is information that the committee wishes to know that we do not have immediately to hand, I will undertake to provide it as quickly as possible. I will also make good use of my colleagues, who have expertise in particular areas in which the committee may have an interest.

I am grateful for the opportunity to make that brief statement.

Bob Doris (Glasgow) (SNP): I will ask about the data that the Government collects and garners from health boards, and whether that is provided in a consistent, meaningful and comparable way.

I will mention some information about anticipated uplifts in hospital drugs prices. Other members might wish to talk about that in terms of cost pressures in the NHS, but that is not my reason for giving an illustration of the figures. In the meeting papers, there is a table showing the anticipated price and volume changes for hospital drugs for 2015-16. NHS Ayrshire and Arran has an assumed price uplift of 2 per cent and an assumed volume uplift of 22 per cent. By comparison, NHS Dumfries and Galloway has an assumed price uplift of 8.7 per cent and an assumed volume uplift of 2.5 per cent. Those are just numbers and in one respect they are meaningless, but when the committee does its budget scrutiny and when the Scottish Government takes a view on the local delivery plans of each health board, how can we be sure that the figures are collected, collated and analysed in the same way?

From looking at the figures, I have no idea whether they reflect the cost-pressure mitigation of drugs going from patent to generic, whether they take account of the £80 million new medicines fund that the Scottish Government has supplied or whether they include horizon scanning of new drugs that are likely to be approved by the Scottish Medicines Consortium and then go through to the area drug and therapeutics committees. I do not know.

The Government has to look at each health board's local delivery plan across a variety of areas. I apologise for starting off on the matter of process, but we are involved in a budget scrutiny process. How do you ensure consistency and comparability to interrogate the figures of the local delivery plans from each health board?

Paul Gray: I signal to my colleague John Matheson that I will bring him in on this shortly, and Dr Calderwood might want to comment on any clinical aspect. I will focus on the example that you used, although the question has broader applicability to other areas where the figures may or may not be comparable.

Boards make an assessment based on their local demography. The patients that they expect to treat and the age of the population are two factors. For example, in NHS Greater Glasgow and Clyde—which was not one of the examples that Mr Doris advanced—certain drugs are used more frequently and at higher cost because of the type of patients in the board area. It is therefore not a concern to us if different boards make different assessments. However, you point to quite sharp variations in the assessment both in terms of the likely cost pressures and the likely numbers.

We look at the budgets across the piece to assure ourselves that boards have made rational assumptions, but we do not seek to second-guess the boards and the clinical advice that they will have received from their medical directors and through the clinical governance and assurance processes that they have in place.

John Matheson may want to say more about that, and Dr Calderwood may want to come in, too.

09:30

John Matheson (Scottish Government): Mr Doris is right to highlight the issue of drugs because, after staffing, that is our next highest spend area—we spend £1.4 billion on drugs. We have a collegiate approach across boards and discuss planning assumptions as we move forward into not just the next financial year but future financial years. We do that through the corporate finance group. We look at pay assumptions, inflationary assumptions and the impact of pension and national insurance increases. Mr Gray is right to the extent that there will be a differential approach, depending on how efficient boards have been. Mr Doris picked up specifically on where the boards are positioned on branded and generic drugs, and we expect variation in that across boards.

We expect boards to include in their considerations the new medicines fund and any pressures. Hepatitis C provides a positive example of a differential approach across boards. There is a high prevalence of hepatitis C patients in NHS Greater Glasgow and Clyde—it covers 25 per cent of the population but it has about 40 per cent of the hepatitis C patients—so the new drug that has been brought out recently that cures hepatitis C patients is having a significant impact in NHS Greater Glasgow and Clyde. We would expect a differential position on that.

I am more concerned about the total trend in expenditure than about the split between price and volume. I am also concerned about how proactive boards are in looking to make further efficiencies within that £1.4 billion spend. For example, we are being proactive around the introduction of the Scottish therapeutics utility tool, which is made available to general practitioners to review repeat prescriptions. It is focused on reducing harm and variation, but it will also create financial savings.

There is a complex matrix, and the differential is not a surprise to me. For me, the key is the robustness of the estimates. Throughout the year,

we go back and review with boards how accurate the estimates have been.

Dr Catherine Calderwood (Scottish Government): I will give another example. Sixty per cent of cancer patients are treated by the Beatson hospital in NHS Greater Glasgow and Clyde. You will know that, as a subset of drugs, chemotherapy drugs are among the most individually expensive. Again, the population in the area needs those expensive treatments. One or two individuals in a health board area may be on very expensive immunomodulatory drugs. We would not know the clinical details of that, but it might be enough to push up an individual board's budget quite a lot.

Bob Doris: I thank the witnesses for clarifying those understandable variations in drug costs. I get that point. We know about NHS Greater Glasgow and Clyde, because the committee visited the new robotics centre in the south of Glasgow. We know about the health board's ability to deal with polypharmacy and about the efficiencies in the system. We get the idea that there can be variations based on performance and best practice, but that was only half of my question.

The other half of my question—which I do not think the witnesses addressed—was about whether there is a matrix or framework whereby NHS boards report to the Scottish Government in a consistent and comparable manner and what the methodology for that reporting is. Is there scaffolding—for lack of a better expression—or a framework around the returns that boards have to give to the Government? All that we have is numbers, and there are variations. I take on board all the reasons for the variations, but we do not have an explanation of whether the boards collect the figures in a consistent and comparable way. That is what we need to know. If such collection has never been done, it is not a matter of blame, but I want to get to a position in which it is done.

The Convener: I ask the witnesses to address the broad issue and not just the issue of drugs. The broader question is about making comparisons. Every time that we make a comparison, we get a long explanation about why there is a variation in Glasgow or a rural area. The important point is the consistency of the information that is being put before us and whether boards use the same methodology to collect the information. In some cases, boards do not collect the information at all.

Paul Gray: That is entirely understood.

John Matheson will help us to understand how we collect the information and the framework that is used, both of which are consistent.

John Matheson: I will make this succinct.

There is a corporate finance network, in which the senior directors and deputy directors of finance come together to review the planning assumptions and look at the consistency of approach across pay and prices.

We get individual returns from boards and respond to them. For example, we might say to NHS Ayrshire and Arran that the average across Scotland for drug inflation and volume increases is X, and it looks as if the board is an outlier. We will ask the board to review its position, and it will either change its position or confirm that there are specific reasons why it is an outlier.

There is a basic framework in place through the corporate finance network, which brings the planning assumptions together for the next year and the two or three years after that. A review mechanism is built in whereby the returns are played back to the boards to allow them either to confirm or to moderate their assumptions.

Bob Doris: I will ask you a final question about this, and I will then come off process and allow my colleagues to ask different questions. The question is, however, important.

I am partially reassured that there is a corporate finance director framework, and dialogue between the finance experts in each of the health boards and the Scottish Government on outliers. I understand all that. My point is about the reported figures that the committee sees. Are you saying that those are collected in the same way to the same framework and that therefore we can compare them directly?

For example, NHS Ayrshire and Arran has a 2 per cent assumed price uplift for hospital drugs and NHS Borders has a 13.6 per cent assumed cost uplift. Can we say that the difference must be because of demography, and not because Ayrshire and Arran has taken generics into account and Borders has not, or because Ayrshire and Arran has done a better horizon-scanning exercise on future cost pressures than Borders has? In other words, are the numbers collected in a consistent way, so that there can be scrutiny other than waiting to see what is collected and asking outliers to explain themselves?

I will not come back for a follow-up question on that point, because I want to come off process, but it is quite important. I have picked drugs because that is what the information in front of me is about, but it could be any part of the NHS. Is the process giving us good budget scrutiny? I understand that there is perhaps good budget scrutiny between the Government and the health boards, but the process should be a three-legged stool with this committee as well. We want to be part of it.

John Matheson: I recognise the critical role of this committee.

The aim here is that the core planning assumptions, which would include those factors that you identify, Mr Doris, if we focus specifically on drugs, are included within the planning assumptions of the boards. Any differentiation is a differentiation in terms of the impact of those core planning assumptions and not the absence of them.

Bob Doris: Okay. I will reflect on that rather than ask a follow-up question, convener.

Paul Gray: Would it be helpful if we set out for the committee in writing the basis on which the financial plans are constructed, scrutinised, and reviewed at the end of the year? Would the committee find that helpful? We would be very happy to do that.

The Convener: I am sure that we would find that helpful.

The follow-up questions would be how important the information that you are gathering is and how important it is to push forward your strategic plan.

How do you build in risk, such as politicians complaining about access to very expensive end-of-life and cancer drugs, which the health boards were squealing about? How do you build in the risk that politicians will announce an £80 million fund for rare diseases that is then in the newspapers? How do you build that risk into all of this strategic and financial planning?

John Matheson: I will make an offer in addition to Mr Gray's offer. I would be happy to explain why there appears to be a differential outcome for a couple of boards, if that would be helpful.

The Convener: Yes.

John Matheson: In relation to the £80 million new medicines fund, the health boards will look at their individual cost profile against that, we will have a horizon scan from the SMC of what drugs are coming through the pipeline over the next financial year, and there will be the impact of individual patient treatment requests and of orphan or ultra-orphan drugs. As Dr Calderwood pointed out, because those drugs are low volume and high cost there is a very different profile for them across Scotland. For example, eculizumab—for cystic fibrosis—is given to a very small number of patients across Scotland, but the cost of the drug is several hundred thousand pounds.

The Convener: It may be useful to compare reality and the pressures that are on the system against those budget plans. I have been on the Health and Sport Committee for several years and, for a number of years now, we have been talking about controlling the price of prescribed drugs. We are still at it, and we have estimated that drugs going off patent would generate X amount of money and that that would reduce the drugs bill, but it has not happened to the significant extent that we expected.

However, we are focusing a bit too much on drugs here. Maybe we will get a wee bit more coherent as we move on. We are trying to see where the budget planning is pushing along the priorities and long-term strategies of Government for moving the delivery of care away from clinical settings and into community settings. We have heard about all the pressures that affect budgets and, obviously, some of the priorities. We are trying to get to the heart of that.

John Matheson: May I just make one point? We are quite rightly focusing here on the cost of drugs, but our focus when we look at how drugs are utilised is as much, if not more, on the variation in patient harm and so on, to ensure that we have a clinical focus in how we review the drug expenditure.

The Convener: It could be drugs, or it could be workforce planning.

John Matheson: Indeed.

The Convener: We assess the health of the health service on the basis of how many doctors and nurses we have. That is an old-fashioned idea now, but we still do it. We spend inordinate amounts of money recruiting people outwith the recruitment and budget plans. That is what we are struggling with here, as a committee.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I begin by congratulating John Matheson on his honour, which is much deserved.

I want to focus on the question of the incremental cost of achieving targets. There is no doubt—I think that the whole committee would agree—that targets have served us extremely well since the Parliament was formed. They have driven forward performance in a way that had not previously been possible.

However, it was quite clear from both a freedom of information request that I made and the evidence that we heard last week that there are some problems. First, in response to the FOI request, the overwhelming majority of finance directors could not tell me the incremental cost of achieving targets—the cost of pushing that final group through. Last week, we heard from Derek Lindsay of NHS Ayrshire and Arran an example of where the board had to pay consultants three times the normal rate to get them to undertake a waiting list initiative.

All the finance directors agreed last week that the cost of achieving that final element in the target, particularly when it is a 100 per cent, legally required target, is a huge cost to the health service that is not a wise way to spend money. Do you think that this committee as a collective, in a way

that has nothing to do with party politics, should be joining the call from the Royal College of Nursing this week to look at whether those targets should be modified for this period of austerity, so that we can spend our money more wisely? What are the costs, do you ask for them and is the money spent wisely?

09:45

Paul Gray: Dr Simpson, you are right to say that it is hard to determine the incremental cost of meeting the last 1 or 2 per cent of any particular target. That would apply to the treatment time guarantee and doubtless to other targets too.

If someone is being paid three times the standard rate, he or she has been asked to work at the weekend and that is the rate that applies. If a waiting time or other high-profile target is being addressed through an initiative, some costs will certainly be incurred and it is possible to calculate what those are. However, the overall cost of meeting the last percentage points of a target is not something that we routinely collect.

You ask whether I think that the committee should join the RCN and others in seeking a review, particularly of the treatment time guarantee. It would be for the committee to decide its own position. As the chief executive of the national health service, however, I must and will be committed to meeting the treatment time guarantee for as long as it is a legislative requirement. I cannot do otherwise.

If the committee, on the basis of the evidence before it, felt that it ought to press for a change in the legislation, that would be a matter for the committee. The last percentage points of the treatment time guarantee target cost money to meet, and some clinicians have questioned with me whether, at the far end of the target, it is clinically necessary to meet it in every single case. Those points having been made, I must nonetheless proceed on the basis of the legislation.

The Convener: It goes back to our original question.

Dr Simpson: The issue is the data collection. The committee cannot make a recommendation unless we understand what is involved. Until we get some modelling, which I am really surprised is not being done, of the incremental costs at the far end of meeting a target—or not meeting it in the case of the 10,000 Scots who did not get the legal guarantee last year—we cannot make a recommendation.

We are not even reaching the treatment time guarantee target. I know that the fractions are small. We are 99 per cent there, which is fantastic and a great achievement. To force the system to achieve that final 1 per cent, or indeed not achieve it, is costing us a fortune that could be much better spent in other areas. Nevertheless, unless the centre can supply the data and get the boards to do the modelling, there is no way we can make recommendations.

Paul Gray: I am happy to take from the committee a request that we first establish what we have available. I will discuss with ministers, because ultimately it will be a decision for them, what more we might do to collect information about the incremental costs of meeting the last percentage points of the target. I am happy to take that away.

The Convener: When we decided to improve the waiting time targets, did the people who were constructing the budgets not say, “That’s a great idea, minister, but this is what it will cost,” or did that not affect this budget process at all? Did they just say that that was fine, with no information about cost and outcome at the heart of the decision to go further? Is that what we are hearing today?

Paul Gray: What I am saying is that I cannot speak for the advice that was given to ministers at the time. Of course, advice to ministers is private, as the committee knows. The decision was made through a parliamentary process. The legislation was scrutinised in the normal way. There would no doubt have been the normal costing information associated with that.

What we were not asked to do once the legislation was implemented was collect information on the incremental cost of meeting the last few percentage points. Therefore we do not have a system in place that routinely does that. I take it that the committee is telling me that it would be interested in having information on that. I will raise that point with ministers and come back to the committee quickly on it.

Bob Doris: I will make this very brief, because I have already had an opportunity to come in. On Dr Simpson’s point about a 100 per cent treatment time guarantee, whether it is 100, 95 or 90 per cent, as soon as you set a target with a number you will always at some point be just 0.5, 1 or 2 per cent away from meeting it. If targets are reduced from 100, 95 or 90 per cent, is the principle not just the same that to meet the target in absolute terms requires additional costs to be met? It is not that the target sits at 100 per cent; it is that, as soon as you put in a target, when you are just short of that target there is one final heave required to get over the finishing line. Is that a reasonable thing to say? We should not just focus on the treatment time guarantee; we should look at the additional cost to reach any target. It is for

the politicians to decide which targets we believe are most important.

The Convener: Can we broaden this out? We heard that it is not just about money. We heard that these targets were driving the priorities more than the planning frameworks. It is not just about money; it is about how the targets are diverting us from some of our other strategic objectives and policy. That is what we heard last week.

Paul Gray: I will bring in Mr Connaghan in a second, convener. The chief medical officer might have a comment on the clinical aspects of this, but let me try to cut this up into three parts. First, there is a difference between a 100 per cent target and a 95 per cent target, such as we have in accident and emergency. What we are saying for A and E is that it will not always be clinically appropriate to have someone seen, treated and discharged from A and E within four hours. Most of the time it will—the clinical advice is that it is appropriate in 95 per cent of cases. In the past few days, a person in one of the A and E departments in Glasgow was there for well over four hours. Throughout that time they were receiving appropriate treatment and care, but they were too unwell and unstable to be moved; it would have been wholly inappropriate to take them out of A and E within that four-hour period. A 95 per cent target, with some flexibility for clinical judgment, is different from a 100 per cent target.

Secondly, the cost of meeting a 95 per cent target will be driven somewhat differently from the cost of meeting a 100 per cent target. There is a degree of flexibility for clinical decision making in the A and E target that is not present in the treatment time guarantee.

Thirdly, I am slightly hesitant to say that targets are one thing and priorities are another. It is a priority to see, treat and discharge people from A and E within four hours. That is a priority as well as a target—although we now call it a standard. I would not like to go as far as to say that targets are deflecting us from our priorities. However, I take the point that the committee is making that, if the expenditure to reach the last fraction of a target is proportionately excessive and does not deliver clinical benefit, that may be something that we should look at.

John Connaghan (Scottish Government): It is probably worth remembering where we were back in 2005-06. At that point, the NHS had what we called a performance assessment framework in which there were more than 200 individual targets. Boards were complaining that they did not know what the priority was—they needed some focus in what they were doing—and out of that came the system of health improvement, efficiency and governance, access and treatment, or HEAT, targets, which was established in 2006-07.

As of today, having listened to the advice that we have taken from the committee and through consultation, we have 20 standards in the NHS. I agree with the committee that they drive investment in certain respects. Those 20 standards can be subdivided into seven broad categories: cancer standards, mental health standards, waiting times, infection rates, finance and governance, emergency services and some standards broadly around health improvement. Those are all-important for both the health of the population and the efficiency of how we deploy our budget.

When we engage with bodies such as the College of Emergency Medicine on what is appropriate, they invariably say that they really do not want to move away from the four-hour A and E standard, because it is important. We do take advice on our standards.

The point about the incremental cost is a moot point, and I have some sympathy with Mr Doris's view. If we were to make the target 15 weeks instead of 12 weeks, there would still be an incremental cost associated with the 15th week—if I can put it like that. The tighter a particular standard is drawn, the more there is an argument about incremental cost. As you heard from the director general, we will supply some information on that.

Dr Calderwood: The four-hour A and E waiting time target is a process measure—it does not tell us how good the outcome is at the end of that time. However, it is based on evidence that the longer someone spends in A and E, the poorer their outcome will be and the more harm will potentially occur. The targets are proxy measures that are driving clinical improvements.

We do have outcome measures—the cancer standards are more along those lines. We know what percentage of patients survive for five years, for example. However, the targets are proxies for our quality-of-care measures because it is very difficult to measure the quality of care. Not everyone will have a good outcome, but we want them to have a good quality of care in our NHS even if we cannot prevent a poor outcome.

We need to understand that the four-hour waiting time is based on good, sound clinical advice. It sounds like just a number, but the targets are always being developed with patient care and patient outcomes behind them. With the RCN having recently raised the issue of the need to look at the targets, we know that it is an evolving process. As Mr Connaghan said, we have changed over time, and I think that we would always be willing to revise targets and standards partly because the way we work in medicine changes.

The Convener: That engagement has been important in making the point that there has been progress. I recognise that, at the moment, there are a number of targets—there are also HEAT targets, performance targets and whatever. There seem to be an awful lot of them. However, compared with what we had, there has been a reduction in the number of targets. As we picked up last week, gathering this information does not really tell us much. It can tell us, for example, how many people died in hospital as opposed to in the community, so that people can boast about the fact that more people are dying at home, but there is no reference at all to the quality of the care or the engagement.

I hope that you see where the committee is going with this. Can there be more clarity? Do we need more clarity and focus? Dr Calderwood made a good point in asking how we can measure quality and the impact on patients in all this.

I will let Richard Simpson back in, because he might want to speak to some of the other headings, but I will let Richard Lyle in first.

10:00

Richard Lyle (Central Scotland) (SNP): A number of years ago, I wore glasses because I had cataracts. I then had cataract operations on both eyes over two weekends at a time when the number of people waiting for cataract operations was halved.

With the greatest respect, I have to ask this question, because it is on something that has always annoyed me. Does it annoy you when politicians from whatever party interfere in the NHS and say, "Change that target, put that target up and put that target down"? How much does that annoy you? [*Laughter*.]

Paul Gray: I will answer for all of us, in the interests of diplomacy.

If it was my stock in trade to be annoyed by politicians, I would not be a civil servant. Politicians are elected, and I respect that. I respect the democratic right of the people of Scotland to elect the politicians of their choice, and I respect the right of the politicians to decide. We are here to advise; politicians are here to decide. I am perfectly happy with that. If I allowed my personal views, or what might annoy me, to enter into my judgments about what I do, I would not be doing my job professionally.

I welcome the challenge and scrutiny of committees such as this, and I welcome the challenge that politicians of all parties provide. Generally speaking, every politician that I have met has a motivation to make things better. They may have different views about how that should be done. I respect the right of the politicians to take the positions that they take and I will work with that.

The Convener: That was a good answer—a politician's answer.

Richard Lyle: Along that line, at the end of the day we have targets, but should we not ask politicians from every party to sit down and agree where we are going with our health service? It annoys me intensely—I have to say it again—that the NHS becomes a political football that every party takes a swipe at; we are all in that game. Based on the points that Richard Simpson has correctly made, should we sit down and give you clear direction that every party signs up to and, once the parties have signed up to it, stop throwing bombs at the NHS?

Paul Gray: Certainly, the more consensual the decisions about the NHS are the better, as far as I am concerned. I do not deny that it makes my life easier if there is agreement about what the propositions, solutions and outcomes should be. That said, I would not want to stifle healthy debate about the future direction of the national health service. It is a complex and multifaceted system that does not operate in a vacuum; it operates in the context of all the other public services that are provided, the demographic trends that we face, and health and social care integration.

To suggest that there will ever be one simple solution to the problems that we face would be naive of me. I would not want to stifle debate about the options that are ahead of us, but at the end of that a consensus will certainly make it easier to implement.

Dennis Robertson (Aberdeenshire West) (SNP): I want to widen the scope a little to look at how you evaluate and account for the preventative care aspect. Mr Gray, you and your colleagues have mentioned improvement several times. When you are looking at that, does improvement equal efficiency and does efficiency still look after patient care? At the end of the day, we would like to prevent people from going into hospital and to look, perhaps, at other integrated services. How do you account for that broad aspect of prevention, given that, as Mr Gray said, the variables across all the health boards are complex and multifaceted?

Paul Gray: Evaluating the efficiencies or savings that are delivered by preventative interventions is hard, because it involves making a judgment about what did not happen as a result of the intervention that was made. Nevertheless, there is evidence across a range of preventative spend that early intervention is cost effective.

For example, it could be argued that the early years collaborative and the raising attainment

collaborative are preventative measures. They are helping people to intervene with a child and family early in the life cycle of a child in ways that are co-produced rather than superimposed. There is clear evidence that, by doing that, the life chances of children are improved.

I cannot say explicitly or absolutely that there will be so many fewer visits to hospital, so many fewer interactions with the criminal justice system and a better educational outcome for every child. However, I can say that the evidence suggests that early intervention in those circumstances means that the life circumstances of children are improved, and that is something that we want.

One example in a narrow health setting would be the hospital at home service. I have seen that in many places, but I will pick Lanarkshire as my example today. The service prevents elderly people from going into hospital and I have spoken to patients and families who have benefited from it. The outcome for the individuals is definitely better. Mr Robertson asked whether improvements are all about efficiency and what we think about outcomes. There is no doubt in my mind that the outcome for the individuals is better, even to the simple extent of a lady being able to give an account to me of spending Christmas at home with her family instead of spending it in a hospital bed.

Dennis Robertson: I understand all those points, Mr Gray. However, I am trying to ascertain how you account for that from the budget perspective. How do your directors of finance model that into the framework across all the boards?

Paul Gray: I will stick with my example of hospital at home, but the point can be applied more widely.

I have asked that further data be collected not just on the outcomes, although they are really what we are striving to achieve, but on the relative costs. In the example that I gave, we are reducing the pressure on accident and emergency and unplanned admissions to hospitals, but we are paying the cost of having, in this case, a senior consultant geriatrician and a number of other clinicians working alongside that individual in Lanarkshire. That cost has moved out of the hospital into the community. We are not yet absolutely clear whether the net cost is the same or lower, although we do not believe that it is higher. I am being honest with you about that.

I will ask Mr Connaghan and then Mr Matheson to add to that.

John Connaghan: For the past few years, we have published a number of case studies in which efficiency and productivity gains have been realised while benefiting patient care. Mr Robertson asked how we account for such things. The annual report for 2014, which is about to be published, contains about 50 case studies, most of which have some quantification.

A small example is a case study in NHS Lothian about how to promote quality and cost effectiveness in the use of wound dressings. This is not just Lothian blowing its own trumpet; it is a series of examples that are applicable to most boards. We encourage most boards to adopt those good principles, and there are other examples. We have been publishing such annual reports for about four or five years.

John Matheson: I will make one generic point and will then give two or three specific examples. The overall strategy that we have in NHS Scotland is the quality strategy, and its thrust is safe, person-centred and effective care with people being treated at home or in a homely setting. Our sub-strategies all point in that direction and support that. From a preventative perspective, prescription for excellence looks at how we can strengthen engagement with community pharmacists to reduce the number of unnecessary admissions that are due to medication errors. At the moment, the figure is about one in seven—Dr Calderwood can correct me if I am wrong. More proactive engagement with community pharmacists would result in a reduction in harm.

Within our overall financial strategy, we identify specific sums of money to take forward that preventative agenda. For example, we have a specific investment in telehealth and telecare, which looks at home monitoring and the use of technology to delay admissions. Another example is in the Scottish Ambulance Service, where we have just invested a sum of money as part of an on-going programme to upskill paramedical technicians to enable them to assess and stabilise people in their homes instead of taking them to A and E departments. Strong community engagement is then needed, through community nursing, social care and so on, to allow those people to be kept in their homes. Those are two specific examples in the context of our strategic direction.

Dennis Robertson: I dare say that, if there is community optometry, for instance, and people have regular eye tests, that can prevent trips and falls. However, it is all pretty subjective, is it not? What monetary figures do you assign to the strategy? Finance directors will have to come up with costings for the strategy in their budgets.

The Convener: We are looking for the definition of investment that is specific, appropriate and sufficient to drive more people being treated. There are no targets to ensure that X number of people will be cared for in the community, at home or close to home or that the number of hospital

admissions would halve if people could get follow-ups through the system. I suppose that what we are seeing is the absence of a number of features that we take for granted in the NHS setting—prioritisation, quality of outcome for the patient, guidelines and standards that apply, targets to drive the activity and budgets to support it. Where are the equivalent features in the community and the integrated boards? Are we investing enough to drive the change over a period of time?

Paul Gray: The outcomes for the integrated joint boards are set in legislation—they are clear. The budgets for the integrated joint boards are subject to scrutiny and this is the shadow year. Going back to Mr Doris's earlier point, there is variation in the budgets of the IJBs that is not all explained by the demography and geography of the IJBs; it is also explained by the fact that there are certain things that they must include in their integration scheme and certain things that they may include in it. Different integrated joint boards will decide to include different things.

I realise that I am describing to you the things that always make comparison harder, whereas you are asking how we can make comparison easier. There is no straightforward answer to that, as different factors apply in each board and in each integrated joint board. However, each board operates to the same financial standards, each territorial board operates to the same performance standards and each integrated joint board operates to the same set of outcomes, which are set in legislation. To that extent, there is commonality.

The question, which is legitimate, is about how I assure myself, as the accountable officer for all this, that the different portions of money—the different budgets that are set in different places—are all going to add up to the outcomes that we want for the people of Scotland. The answer is that I do that through a series of assurance processes that already exist. I have to accept some of the assurances that I get on clinical and financial matters from the people who are expert in those matters. Nevertheless, I can look at a series of assurance and governance mechanisms that help me to draw that together into a single picture. I am confident that what we have in place currently provides me with sufficient assurance. I am equally confident that it could be better. There are areas where we could improve.

In the year of the shadow integrated joint boards, we will look to review and analyse the propositions that the integrated joint boards have put forward and to learn from them so that, when we come to the first full year of operation in 2016-17, we will not simply walk into it as though this year had not happened.

Dr Calderwood has a specific example on maternity services, which may be of assistance to the committee.

10:15

Dr Calderwood: I am delighted that Mr Robertson has asked about preventative spend. As he may know, I am an obstetrician, so I am always telling my colleagues that, if only they invested in the pregnant woman, they would have a healthier baby, who would grow into a healthier child and adult. In fact, I could solve the problems around the costs of the NHS in future.

Dennis Robertson: You have got the job.

Dr Calderwood: Thank you.

I am sure that the committee is familiar with quality-adjusted life years and the question of how much we need to spend in order to have one more year of quality life. The prevention of pre-term delivery is the ultimate opportunity. If babies grow up to live long and healthy lives, they live very long lives. The prevention of pre-term delivery costs only £300 per QALY, whereas we would deem up to £10,000 as offering value for money.

The investment is difficult, however, as it is multifactorial. The Scottish Government has invested in a maternity safety collaborative, which involves reducing all sorts of problems in pregnancy, such as smoking, which would, in turn, prevent pre-term delivery. The difficulty in measuring that is that, if we also reduce all sorts of other issues, there may be knock-on effects on pre-term delivery.

The boards have invested £1 million across Scotland in maternity champions, who seek to tackle all those outcomes for pregnant women. If we went back to them and asked how much they saved, it would be difficult to quantify an answer. We can already see a very impressive reduction in the stillbirth rate. We know that the smoking ban across Scotland has generally reduced the pre-term delivery rate. However, it is extremely difficult to say that we spent X and gained Y. Nevertheless, I commend Mr Robertson for continuing to ask that question.

Dennis Robertson: I am trying to get at the matter of efficiency. Every board is asked to have efficiencies—a reduction, I suppose. I am concerned about how they prioritise and what falls off the end, or what is not happening to attain those efficiencies. To get the outcomes that we are looking for, are we not delivering a particular aspect of care to a patient? When you are asked to prioritise, does something have to give? If so, what is it? Is it around the preventative spend or through the joint integrated boards? I am trying to work out what happens to the spending. We have

finite resources, and everybody has their own budget. Every board is being asked to make efficiencies, but how do they prioritise?

Paul Gray: I will ask Mr Matheson and Mr Connaghan to come in on that shortly, but I will first share with you an area where I am currently taking steps to see if we can improve. I am concerned that, in the pursuit of efficiency and delivery, we are underplaying our hand on developing leadership capacity in our workforce.

Dennis Robertson: Does that equate to improvement?

Paul Gray: Well, it would, you see. Leadership capacity is, in my view, one of the keystones of prevention. It prevents things from going wrong. For example, we have had a very helpful and robust conversation with the Academy of Medical Royal Colleges and Faculties in Scotland. In part, that has been about the extent to which consultant contracts allow sufficient time for consultants to develop themselves and their leadership capacity.

Although I have not sought to impose a particular solution on health boards, I have told them in writing that I expect them to be flexible in setting up and reviewing consultant contracts. I attach great importance to senior colleagues in the NHS, whether they are clinicians, administrators or whatever, having the time and space to develop and exercise proper leadership. If they do not, the impact of that can be high. That area is perhaps overlooked when considering prevention, but I see a strong link between leadership capacity and prevention.

Dr Simpson: I made an FOI request 18 months ago, which I am just repeating, on the consultant contracts. The standard consultant contract is split 7.5:2.5—7.5 sessions are to be spent on direct clinical care activities and 2.5 sessions are on supporting professional activities, or SPA. That is the nationally agreed contract.

However, 60 per cent of all the consultants appointed since 2011 are on contracts that are split 9:1. How does that fit with your concept of leadership, if we are requiring our consultants to have only one session for audit, research, leadership development, continuing professional development and training of staff if they are not in a teaching hospital? That really does not fit with what you are saying. I entirely agree with what you say about leadership, but the approach is not working.

In the same FOI request, I asked how many consultants are converting their contracts. It might be argued that, as consultants are starting younger now, they do not have the same breadth of experience, so they need to do the clinical work for a year—that is what Tayside NHS Board told me when I raised the matter originally. I asked how many consultants were converting their contracts to 8:2 or 7.5:2.5 after a year or two. There is very little sign of conversion.

I agree with you about the importance of leadership, but we should start by monitoring the contracts of those clinicians. They are complaining quite strongly about being overworked and stressed, and we have the highest number of consultant vacancies that we have had for a long time in the health service. You cannot control that from the centre; it is the health boards' responsibility. However, we have the national contract. How do you monitor it, what advice do you give the boards and how does it fit with your leadership plans?

Paul Gray: The simplest thing that I can do is share with the committee what I wrote to the health boards and what I agreed with the Academy of Medical Royal Colleges and Faculties in Scotland. I would be happy to share that. Dr Calderwood may have something to say in the meantime about the approach that we are taking to consultant contracts and to ensuring that consultants have sufficient time to develop themselves and the people around them.

Dr Calderwood: My colleagues have been raising the matter with me, particularly in some health boards where the national contract has been applied more stringently. We need to remember that, although 60 per cent of consultants appointed since 2011 are affected, that is a very small number of the total consultant body.

We also need to remember that departments now have many more consultants. That perhaps provides an argument that not everybody needs all of the time that was needed previously to do the extra things. For example, in emergency medicine, there has been a 170 per cent uplift in consultant figures over a very short time.

We are talking to the clinicians about the standard contract including one SPA session. However, if consultants come to an interview or job plan and say that they are, for example, teaching a session and involved in college work X, Y and Z, which can be defined as time that is being spent properly and that the NHS is getting good value for, they can take that negotiating stance with their health boards.

We worried that people were being automatically given that time, which is a lot of additional time in a week if it is not being used efficiently and effectively. There was evidence that the time was not being used efficiently—people were going home early or doing other things with it. With proper job planning, those sessions can be allocated, but only if they will be used properly for

additional improvement to patient care through teaching and so on.

The Convener: Does anyone want to come in on wider workforce planning and the overall strategy to treat more people at home or closer to home? Some thinking has been going into that. When consultants are not at the hospital—because they are at a conference or a training session, for example—that impacts on the rota, weekend cover and so on. Such issues may make the job less attractive in smaller health boards, as I recall from my experience in Inverclyde.

What is the response through workforce planning? How do we view the total workforce, not just the consultant end? It is not the consultant who provides day-to-day, hour-to-hour care at home. What is happening there?

John Connaghan: About a year ago, I gave evidence on the same topic. I said that we needed to consider workforce planning as part of a triangulation that involves looking at what service we want for the future and at the available resources. We have a comprehensive framework—if we have not given that to the committee, perhaps we should do so.

At the broadest level, the framework has three big principles: designing the future workforce, which means having an understanding of what impact new services will have on the current and future workforce; developing the workforce—Mr Gray referred to one element of that, which is leadership; and delivering the future workforce. I will not go into the details of the framework now, but it lays out a clear step-by-step methodology that we expect each NHS board to follow. We call it the six steps methodology and it is contained in the guidance.

The Convener: Does that focus on the NHS workforce? Does it recognise that the new strategy will include the private and voluntary sectors, too?

John Connaghan: It will also include the integrated joint boards.

The Convener: Does the framework include what I mentioned? Does it talk about the NHS workforce or does it take a broader view of the workforce and the strategies?

John Connaghan: The guidance that we have concentrates by and large on the NHS workforce. It refers to the fact that planning for other groups, including voluntary services, should be taken into account.

The Convener: Mr Gray, can you tell us what else is going on to join that up?

Paul Gray: When I came into the role of chief executive of NHS Scotland, I became chair of the leadership advisory board. When I took over that board, it was a health service leadership advisory board. I changed that. The second meeting of the new leadership advisory board is tomorrow and will include representation from social work, social care and the third sector. I changed that deliberately because I did not see how we could construct a leadership development offering that was narrowly restricted to the national health service.

In the directorate that is responsible for the integration of health and social care, under the leadership of Geoff Huggins, we have a specific work strand on workforce development, which recognises that we are asking colleagues from health, local government and the voluntary sector to work together in new ways and that simply saying that it is a good idea and that we hope that they will get on with it is wholly inadequate. We need to provide workforce development across all the elements of the workforce.

10:30

The Convener: Are there budget allocations to drive that?

Paul Gray: Yes.

The Convener: Is that additional money?

Paul Gray: To use a phrase, it will be within existing allocated budgets.

Dennis Robertson: How do we assign the budgets for that efficiency? We did not get to that and I am not clear about it.

Paul Gray: I am sorry; I am not getting that.

The Convener: Dennis Robertson is asking for an answer to his question about how budgets for integrated boards are assigned; there are some differences on that issue. I think that you responded that this is a shadow year, and you acknowledged that there are some differences, but I do not think that that satisfied him. Does Dennis Robertson want further clarification?

Dennis Robertson: I asked the question because we have considered all other aspects. Efficiency equals improvement, and I am trying to find out how we assign the budgets. This is about priorities. Does something fall off the end if we need to prioritise because we have set efficiency targets?

Paul Gray: In the leadership discussion, I was giving an example of something that I was concerned might be given less priority because of the pressure on delivery. I had a discussion with the Academy of Royal Colleges, and concern was expressed that newly appointed doctors and consultants would be given less time for personal development because the focus was on getting people through A and E or the hospital, and that

would not be to the doctors' benefit. Mr Matheson will speak in a moment, but efficiency is not all about stopping doing things; sometimes it is about doing things in a completely different and innovative way and changing completely how we deliver a service.

To give one simple example, a gentleman in Cumnock with chronic obstructive pulmonary disease would have received regular visits from a clinician or gone regularly to a place where he could be cared for. He can now have most of his care, and the diagnosis of any difficulties linked to his condition, conducted through telehealth and a videolink. I have seen that in operation; it is far more efficient and far better for the individual concerned. That was not stopping doing something; it was doing something in a completely different way. The efficiency gain accrues to the individual and the service. Does Mr Matheson want to say more about that?

John Matheson: To me, efficiency is doing what we do at the moment in a way that is not necessarily cheaper but is more cost effective. Innovation is doing things differently and in a more radical way. For efficiency, we consider procurement, not just of drugs but of general supplies. We have a national procurement service, and the NHS in Scotland is considering health and social care integration and how expertise can be used more broadly across the public sector. We consider locum expenditure, both nursing and medical, and how it can be reduced. When I mention financial performance and efficiency, I mean quality-driven financial performance. If we get the quality right, the money tends to go in the right direction.

In Scotland we have eight innovation centres, including two in the health service. The digital health institute has just moved from the centre of Edinburgh to Eurocentral in Lanarkshire. There it will set up a simulation laboratory with a ward and a home environment, which will allow small and medium-sized enterprises to come in and show their products and innovative practices in a real-life environment. That will allow clinicians to take a view on the applicability of those things.

We have delivered £1.4 billion of efficiency savings in the NHS in Scotland over the past five years, and that has been reinvested in the health boards. Mr Gray mentioned the performance at the end of 2014-15, which was just under £300 million, and boards have identified a further £300 million of efficiencies and innovative practices going into 2015-16.

We will look at that closely to ensure that that is about sharing and delivering best practice, so that the efficiencies identified are consistent with and do not step back from our strategic direction. The efficiencies made have been positive, but we must be more innovative about where we look for solutions.

The Convener: On the 3 per cent efficiency savings applied across the board, we have heard this morning that many of the boards have different challenges. For example, NHS Greater Glasgow and Clyde has a specific hep C challenge, which includes costs, while other boards could make savings on prescribed drugs, productivity, staffing and so on. How will boards such as Glasgow, which faces a disproportionate pressure, meet the required savings? How does the Scottish Government discuss with the boards the varying pressures that they face in the context of the efficiency savings?

John Matheson: If I gave the impression that there is a set target, I apologise. I was talking about the overall position in NHS Scotland. Boards have individual targets and, across Scotland, that averages out at around 3 per cent.

We assist boards to make efficiencies by identifying best practice. Mr Gray mentioned the Cumnock experience. We have a number of European projects that are looking at and sharing best practice on comorbidity. We look to ensure that boards are aware of that best practice.

Prescribing is a good example. To return to Bob Doris's point about generic prescribing, we have excellent performers in that area, and we share that best practice with the rest of Scotland. We allow people to learn from best practice.

The efficiency savings are identified at local level. When we see something innovative, we ensure that other boards are made aware of it, and the corporate finance network and other fora are part of that mechanism.

The Convener: Is a target in place for each board to achieve savings of 3 per cent?

John Matheson: There is an overall target across NHS Scotland, but individual boards determine their local needs—

The Convener: Coincidentally, that saving is 3 per cent across the health boards.

John Matheson: The percentage is not coincidental; that is what the saving rate has been over a number of years. We do not say that individual boards must achieve a 3 per cent target.

The Convener: What happens if they do not? What happens to the process if a board says, "This year, I'll not be saving 3 per cent. I'll not be saving anything, because I've got all these prescribing costs"?

John Matheson: That situation has never occurred. It would mean that a board would not achieve its statutory financial targets.

We ensure that boards have all the information on best practice—not just in Scotland, but internationally—available to them on how they can improve the efficiency of the services that they provide cost effectively.

The Convener: Glasgow has been mentioned twice. The board there has disproportionate costs in relation to the Beatson west of Scotland cancer centre, as well as the high cost of cancer drugs. It also has disproportionate costs because of the high levels of hep C in its population. We know that some of the measures that are taken will be preventative, so there will be long-term savings. How does the Glasgow situation play into the financial plan and the target? Is there a variance in the target? Is it flexible? Is there a recognition of Glasgow's situation?

John Matheson: There is flexibility. We give a differential supplementary allocation to recognise that, for example, the high-cost drugs for hep C are atypically weighted across the country.

Bob Doris: Mr Matheson has answered the question on hep C much more eloquently than I was going to put it. I understand that a lot of the new curative, revolutionary hep C drugs are coming to health boards through the new medicines fund. Will that deal with cost pressures?

I have listened to the talk about efficiency savings. I understand that it has been the case for the past few years that, if a board makes a 3 per cent saving by redesigning services, the moneys that are freed up stay in the health board. Is that correct?

John Matheson: That is absolutely correct and has always been the case. I made the point that the £1.4 billion of past efficiency savings have been retained and reinvested by health boards.

Bob Doris: That is fine.

Mike MacKenzie (Highlands and Islands) (SNP): I was interested in what Dr Calderwood said about the health economics of preventative spend. The interplay between finance and economics is an interesting one. We usually look at budgets and targets on a yearly basis, or perhaps at shorter intervals, yet the results from preventative spend often manifest themselves over longer timeframes. I am also mindful of Paul Gray's comment that it is difficult to do a financial analysis of the benefits of preventative spend.

My question is twofold. First, how do you decide how much of a budget to allocate to preventative spend in any given year? Do you just think of a number and double it or is there some rationale or calculation? Secondly, is there a higher, strategic-level overview of the planning of spend beyond the year-to-year finessing of and reacting to targets?

Paul Gray: I will bring in Dr Calderwood, Mr Matheson and Mr Connaghan, if he wishes, on that.

We expect all expenditure in the NHS to be based on evidence. On the question about whether we just put our finger in the air and say that we will spend 3 per cent or 26 per cent on preventative spend, the answer is that we absolutely do not do that. If a health board advanced a proposition for preventative spend for which there was no evidence base, we would say no. I can be perfectly clear about that. That is my answer to part one of the question.

On part two, Mr Matheson will speak in a moment about our long-term financial planning. We do that planning every year, not just for one, two and three years ahead but for five and 10, and we take it very seriously. We look ahead based on the demography and trends that we expect. In our case, those are the pressures of an ageing population and multimorbidity. We plan for services not just for now but for the future.

One of the things that I hope that the integration of health and social care will do is to help with the somewhat artificial barriers that meant that, if a saving was made in one place, the benefit accrued in another. Someone might therefore have asked why they would make a saving to benefit another organisation. I try hard to see public sector money as a whole rather than in a series of pockets. If I do something that helps the police service, I do not regard that as a bad investment. Rather than saying that I will not do something because it will save me nothing, the conversation has to be about what the police might do to help me in the future.

Dr Calderwood might want to come in on the evidence base for preventative spend, and then John Connaghan or John Matheson on the longer term.

Dr Calderwood: The public health aspects of preventative spend are all long-term strategies. Although the money is allocated year on year or three yearly, the Scottish obesity and smoking strategies and so on all have long-term goals, some with targets attached to enable us to keep working towards them. It is difficult to measure the financial impact on a person-by-person basis. We always go back to asking whether a measure will make a difference. The decision is definitely based on clinical evidence and, more and more, we have health economic evidence for everything that we do.

Let us take the example of our recent investment in in vitro fertilisation treatment for fertility problems. I was tasked with looking at the clinical evidence on what it would do for the success of the treatment if we were to change the criteria. Women who do not smoke and women

who have a healthy weight have much more successful IVF treatment. It could be asked why something would be given to somebody that would not be as successful if we know that something else would work more effectively. That treatment is relatively invasive. Some of the work is done on the basis of better clinical outcomes, but investment in preventative measures in society as a whole, particularly around obesity and smoking, is a much better use of our money in all sorts of other parts of the health service.

10:45

John Connaghan: I will give a practical example with some figures that might be useful.

I think that Mike MacKenzie is asking about a rational allocation model. One objective of enhanced recovery for patients who have undergone surgery is that they will spend less time in hospital and be able to spend more time at home. That work is led very impressively by our clinicians. It started in the Golden Jubilee hospital national waiting times centre a few years back. It was about mobilising patients almost immediately after joint surgery such that they were up and about and could go home earlier. There are also clinical benefits in reductions in catheterisation for patients. The results of a three-year pilot show that catheterisation halved in a select group of patients, and blood transfusion requirements have also halved.

Since that pilot started back in 2010, most boards have started to adopt enhanced recovery pathways. That will drive investment decisions on where they will put support in to achieve enhanced recovery. It will also drive future investment decisions on how much they want to spend on surgery—orthopaedics and so on—and how to recycle some of that money.

That is a practical, clinician-led change that started with a pilot. The investment in that pilot has been proven to have paid for itself many times over as we have rolled it out through the country. As we roll it out, different boards are at different starting points. Some change in clinical practice is involved. I use that as an example of why we can say that boards sometimes have differential savings targets as they go through the year, as boards might have started later, but are still pursuing the aim. We expect all boards to eventually get to a much more acceptable clinical model.

Mike MacKenzie: Thank you. That is useful.

John Matheson: I have a couple of comments to make on that. First, because we have annual financial targets on breaking even within a 12-month period, there is a potential tendency to have a short-term approach to financial planning, which is not sensible. A medium and long-term approach is needed.

The corporate finance group looks at planning assumptions over the next four or five years. Some of the major pressures that we currently face are from the pension increase in 2015-16 and the national insurance increase next year. We have known about those for the past four or five years. Finance directors have known about them and have included them in their planning assumptions. We have a 10-year capital plan, which was signed off by the previous cabinet secretary, and that will take us forward over that horizon. On the strategic direction, we have our 2020 vision and a financial plan that underpins that.

The other factor, which is an important one, is about not micromanaging the boards' financial planning and financial allocations. About three or four years ago, I introduced the bundling of discretionary spends so that the boards have flexibility in how they spent in that area. I have given the three island boards total discretion in 2015-16 for the first time. Rather than having just a reduced number of bundles, they will get one bundle of funding. They will still have to meet the targets and standards that are associated with those allocations, but they will have flexibility within that.

That has been generally welcomed by the island boards, and I would like to see that model going forward. It gives boards financial flexibility at the local level. If they do not need to spend money on alcohol services because they are meeting their target on brief interventions, they can divert that money into other local priorities.

Mike MacKenzie: I am struck by the idea of the rational allocation model, which is quite a sophisticated one. However, rather than this being a subjective and anecdotal discussion in which we all speak from the point of view of our hobby-horses, it would be good if you could share with the committee in writing some of the thinking or calculation that goes into the operation of the rational allocation model. It strikes me that that should be used in the context of guidance.

I take your point about the island boards, discretionary spending to suit local circumstances and challenges and so on, but it would be comforting to know that rational decisions are being made in the short term and the long term, bearing in mind the possibilities for preventative spend and the tension that will inevitably creep into any budgetary discussion about spending for the here and now and spending for longer-term benefit.

Paul Gray: I would be happy to write to the committee on those points if that would be helpful,

unless you would like Mr Matheson to say something about them now.

The Convener: It might be useful to have something in writing. You mentioned the 2020 vision, but I noted from recent statements from the cabinet secretary, including in the chamber last week, that people are starting to talk about the period beyond 2020 or even 2030. I do not know whether that has been tweaked for financial reasons or some other reason, but it would be useful to have a written note about the points that Mr MacKenzie raised in the context of discussions about the period beyond 2020. That would inform the committee and satisfy Mike MacKenzie.

Colin Keir (Edinburgh Western) (SNP): Earlier, Mr Gray talked about the public pot being one pot and not several. It might be that this was discussed earlier and I did not pick up on it, but I would like to hear more about the strains between the different sides that are involved in setting up the integration joint boards. Have there been any difficulties with people being a bit overprotective of budgets?

Paul Gray: All the integration joint boards delivered their schemes on time, by 1 April this year. I am absolutely certain that the health and local government components will have thought carefully about what elements of the budget they would put into the process. However, I would be hesitant at this stage about suggesting that either side has taken a protectionist approach. In the course of the year, we will look at the budgets with the partnerships. Ultimately, we have to give ministers an assurance that the budgets are sufficient to deliver the outcomes that the partnerships have been set up to deliver.

It would be fair to say that local government and health boards face pressures as a result of the demographic trends and the expected change in the health status of the population over time. However, I have seen good evidence of joint working. The rate of delayed discharge in Fife has come down considerably. I am certain that there have been some fairly tough discussions between the health board and the council—I know that there have been—but they have been committed to achieving a solution.

I do not mind if people have robust discussions. Frankly, it is sometimes worse if people feel that they all have very good relationships with each other and nothing much actually happens. I would rather that people got to the nub of a difficult issue, and I do not see that as protectionism or as in any way deviating from the overall standards that we set. It is important that people have robust discussions and I can see that, when they have them, results are produced.

That was a rather long answer to a short question.

The Convener: Thank you for that.

Nanette Milne (North East Scotland) (Con): I was going to ask about efficiency savings, but that has been dealt with, so I will change tack. Before I do that, however, I want to flag up for future discussion the emerging serious issue of the recruitment and retention of doctors in general practice. I know that there are other ways of delivering general practice, but that is becoming a serious issue in parts of Scotland, and we need to look at it.

I want to raise the issue of palliative care. Some boards said that it was not possible to separate general care from palliative care, while others gave information on either specialist care or general care. Is it possible to get data on palliative care costs? How can we improve the availability of that information? If there is no financial data, how can Government assess whether appropriate resources are being devoted to palliative care?

My next question is on the health boards' agreement to provide 12.5 per cent of Children's Hospice Association Scotland hospice funding, which is co-ordinated by NHS Tayside. I do not think that that agreement is being met by a number of health boards. Will you also comment on that?

Paul Gray: I got some information on the CHAS funding this morning, but it is not in my pack. I will have to write to the committee about that, because I did not think that it would come up. Getting that information would involve me switching my mobile phone on. I will not do that right now, but I will write to you on that question.

When someone receives palliative care as an element of other care that they are receiving, it is genuinely difficult to separate that out. We discussed that in an evidence session recently. I am clear that we could do more to separate it out, and in the evidence session I undertook to consider that further. However, the way that information is recorded at present does not make it particularly easy to separate it out, so you are right to ask how we know whether the resources are sufficient.

This is a slightly different point, but one of the ways in which I am seeking to advance the issue is by ensuring that more individuals have anticipatory care plans so that we will be much clearer about what individuals are looking for, particularly as they come towards the end of their lives.

Dr Calderwood, do you want to add anything on palliative care?

Dr Calderwood: Nanette Milne may already be aware that there is a commitment to a strategic framework for action on palliative care. I concur with Paul Gray that the difficulty that she points out regarding data and the way that we are collecting it, or rather not collecting it, means that we are not able to understand what is going on in different boards, which is perhaps why they cannot articulate the situation to your committee.

Stakeholder events and engagement events are planned in different parts of the country as part of the development of that strategic framework, and I will be keeping a very close eye on that to ensure that your concerns are brought up in discussion and we find a better way forward.

Nanette Milne: That is helpful. Anticipatory care planning is important. We know from organisations such as Marie Curie Cancer Care that many people who ought to be receiving palliative care are not receiving it. They need to be identified very early so that that care can be planned for. I look forward to receiving more information on that.

The Convener: Does that amount to a commitment to try to establish some sort of database of what is available?

Paul Gray: Yes, convener. We need to improve the information that we have. As Dr Calderwood said, through the strategic framework for action, we are seeking to improve the delivery of anticipatory care, our understanding of what people want through their anticipatory care plans and the information that we have, in order to assure us that palliative care is being delivered appropriately in appropriate settings. We absolutely want to improve things.

11:00

The Convener: I have seen some briefing papers, possibly from 2008, that show almost an audit of how many beds there were, who provided palliative care and so on. Is that baseline worth anything? Are we building on that or are we starting something completely new?

Paul Gray: We need to refresh what we have. The 2008 information is good as far as it goes, but it will not take us much further forward. I wrote to the committee about the issue fairly recently. In my previous evidence session, Mike MacKenzie asked how many people had palliative care plans and how many people needed them, and my answer was that I want, as far as possible, everyone to have a palliative care plan. For certain situations, including someone dying suddenly, an anticipatory care plan would not be either necessary or helpful. However, the evidence, such as it is, suggests that roughly 70 per cent of the population would benefit from having one. We are quite far away from that.

The Convener: Will you keep the committee up to date on that?

Paul Gray: Yes.

The Convener: Are there any other questions?

Members: No.

The Convener: Good. [*Laughter*.] That concludes the session. Thank you very much indeed for your attendance and the evidence that you provided.

I will suspend the meeting to allow us to set up for the next panel.

11:01

Meeting suspended.

11:06

On resuming—

Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill: Stage 1

The Convener: Agenda item 4 is evidence on the Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill. I welcome Simon Clark, director of the Freedom Organisation for the Right to Enjoy Smoking Tobacco. Thank you for attending. We have your written submission so, in the interests of time, we will go directly to our first question, which is from Richard Lyle.

Richard Lyle: I am a car driver and a smoker, and I do not feel threatened by the bill. Your position as expressed in your submission is:

"FOREST does not support the introduction of a ban on smoking in cars carrying children. We would encourage adults not to smoke in cars carrying children because, in our view, children should not be exposed to cigarette smoke in a small confined space".

You then go on to say:

"In our opinion however there is no justification for government to ban smoking in ANY private vehicle, with or without children."

How do you square your position? You say that people should not smoke in cars when children are in them, but then you say that the Government should not ban that.

Simon Clark (Freedom Organisation for the Right to Enjoy Smoking Tobacco): I do not think that you should ban everything that might not be wise. Parents should err on the side of caution on certain things. We have been saying for many years that smokers need to be considerate to the people around them, particularly children and particularly if they are smoking in a confined space. We do not condone it and we certainly do not encourage people to smoke in a car where there are children.

In the past 10 to 20 years, huge numbers of smokers have changed their behaviour because they realise that it is wrong. The reality is that few people smoke in a car if children are present. I would like to think that we could give credit to smokers for having changed their behaviour and become increasingly considerate to the people around them and children in particular.

For a number of reasons, we do not think that legislation is necessary. First, very few people still do it. People often ask about the seat belt law, which came in in 1982. As I understand it, only about 25 per cent of people wore seat belts at the time so it was decided that, to increase the number significantly, a law had to be brought in. We do not need to do that with smoking in cars around children, because the majority of smokers would not dream of lighting a cigarette in those situations. They feel as you do, Mr Lyle. They do not feel particularly threatened by legislation, but I do not see why we should bring in legislation when it is not necessary and so few people do it.

Also, as we might hear in the next session, a ban will be difficult to enforce. We might come on to talk about that later. You would be asking the police to enforce it. If someone is driving along at 20, 30 or 40mph smoking a cigarette, I honestly do not know how anybody would be able to tell whether there is a small child in the back of the car. The only way that it could be done would be to have spot checks and pull drivers over, which I think is a waste of police time.

Richard Lyle: I have two grandchildren. I have two child seats in the back of my car. I do not smoke in my car when my grandchildren are in it. At the end of the day, the police can spot someone as they are going along if they are on their phone. Most of the time, the police can spot someone if they do not have their seat belt on. I am sure that the police could spot it if there were two kids in the back of my car while I was sitting in the front smoking a cigarette—not that I would be doing that.

The British Lung Foundation Scotland told us that 19 per cent of children aged 11 to 15 and 51 per cent of children aged 8 to 15 reported being exposed to cigarettes and that research has shown that 86 per cent of children across the UK want people to stop smoking when they are in a car. What do you think of those figures?

Simon Clark: To be frank, I am slightly sceptical about them. Introducing legislation on the basis of surveys of children of that age is a bit dodgy. We cannot simply assume that children are being totally accurate when they respond to questions of that sort. I would like to think that, before legislation is introduced, proper hard evidence, not just the opinion of children, is taken into account.

Two years ago, University College Dublin did some research in which it monitored 2,300 vehicles during rush hour in Dublin as people were taking children to school. In those 2,300 vehicles, only eight drivers were smoking and of those eight, only one had a child in the back of the car. Similar research was carried out in New Zealand, although it was a much bigger survey covering something like 189,000 vehicles—a huge number. It found literally only a handful of vehicles in which the driver was smoking and there were children in the back. I accept that that research was in other countries, albeit English-speaking countries. I would like similar research to be carried out in Scotland to find out exactly how much of a

problem there is. In terms of the numbers involved, I do not think that there is as much of a problem as is being made out.

I believe in education, not legislation, if at all possible. Legislation should be a last resort. We would happily join the Scottish Government in a media campaign to encourage the handful of people who still smoke in a car with children present not to do so, saying, "Think of the children. This is inconsiderate. Don't do it." We should consider doing that before we go the whole hog and introduce legislation.

It is important that we do not stigmatise the vast majority of adult smokers. Introducing such a law would stigmatise smokers. It would basically be saying to smokers, "You don't know how to behave around children," which I think is wrong. The reason why the issue is important to us is that the bill is quite a symbolically important step. It would be the first time that smoking in a private space, as opposed to a so-called public space, would be banned.

Richard Lyle: The nub of your argument is that you feel that the bill is an encroachment on people's civil liberties. I smoke, and I smoke in my car, and I do not feel threatened by the bill. You are basically saying, "If you allow this, you will then ban everyone from smoking in their car. Where are you going to go next? Are you going to ban us from smoking in our house? Are you going to put us all on a desert island somewhere?"

One of your arguments is that the police should not enforce the bill and that environmental health officers should do it. What are we going to do? Are we going to station environmental health officers in streets? We certainly cannot have them driving round trying to spot a smoker. The police have done well with enforcing seat belt and car phone legislation so, at the end of the day, if the bill becomes legislation, I am sure that the police in their cars could spot someone who is smoking in a car with a child seat in the back.

11:15

Simon Clark: Obviously, I cannot speak for the police. They are going to speak on the subject a bit later. As a member of the public who does not know enough about the police's work, I would have thought that they have enough to do without another section of society being criminalised.

On pulling cars over to check that a driver who is smoking does not have a child in the back, you said earlier that the police can tell quite easily whether there is a child in the back—well, I disagree. These days, a lot of cars have tinted windows in the back, and the police will never see whether a small child is there.

We have serious concerns that, as soon as the bill is enacted, the anti-smoking lobby will come back and say, "Let's ban smoking in all private vehicles, regardless of whether children are present." We know that that is going to happen. Since 2011, the British Medical Association has been calling for a ban on smoking in all private vehicles, regardless of whether children are present. Action on Smoking and Health in London has published its five-year strategy in a report called "Smoking Still Kills", in which it calls for a consultation on banning smoking in all private vehicles. We know where that is leading—ASH wants a ban on smoking in all private vehicles. We will have a situation where a lone driver, sitting in his own car on his own, lights a cigarette and suddenly he is a criminal. He can be prosecuted for it. That is very worrying.

You say that we will not have a ban on smoking in the home if children are present. I certainly hope not although, likewise, I hope that parents will be considerate and perhaps will have one room where they smoke or will smoke in the garden. Let us face it, though: 15 years ago, nobody thought that we were going to have a public smoking ban that would not allow smoking in any pub or club in the country, including working men's clubs. Nobody foresaw that back in 2000 yet, within five or six years, we had a comprehensive ban in Scotland, and in another year we had a comprehensive ban in England and Wales.

That is why it is unwise to predict that such things will not happen. I am afraid that the tobacco control lobby has a policy called the next logical step. It is never satisfied. It will go from a ban on smoking in cars with children to a ban in all private vehicles. It will then up the ante and quite likely try, if not to actually ban smoking in the home, to name and shame people and to make people feel incredibly guilty about having the temerity to light a cigarette. I did a phone-in on Radio Scotland this morning. Somebody said that we need to ban mothers who are pushing their buggies from smoking at the same time. Where is this going to go? Are we seriously going to ban a mother from pushing her buggy in the park and smoking at the same time?

I am a great believer in education. The big drop in smoking rates in this country happened between the mid-1970s and the early 1990s, and it was all down to education of people about the health risks of smoking. Over the past 15 years, in Scotland and in the UK generally, smoking rates have continued to fall, but not by huge amounts, yet we have had a series of pretty draconian legislation—a ban on tobacco advertising and sponsorship, a smoking ban, a ban on vending machine sales, a ban on display of tobacco in shops and now the introduction of plain packaging. All that legislation has had relatively little impact

when compared with the impact of the basic health education that people were given in the 1970s, 1980s and 1990s.

I am concerned that we are legislating for legislation's sake, and I am not convinced that it will have any significant impact. The sad fact is that the people who are antisocial and inconsiderate enough to smoke in a car with children will probably just ignore legislation against it.

You mentioned that the mobile phone legislation has been a success, but I am not convinced that it has been, to be honest. Of course, before the mobile phone legislation was brought in, there were some very clear cases of accidents involving lorries where drivers were on the phone and cyclists had been killed, for example.

I am not suggesting that there is no risk to a child's health from someone smoking in their presence, but the point about the evidence on passive smoking is that someone has to be exposed to environmental tobacco smoke consistently—day after day, month after month—for perhaps 10 or 15 years for it to have any significant impact.

I am not suggesting that we go back to the 1960s and 1970s, but the fact is that, in those days, the majority of the population smoked and children grew up in smoky households and were transported in smoky cars and vehicles. We do not want to go back to that, and yet that baby boom generation is living longer and healthier lives than any generation before. Before anyone jumps in, I am not associating the two things; rather, I am saying that sometimes the impact of second-hand smoke is exaggerated in order to make smokers feel guilty about their habit.

I am a lifelong non-smoker. The attacks on smokers over the past 10 or 15 years have been disproportionate. Smokers are an easy target and it is very easy to make them feel guilty. I do not think that smokers should feel guilty as long as they smoke responsibly and considerately. They are smoking a legal product and are making a huge contribution to the country's finances through tobacco taxation. We must draw a line and say, "Enough's enough." There is a public smoking ban, a display ban and there will be plain packaging—where will it end?

Dr Simpson: May I just correct one thing? Kenny Gibson, with my support, introduced a bill in 1999, proposing that there should be a ban on smoking in restaurants—anywhere that food was being served. Bans on smoking in public places were not first thought of post-2000; considering such a ban was one of the first things that the Parliament did. I should declare that I am co-convener of the cross-party group in the Scottish Parliament on tobacco and health.

If I can summarise your arguments, Mr Clark, they appear to be: we should not do it because it is a slippery slope; we should not do it because the numbers are small; and we should not do it because it would be difficult to enforce. There was real concern about the ban on smoking in public—people said that there would be riots on the street, that people would act against what could be seen as an infringement of liberty, and that it was going far too far. Some people said that second-hand smoke could be dealt with by pumping the stuff around or by air conditioning; clearly that was rubbish. However, the fact is that people obey the law.

By your own admission, it is the irresponsible individual who smokes in the car, not the responsible smoker. The bill is not about the smoker; it is about protecting children. Are you really saying that the Parliament should not seek to protect children by introducing legislation that will ensure that they are not exposed to second-hand smoke, given that we know from the research—I wonder whether you accept that research—that smoking in the enclosed circumstances of a car leads to levels of pollution that are far higher than they are in most other circumstances? Smoking in the car creates one of the most polluting sets of circumstances that there are.

Simon Clark: I am not an expert, so I probably should not answer that question. I think that parents should err on the side of caution. It is common sense that any parent who has small children, particularly babies, should err on the side of caution, and I think that most would.

Much of the research into passive smoking has been flawed. The largest-ever study on passive smoking, which was carried out in California, studied a group of 119,000 people between 1959 and 1999, and found that it had no significant impact.

The problem with the research that has been carried out in cars is that it is inconsistent because there are so many variables—such as whether a window is open and whether it is open one inch or two—that all make a huge difference. Often, the research that we have seen focuses on that moment—it may be literally a few seconds—when someone has just lit a cigarette and there is a significant amount of smoke in the car. Within seconds, that smoke has normally been massively diluted because a window is open, or whatever. I do not want to come across as if I am justifying or defending people who smoke in cars with children, because I am not. I simply think that the legislation is excessive.

Perhaps I may step back a bit and talk about the smoking ban in Scotland in 2006, which I think was grossly excessive. I totally accept that it is fine to ban smoking in restaurants, but I think that a comprehensive ban in every pub and club in the country, without even allowing designated smoking rooms, was outrageous. I still believe that nine years later, and I am not alone. A Populus poll last week before the ASH report came out asked a random sample of 2,000 people whether they would allow well-ventilated designated smoking rooms in pubs and private members clubs, and 57 per cent said that they would. I accept that people obey the law and do not want to get their landlord or publican into trouble, but I dispute the idea that the smoking ban has been hugely popular. It has very high compliance rates, but when people are asked whether we should allow well-ventilated designated smoking rooms, in general the majority of people favour that idea.

You said that the idea of a well-ventilated smoking room is complete nonsense, but it is not. Modern technology can solve the problem of environmental tobacco smoke extremely well, but sadly we have not gone down that route. Underlying this legislation is a desire to stop people smoking—that is what it comes down to, despite the fact that tobacco is a perfectly legal product. People talk about making Scotland smoke free by 2035 or 2030, or whatever, but if we leave smokers alone, smoking rates will continue to fall slowly for a number of reasons. Health is a serious issue. A lot of people start smoking when they are quite young, but they give up in their 20s and 30s when they start having families and do not want to smoke around children and all the rest of it.

We will continue to see a gentle decline in smoking rates, but unfortunately that is not good enough for the tobacco control lobby. It has already set a target of getting Scotland to be smoke free by 2035—smoke free means that just 5 per cent of the population smoke. The only way that we will get smoking rates down to 5 per cent is by introducing more and more bans and legislation restricting where people can smoke. The way we are going, eventually people will not be allowed to smoke in a public park. We are starting by banning smoking in children's play areas, even though they are in the open air. Some councils in England have exclusion zones around play areas—eventually people will not be able to smoke anywhere where a child might be present. Those rules and regulations have not been brought in for health reasons, because nobody argues that smoking in the open air is a risk to any bystander, whether they are an adult or a child.

The argument now is, "We do not want you to smoke in a public park or anywhere near children because we do not want you to be a bad role model for children. If a child sees you smoking in a park, it might encourage them to take up smoking". Again, there is no evidence that children take up smoking because they see a complete stranger smoking. All the evidence suggests that children take up smoking because of peer pressure or the influence of family members. That is another reason why some people are trying to crack down on family members smoking, whether in the car or at home, or whatever. There is a desire to stop parents smoking in case they become bad role models for their children.

We must remember that tobacco is a legal product. I would have far more respect for people who came out and said that we should ban tobacco completely. Instead of that, Governments are more than happy to put 86 per cent taxation on tobacco—that is the average taxation on a pack of cigarettes in this country; 86 per cent goes to the Government.

11:30

It comes back to the principle that we should try to discourage the few people who smoke in a car with children present. FOREST would be more than happy to join that campaign, so long as it was educational rather than threatening people with fines, penalties and all the rest of it. We feel the same way about litter. We would like to encourage smokers not to drop litter, but it is a two-way thing. It needs some help, rather than rather draconian bullying tactics through which smokers are threatened with fines and other penalties if they drop litter or smoke in a car.

Dr Simpson: So we can add to the list that passive smoking research is not valid, and research on smoking in cars—

Simon Clark: Now you are exaggerating.

Dr Simpson: That is what you are saying.

Simon Clark: I am not saying that it is not valid.

Dr Simpson: You are saying that the research is not valid unless it supports your case.

Simon Clark: I am saying that the threat of second-hand smoke has been exaggerated. I cannot repeat often enough that I am not encouraging people to smoke in a car with children. I would urge anybody to err on the side of caution. However, I think that the research exaggerates the risk, because in real-life conditions most children are exposed to other people's tobacco smoke for only a very short time.

Dr Simpson: The Government did not accept Kenny Gibson's proposals in 1999 because, at that point, the research on passive smoking was not good enough. However, within two to three years a lot of studies were completed that

demonstrated very clearly that passive smoking has an effect—not as much as direct smoking, but a significant effect. That is one of the reasons why the Government adopted the public health smoking ban. That ban was also about protecting workers in the restaurant and pub trade from exposure to smoke, because they are working there all day. We will continue trying to protect people from the effects of irresponsible smokers, in cars and in other places.

Simon Clark: The problem is that workers could have been protected by the provision of designated smoking rooms.

Dr Simpson: We tried that. When Susan Deacon refused to take up Kenny Gibson's bill in 1999, she said that ventilation systems would be introduced. It was clear from the research that was subsequently carried out that that was ineffective. The technology may have moved on, but at that time it was certainly ineffective—it was a sop.

The Convener: That is in the past. We are dealing with another bill today.

Dennis Robertson: I am a bit confused, Mr Clark. You say that you would have more respect if the Government called for a ban on tobacco altogether. Fair enough, there would be no taxation, and I am not saying that I would disagree with that. However, you keep referring to small numbers and then huge numbers but you do not actually associate the numbers. The submission referred to something like 24 per cent of children who were exposed to smoking in a vehicle, which is quite a high number. I do not see 24 per cent as a low number. I actually think that one child being exposed to smoke is one too many.

Dr Simpson mentioned ventilation. That gets rid of the smoke, but it does not get rid of the chemicals—the toxins—and those cause most of the damage. I hear what you are saying. I asked last week whether legislation is necessary, or whether we should be doing more education. The answer I got was that education has been tried and continues to be used, and that it will continue alongside the legislation, but that legislation is deemed to be necessary. Do you not accept that argument?

Simon Clark: No, sorry.

Dennis Robertson: I did not think that you would.

Simon Clark: I am not sure where you got the 24 per cent figure. Our understanding is that research shows that fewer than 13 per cent of children are exposed to tobacco smoke in a car. That is still probably too high, but in terms of being regularly exposed—

Dennis Robertson: So you say that that is too high.

Simon Clark: About 1 per cent of children are regularly exposed to tobacco smoke. If someone is just exposed very occasionally, among that 13 per cent, I do not believe that they will come to serious harm. However, let us try to bring down that figure and let us do that through education, not legislation.

Dennis Robertson: You mention the figure of 13 per cent, but that gives you no idea whether any of those children have respiratory problems. If an adult is smoking irresponsibly near a child with a respiratory problem—asthma, for example—it will be exacerbated. We have tried the education route and we have done as much as we can through it, but it is not working. People still think, "Well, so what?" However, we have seen that the law that was introduced to ban smoking in public places works. People have obeyed that law—they go outside to smoke and they do not smoke in restaurants, pubs or clubs. Given the distance that adults might travel with children in a car, surely we should say that there should be absolutely no smoking in the car.

Simon Clark: Again, that would be patronising for the vast majority of smokers who know how to behave. I am a bit disturbed about some of the language that you use—for example, you used the word "obeyed". A lot of people are beginning to feel that the reason for tobacco control is, in fact, to have control; in this case, that would mean parental responsibility being taken away from a lot of decent people. If we introduce legislation on smoking in cars, what about the parent who has an overweight child? Will they be prosecuted? Where does this go? I am glad that you mentioned asthma, because smoking is often blamed for asthma.

Dennis Robertson: I did not say that smoking was to blame for asthma; I said that a child's asthma could be exacerbated by an adult smoking.

Simon Clark: Sure. However, I do not think that we have gone down the education route on smoking in cars when children are present. I think that legislation should be a last resort in that regard and that there should be a three-year moratorium on any legislation in order to have an education campaign that specifically targets the issue of smoking in cars when children are present. We would be more than happy to support such a campaign.

I believe that legislation on smoking should not cover private vehicles. The difference is that, for example, pubs and clubs are public spaces in the sense that the public can go into them, although they are still private businesses—but that is a different argument. However, with the new legislation, we are talking about private spaces. As I said, I can guarantee that as soon as the bill is

passed and a law is introduced, the tobacco control lobby will be back here and I will probably be back here in five years' time or less—maybe in three years—having the same discussion about banning smoking in all private vehicles. The tobacco control lobby is relentless: it never stops. Of course—

Dennis Robertson: The point that I cannot come to terms with in your argument is that you seem to accept that, during a three-year moratorium, children will still be exposed to smoke in a confined space—you are happy for that to happen.

Simon Clark: As I tried to explain, I think that the health impacts are exaggerated. However, I hold my hands up and say that I am not an expert on the subject. As I said earlier, a generation of children grew up in smoky households and in smoky cars, and that generation is the longest-living generation in human history. I am not suggesting that there is a correlation between the two things, clearly; however, that baby-boom generation of the 1950s and 1960s does not appear to have come to any long-term harm.

I brought up the example of asthma a few minutes ago because it is interesting that, during a 40-year period when smoking numbers have halved, cases of asthma have tripled. We also know that allergies are a huge problem these days in a way that they were not 40 or 50 years ago, but there is a constant obsession—I believe this very strongly—with smoking and giving smokers a good kicking. As I said, I am a non-smoker but, in my lifetime—I grew up in Scotland—I have seen smokers treated abominably. They are an easy target.

Since the smoking ban came in, people are complaining about the smell of tobacco. That has nothing to do with public health; it is simply because people are now sensitive to any whiff of tobacco smoke. Most people are not normally exposed to tobacco smoke in their daily lives—we are not exposed to it in the workplace and are rarely exposed to it in the street—and, when some people get a little whiff of tobacco smoke, they react with shock. It is getting utterly ridiculous. We have to have a bit of proportion here, and I think that legislation to ban smoking in private vehicles is disproportionate to the problem.

Dennis Robertson: I agree with Dr Simpson that the issue is about child protection. I will leave it there, convener.

The Convener: As there are no further questions, I thank Mr Clark for his attendance and his written evidence.

11:40

Meeting suspended.

11:43

On resuming—

The Convener: We continue our evidence taking. I welcome Brian Auld, the director of professional development at the Royal Environmental Health Institute of Scotland; William Hamilton, the environmental health manager at Glasgow City Council; Professor Alison Britton, the convener of the health and medical law committee of the Law Society of Scotland; Margaret Wallace, the communities service manager at Stirling Council; Bernard Higgins, assistant chief constable—operational support; and Chief Superintendent Iain Murray.

Nanette Milne will ask the first question.

Nanette Milne: I want to discuss the enforcement part of the bill, which is the one aspect that has given me some concerns.

Most of our evidence suggests that the offence should be enforced by Police Scotland, but some organisations, including Police Scotland, do not agree that that should be the case. I would welcome views from the panel on how the offence should be enforced and who should be responsible for enforcement.

Assistant Chief Constable Bernard Higgins (Police Scotland): Good morning, convener—I will start.

First, Police Scotland absolutely supports the bill. We buy into anything that makes Scotland a healthier place and protects communities from harm—there is no question about that. We are happy to be an enforcement agency that enforces the legislation, but there are some practicalities around that. If you want the bill to make as much of an impact as I believe you want it to, we should not be the sole enforcing agency.

11:45

The reason for that is quite simple. One of our key priorities is to reduce road deaths and the number of people who are seriously injured on Scotland's roads. Sadly, in the fiscal year ending 31 March, 191 people were killed on Scotland's roads. As I understand it, smoking was not a contributory factor in any of those fatal road accidents.

Although the policy has clear health benefits, it would not, in our view, necessarily have a great impact on reducing the number of people who are killed on Scotland's roads. The clear causal factors in fatal and serious road accidents are people speeding, using mobile phones, not

wearing seat belts and drink-driving, and we wish to continue targeting those areas.

Having said that, I emphasise that we believe that we would have a role to play in enforcing the legislation as an enforcement agency. I just want to make the committee and Parliament aware that, with regard to how much we could contribute to enforcement, there might be benefit in extending the legislation to authorise enforcement by, for example, environmental health officers, local authority officers, traffic wardens and the numerous people who have the power just now to issue antisocial behaviour tickets. They could comfortably deal with cases involving stationary vehicles.

I accept that only Police Scotland has the authority to stop moving vehicles on the road, but I contend that there are a number of people who smoke in stationary vehicles in car parks or parked up on the road with children in the back. The legislation could be extended to authorise other authorities to deal with those circumstances.

We are wholly supportive of the bill and happy to be one of the enforcement agencies.

The Convener: Are there any other views?

Margaret Wallace (Stirling Council): Stirling Council also fully supports the bill. Our view is that there should be a partnership approach. Police Scotland should be the enforcement body, but enforcement should involve different partners playing their part, too, as part of a wider prevention, intervention, education and enforcement approach. Enforcement for the people who are not responsible for it should be about a partnership approach, as it is for us.

As Assistant Chief Constable Higgins said, from a council perspective, enforcement is more about dealing with cases involving stationary cars, because that is a more practical aspect for us to address.

Professor Alison Britton (Law Society of Scotland): Good morning. The Law Society of Scotland is very happy with the provisions in the bill. We welcome anything that will protect children in Scotland. We see the bill as one measure in a range of measures in the smoking cessation strategy.

Our concern is to make enforcement workable and practicable within the limited resources across all the organisations to which the legislation pertains. We suggest that the committee considers legislating to place responsibility on the driver, rather than attributing responsibility for smoking and giving penalties to the person who is smoking in the vehicle. The driver maintains control of the vehicle, and he or she is responsible for it. That is the case in situations involving young children under the age of 14, where the driver is responsible for ensuring that the child wears a seat belt.

Evidence has been given on how challenging enforcement will be, not necessarily when the situation involves young children in car seats but when there are children from the age of 12 onwards in the car. It is so hard to know how old children are, so we would want them to carry some form of photographic evidence of their identity that shows their date of birth. We need something that might simplify that procedure and allow us to utilise resources effectively. Placing responsibility on the driver might be one way of doing that.

Brian Auld (Royal Environmental Health Institute of Scotland): First, the institute fully supports the premise of the bill.

My understanding is that about 79 per cent of those who responded to the Government consultation fully supported Police Scotland undertaking the role of lead enforcement authority for the bill. We fully appreciate the difficulties and restrictions that Police Scotland is under, as are many public services across Scotland.

The environmental health profession has had a leading role in the banning of smoking in enclosed public spaces. Between 2006 and 2012, approximately 5,000 fixed-penalty notices have been served across Scotland. However, the one thing that is really important to recognise is that enforcement is part of a multimodel approach to smoking that includes a lot of education and a lot of guidance. We would fully support taking such an approach with the new legislation.

Environmental health departments across Scotland routinely work with Police Scotland as things stand. We buy in, for want of a better expression, the resources of Police Scotland—for example, with emissions testing. There are some issues with that: it is very reactive, and the chances are that we will miss a lot of the individuals we want to target with the bill. However, we would appreciate a partnership, collaborative approach to undertaking enforcement activities under the bill.

William Hamilton (Glasgow City Council): I will add my perspective and speak about enforcement from Glasgow City Council's point of view. I endorse the views of my colleague from REHIS. My council also supports the bill. However, I sound a cautionary note from our perspective, which is that we have real difficulty seeing how environmental health can really engage with the bill to a meaningful extent.

I take the point about stationary vehicles, but in reality, we do not have the people on the ground, in the street, to the same extent that the police do.

It is conceivable and feasible that we could intervene in a case that involved a stationary vehicle, but I cannot imagine that being done to any meaningful extent, simply because the number of people involved is so low.

People might pick up on something while they are travelling from A to B, but I do not see there being any huge incentive for local authorities to enforce the bill. If a local authority enforced the bill proactively by stopping vehicles, again that would involve Police Scotland and we would be more than happy to work in partnership in that way. However, the concept of unexpected or unplanned intervention is problematic and, to be truthful, I think that it would be unlikely to happen to any great extent.

Nanette Milne: Thanks for those responses.

I am slightly worried about the actual practicalities of what would trigger investigation in terms of identifying young people in a car. A lot of the talk has been about young children who would be in car seats. I can fully accept that those situations would be relatively easy to deal with. However, I have a grandson who is 15 and 5ft 2in. If he was sitting in a car, people could quite easily think that he was over 18, and the bill covers people under the age of 18. What would trigger investigation in such a case? Would it depend on someone saying that the adult in the car with them was smoking? I just cannot work out the practicalities of how we would get to the stage of accusing someone of smoking in a car with children in it. Does anyone have any advice on that?

Professor Britton: To go back to the point about whether the responsibility should be on the driver, there was some discussion earlier about the success of sanctions for not wearing a seat belt. Cameras can pick up drivers who are not wearing a seat belt or who are using a hand-held phone. Those things are clear and reasonably easy to evidence because the person is sitting in the front of the car. However, someone could be sitting on the back seat smoking, or inhaling and then putting the cigarette underneath the dashboard. I have teenagers, so I know how crafty they can be in passing cigarettes back and forth. People could stub the cigarette out by the time that they were apprehended. The smell of cigarette smoke lingers for a long time. Evidence is going to be so difficult to get, and since this is such an important component part of the smoking cessation strategy, we have to make sure that we are as resourceful as we possibly can be.

William Hamilton: I support Professor Britton's point of view. Making the driver—the keeper of the vehicle—responsible would mirror the original smoking ban legislation, which was effective largely because the licensee of a pub, for example, is held responsible for people smoking on the premises. That led to people managing compliance themselves, and the same principle could apply in this case.

To be truthful, that would also make it more straightforward to identify the person who was responsible—it would be the keeper of the car. If the passenger in the vehicle had to be identified, that would cause significant difficulty. If environmental health officers intervened in a situation because no police constable was available, they might have difficulty in getting any meaningful information out of the person involved.

Nanette Milne: Do you envisage random checks on drivers? If you thought you saw a driver or a passenger in a car smoking but were not sure, would you target them randomly? Is that how you envisage the policy working?

William Hamilton: There are two main ways in which the legislation could be applied. My colleagues in the police may also want to comment, but I envisage environmental health officers responding to complaints and accusations, although that would not be a major part of our work. Alternatively, we could identify or notice somebody smoking in passing. A third way would be to pull vehicles over relatively randomly. That happens at the moment for emissions testing, for instance, and is pretty successful—it works well. We would need to work in partnership with the police if we were to do that, but I can imagine that happening. It would probably be quite effective in sending out a message and getting the awareness levels up, which is what will lead to the success of the bill, rather than any real enforcement activity.

Assistant Chief Constable Higgins: There has to be a degree of pragmatism about how the legislation would operate. Our officers make judgment calls constantly—every minute of every day—in deciding what action to take or not to take. For example, if kids are in possession of alcohol, our officers have to assess whether they are under 18.

Our officers are well versed in assessing a situation as they see it from a pragmatic point of view. If they passed a car and saw somebody smoking in it, and if they also saw child seats in the back, that would give them a fair indication that the child was under 18. It would be about overlaying a commonsense, pragmatic approach in considering every circumstance as it presented itself at the time.

For clarity, there is no will within Police Scotland not to enforce the legislation; I am simply saying that there are perhaps opportunities to widen the number of authorities that can enforce it, thereby having a greater impact. I make it absolutely clear that we are in no way abdicating responsibility for

enforcing it, but I must be frank with you about our capacity to do that over a long period of time. There are other opportunities.

The Convener: What actions would be necessary to create that wider partnership? If you wanted to involve community wardens and traffic wardens, for example, would they need additional powers?

Assistant Chief Constable Higgins: I do not know. I assume that there would need to be some extension of powers, either through the bill or through local byelaws. I walked through the streets of Glasgow at the weekend and saw a number of community wardens issuing fixed-penalty notices for littering. Although it might be rare for them to have to deal with somebody who was smoking in a car while a young child was present, it might be better for them to have the ability to deal with that than not to have it.

I echo colleagues' comments about partnership working in education, which we engage in on every aspect of road safety right across the spectrum. We are very much signed up to that way of working and would work in partnership with colleagues on the education aspect of the smoking ban. There are opportunities for that, and we are happy to offer our advice on it.

The Convener: Are there any other responses?

12:00

Brian Auld: I will add a couple of points, the first one being that, to meet the needs of their local communities, many local authorities in Scotland have warden-based services. Wardens can tackle littering and dog fouling, for example, and they are skilled in some legal procedures and can serve fixed-penalty notices.

There is something missing from the bill. Although it looks at enforcement, there is nothing about working with industry. For example, when people buy a car at a dealership or take their car in for an MOT, they could be given an advisory notice. That is another avenue that we would ask the Government to consider.

The Convener: Is there any barrier to giving additional powers to people such as litter wardens?

Brian Auld: There is no barrier per se.

The Convener: Is it easily done?

Brian Auld: It comes down only to the training and competence of the officers to whom the powers are given.

The Convener: If no one else covers them, we need to come back to some of the unintended consequences, such as whether there would be any for the getting it right for every child approach, the Children and Young People (Scotland) Act 2014, and the potential for third parties to report people smoking in cars and how that would be dealt with.

Mike MacKenzie: My question is directed at Professor Britton.

I am surprised that the Law Society is suggesting vicarious liability for drivers. A passenger might light up a cigarette and the driver could ask them to desist, but they may be on a motorway or another road on which it is not possible to stop. Assistant Chief Constable Higgins or one of his sharp-eyed colleagues might happen by at that moment, the blue light goes on and the poor old driver is charged. If you were representing the driver of that vehicle as a client in court, what kind of defence would you mount to try to prevent a conviction?

My next point is about this being a form of summary justice. Perhaps the police might feel under pressure to produce statistics that show that they are enforcing the legislation. I am not implying bad faith on the part of the police, but there are opportunities for mistakes about the age of children—I know some 18 year olds who look younger.

I take you back to your days as a law student when justice was perhaps uppermost in your mind, in a way that I am getting the sense it may not be now.

Members: Oh!

Professor Britton: Mr MacKenzie, that is a terrible thing to say. Thankfully, I am an academic and will not be representing anyone in court.

Mike MacKenzie mentioned vicarious liability. The driver of a vehicle has a very special responsibility in relation to road safety. We are talking here about the health and wellbeing of the occupants of the vehicle. The example that has already been given was that, if a child under the age of 14 is not wearing a seatbelt, the responsibility is the driver's.

Everyone who has given evidence in this meeting is very supportive of the bill. The issues tend to be ones of effectiveness, good use of resources and ensuring that, if the legislation is going to be passed, it is as effective as possible in protecting young people. I am certainly not trying to be draconian; I am trying to take a practical approach to a set of circumstances that everyone has said can be challenging in terms of enforceability.

I believe—on behalf of the Law Society and personally—that there could be a statutory defence built in to the legislation to say that the driver of the vehicle believed beyond reasonable

doubt that the people in the vehicle were all over the age of 18.

If we are looking at ways of being able to set a good example in relation to smoking cessation strategies, there is evidence from New Zealand, Canada and Ireland, where such legislation is a little more established, that such action is a very effective way of setting as normalised behaviour that people do not smoke in vehicles. We must use the resources as effectively as we can, and that seems to be the most logical way to do that.

I do not even begin to feel near enough qualified to answer Mike MacKenzie's second question.

The Convener: Are there any other responses to Mike MacKenzie's questions?

Assistant Chief Constable Higgins: On enforcement and my "sharp-eyed colleagues", that would be down to professional judgment. That is what we ask our officers to do.

From day 1, in addition to our ethos of treating everyone with fairness, integrity and respect, we train our officers to use their professional judgment and, on occasion, their discretion. Although we might stop someone who is smoking while young children are in the car, it would not necessarily be the case that they would get a ticket. It might well be that part of the enforcement strategy is that police officers issue as many warnings as tickets. There is a rounded way in which we can work jointly and make the legislation as impactive as you want it to be.

Mike MacKenzie: That is reassuring. With your indulgence, convener, I will return to Professor Britton.

With the greatest of respect, Professor Britton, I say that I do not think that you properly answered the question. Perhaps I could rephrase it slightly differently. You have not made the case for the merits of prosecuting the driver rather than the passenger who is committing the offence. I am not clear where the advantage is in prosecuting the poor old driver through vicarious liability, rather than prosecuting the passenger who is committing the offence.

Professor Britton: It is not the Law Society's role to look at issues around why someone should be prosecuted. In our submission, we have considered the robustness of any possible legislation. Prosecution is not in our remit, but I hope that contributing to effective legislation is. That is what we try to do in our submission.

Were the vehicle moving, the decision on whether to prosecute would lie with Police Scotland. Assistant Chief Constable Higgins has said that the police would take a practical approach. The police have experience related to other road traffic offences, and they would apply that experience.

Mike MacKenzie: I can comment only that I am, yet again, disappointed by the response. The Law Society has suggested that, if the bill is passed, the driver would be liable rather than the passenger, when it is the passenger who is committing the offence.

I would be pleased if Professor Britton could describe why the driver should have legal liability and not the passenger who is committing the offence. I do not understand what you consider to be the merits of that argument.

Professor Britton: I can only reiterate what I have said. First, we are trying to place a responsibility for protecting young people in a vehicle, and for setting good patterns of behaviour to protect their health and wellbeing.

Other jurisdictions have introduced legislation similar to that which is before the committee today. The issue that they keep returning to is the challenge of enforceability. A possible consideration for the committee would be that it may be easier for that to be incumbent on the driver.

The Convener: Are there any other views on whether it should be incumbent on the driver or the person smoking?

Brian Auld: It should be the driver's responsibility. In the simplest terms, without the driver, the vehicle cannot move. Therefore, drivers are responsible for those whom they are transporting in the vehicle.

We understand that there may be situations in which the driver may not be able to control the behaviour of individual passengers, but that would be considered as a defence to allow someone to smoke in a vehicle.

The Convener: Does Police Scotland have a view? Come on now.

Assistant Chief Constable Higgins: It would be possible to use "cause" and "permit"; the person in charge of a vehicle who causes or permits someone to commit the offence would be as liable as the person committing the offence. I do not want to give the committee another option, but you could charge both the driver and the passenger.

The Convener: There we go. [*Laughter*.]

Assistant Chief Constable Higgins: How is that for a neutral stance?

Dr Simpson: That resolves that one.

The Convener: Put that in your pipe and smoke it. Very good!

Richard Lyle: The witnesses have heard Mr Clark's evidence. Have you not all just made the case for Mr Clark? We now have the police, council officers, traffic wardens, community officers, the general public and closed-circuit television—and by the way, we are going to set up roadblocks to pull people over. Have we moved away from relying on the police, who do a good job checking people for wearing seat belts, for drunk driving and for using their phones? Most police cars still have two officers in them, checking for those things. As I have said, I have two kid seats, so you can see my three-year-old grandson and my one-year-old granddaughter sitting in the back. Have we not just made the case for Mr Clark saying,

"Infamy! Infamy! They've all got it in for me"?

Assistant Chief Constable Higgins: I do not agree with that. In my opening comments I spoke about the number of people who are dying on Scottish roads. That is a priority for Police Scotland. Smoking cigarettes is not, as we understand it, a cause of people dying on the roads, but it is a significant health issue. We are saying that, in terms of the benefit to the health of the nation, we absolutely get it—we absolutely support the move. However, the reality is that I will not be setting up roadblocks to check for people smoking in cars, because I need my officers on the fast roads and the big roads where people are dying, so that we can tackle the issues that cause people to die on our roads.

I will draw a crass comparison—forgive me for doing so. Dog fouling is a huge concern right across every community. People tell us that it is antisocial and unhealthy. We have powers to deal with dog fouling but, more often than not, it is community wardens who deal with it.

We absolutely have a role to play in enforcing the proposed legislation, but it will not have a huge impact on our priority of making the roads safer and reducing the number of people who are killed. We have to prioritise action that we take to reduce the number of people who die on Scottish roads; I dare say that smoking does not fall into that category.

Although we would absolutely enforce the legislation, I suggest that the committee look beyond the role of the police and see who else could assist on that aspect of the bill—bearing it in mind that all colleagues at the table have said that the measure cannot be taken in isolation. There has to be a collaborative partnership approach, and it has to be on the back of a fairly robust education programme.

Professor Britton: I support exactly what has just been said. One would hope that any form of criminal sanction would be a last resort. The law would raise awareness and would perhaps make people think about whether they should smoke in a vehicle. It might help them to consider whether or not to look for smoking cessation strategies or to change their pattern of behaviour and how they wish to enjoy cigarettes. I hope that, as one of a wide range of measures, the bill will raise the profile of the matter.

The statistics on the dangers of second-hand smoke are incontestable: 1 billion people will die worldwide by 2050. Such statistics are beyond argument. There are fewer statistics available on the benefits of legislation such as the bill, but jurisdictions that have such laws acknowledge that an improvement is starting to show among young people for smoking-related disease. For the teenage years in particular, that involves setting a pattern of behaviour such that those people will not smoke in the future.

The proposal in the bill should not be something that we rely on as the first resort; it should be part of a range of measures and should raise awareness in people's minds and empower them to make other choices themselves.

12:15

The Convener: Professor Britton, people have made arguments about education, campaigns and whatever. Has the case been made for legislation? That could be difficult to enforce, and enforcing it would be a low priority as there are lots of bigger issues. Is legislation necessary or should we just do a better job in communicating and educating?

Professor Britton: The Law Society believes that legislation is necessary.

Brian Auld: I agree with everything that has been said on that issue. With respect to Mr Lyle, he gave some examples of the different enforcement options that are available, but it is unlikely that all of that would be undertaken, simply because of resources.

Richard Lyle: Sorry—

The Convener: Wait a minute, Richard. You can come back in in a moment.

Brian Auld: Sorry. I do not mean any disrespect, but enforcement authorities work with many different tools. They want to ensure compliance through advice, education, publicity, guidance and a fair and reasonable approach to enforcement. I agree that enforcement is regularly regarded as the last method to be used to ensure compliance, and that has certainly been seen with the smoking ban. I mentioned that the number of fixed-penalty enforcement notices that have been served in Scotland is relatively small given how long the legislation has been in force, and that is partly due to the enforcement activities of the

regulatory bodies. Enforcement should be seen as the last resort for any form of compliance, and that also supports the principles of best regulatory practice.

Richard Lyle: With the greatest respect to Mr Auld, I note that most of the witnesses said that they can take part in enforcement. The police can issue tickets, and council officers can issue tickets for dog fouling. There is a successful campaign in Sauchiehall Street and other places in Glasgow to stop people throwing down cigarette butts—they can get a ticket. Traffic wardens and community officers can also issue tickets. If people were listening closely, they will know that I did not support the point that Mr Clark made earlier. I am a smoker but I believe that the bill is required. However, you have just made the case for Mr Clark that everyone is going to pick on smokers who sit in their cars.

Brian Auld: You are absolutely right about who can deliver enforcement activity, but it would not be reasonable to expect that all those activities will be undertaken at the same time, because there are just not the resources to do that. It will be up to the local enforcement authority to determine the best course of action to ensure that there is compliance with the legislation.

The Convener: I think that we all understand that most people are law abiding and will comply with the law. That is the context. The focus on enforcement is due to the nature of the panel—that is where your focus takes us.

Bob Doris: The written evidence provides some views on whether the bill is clear enough about exemptions for vehicles that are used for

"human habitation for not less than one night".

That could be mobile homes or caravans. Would any of the witnesses like to put their views on that on the record?

Chief Superintendent Iain Murray (Police Scotland): We are content with the exemptions in the bill. There is nothing that we would want to come back on.

The Convener: Does everyone agree with that?

Brian Auld: We fully agree with the exemptions in the bill.

The main area of contention for us concerns convertible vehicles, in relation to which there are arguments for and against. The science behind third-hand tobacco smoke and convertible vehicles is still a moveable feast. People think that, when they are in a convertible car, the cigarette smoke will dissipate quite freely, but many more people drive convertibles with the windows up, which presents a barrier. Volatile organic compounds settle on upholstery, and more evidence is coming through on how long they remain there and how they get into the human biological system.

We fully support not including convertible vehicles in the exemptions and making the ban enforceable for people who are driving convertibles.

The Convener: There do not seem to be any other responses on the point about third-hand smoke. That is a lesson for those people who smoke in their car when their grandchildren are not in it. I will leave members to ponder that one.

Richard Lyle: Point taken, convener. [*Laughter*.]

Dennis Robertson: You have made me smile today, convener. That is unusual.

We all accept that most people are law abiding. Earlier this year, another piece of legislation was introduced to give local authorities powers—rather than duties—in relation to disabled parking and blue badges. That was brought about because there was a level of non-compliance by some members of the general public. Are we saying that we need the bill because the education has not worked and so we need something to try to enforce the sensible approach to smoking in cars when children are present? That is what we had to do for disabled parking and blue badges. For years, we thought that the message had got across, but it had not, so we had to introduce legislation. Do you see this as a similar situation? Perhaps Police Scotland could respond to that first.

Assistant Chief Constable Higgins: That is a difficult question for me to answer, Mr Robertson, and I will tell you why. At the risk of repeating myself, we concentrate on road deaths—on fatalities. There are potentially child protection issues where people smoke in vehicles, but that has not been on our radar in relation to us reducing the number of fatal incidents and people being seriously injured on Scottish roads.

Dennis Robertson: I am talking more about parked vehicles and police officers being on the beat. It used to be only police officers who could enforce the powers in relation to blue badges, but now that has been widened to include council officers. That collaborative partnership sounds sensible to me. I am asking whether, in relation to smoking in cars, we have not got the message through using education alone, and that is why we require the bill and a partnership approach.

William Hamilton: There is a clear correlation between making something illegal and diminishing it. We are not going to eliminate the problem, but if it becomes known to the public that it is a criminal offence, people will stop doing it—not everyone, but the majority. The requirement to wear a

seatbelt was the first obvious example of that. It is not really a fear of being caught that deters people, but the fact that not wearing a seatbelt has become socially unacceptable.

If you are happy with the impact that it will have on people to that degree, it may just be enough to satisfy us all. That approach will not eliminate smoking in cars when children are present, but it will probably reduce it quite significantly.

Margaret Wallace: When we are trying to make a big cultural change to make people good, responsible citizens and to allow children to have a voice, enforcement becomes the next step. It would be great if people were responsible and the education, prevention and intervention had a wider impact. However, when something is enforceable, people start to see that and to question the activity, which helps to change the cultural element and views about what is and is not acceptable.

Dennis Robertson: Should we give local authorities powers rather than a duty under the bill so that they can enforce it? If we give them the powers, it will be up to them whether they go down the road of enforcement. A duty is a completely different approach and is more about ensuring that the law is complied with. Should the bill confer powers or duties?

Assistant Chief Constable Higgins: Police Scotland supports giving local authorities the powers, Mr Robertson. I do not think that the legislation would have the full impact if the police were the sole enforcing agency. As I said earlier, it is better to have the ability to do something and use it rarely than not to have the ability to do it at all.

The Convener: I would like to hear some views on the comments in Police Scotland's submission about the potential consequences of legislation. If somebody is found to be smoking in a car with a child, would it lead to the raising of a child concern form that would be shared with the named person under the GIRFEC principles and the Children and Young People (Scotland) Act 2014? Does everybody agree that the legislation would have that effect? If somebody is speeding with a child in the car, they are putting the child in danger. Is a report raised as a consequence in that situation?

Chief Superintendent Murray: That does not happen in every case, although we might end up doing it if there is a road traffic offence. The purpose of our submission was to highlight the public health concern and to air the issue of child concern forms where we find children who are believed to be in the way of harm. They would go to the named person and the case would move into a different sphere, such as education and intervention with parents through the named person, schools or whatever. There would be implications for local authorities and named persons if they were to take that work on, especially if there was continuous repeat offending.

The Convener: Has anyone else thought about that issue? It might be useful if some of our other witnesses gave it consideration.

Professor Britton: I am writing it down.

The Convener: Perhaps the local authorities could consider the possible impacts on their responsibilities.

Third-party reporting was also raised. We have heard a list of priorities. If somebody reported regularly that their neighbour or the guy across the street was smoking while he was taking the kids to school, would that result in an investigation? Would there be action on third-party reporting?

William Hamilton: To come back to the point about duties and responsibilities, it happens all the time with pubs. They are workplaces, so we would respond if somebody was smoking there. If we were advised that a neighbour was regularly smoking while they were driving a car with a child in it, it would not be unreasonable for us to approach the individual and warn them that they had been observed and reported to us and that they should be mindful that they are committing an offence. I cannot see us taking formal enforcement action on the back of a third-party report.

Assistant Chief Constable Higgins: Our position is similar. If we got a third-party report, we would be duty bound to do something with it. I envisage that it would simply be to contact the person who was allegedly committing the offence to highlight that it had been brought to our attention and to ask them not to do it. I do not envisage investigating in the traditional sense, as in taking statements from people and doing scene-of-crime examinations on the car. Our response would have to be proportionate and pragmatic, which echoes what my colleague has just said.

Brian Auld: I completely agree with what my colleagues have said with regard to reactive third-party reporting.

Earlier, I mentioned proactive third-party reporting, which would involve working with the motor industry to ensure that if, for example, someone who is doing an MOT on a car notices that there is evidence of children being transported in the car and someone smoking in it, an advisory notice will be given to the owner. I am not suggesting that that would be reported to Police Scotland or another authority; it would just be something that would come under the educational approach.

12:30

Professor Britton: We have to remember that the ultimate aim of the bill is to reduce harm to young people and to protect their health. One would hope that all the stakeholders who are involved in taking the bill forward will remember that. A view should be taken that the issue is different from, say, running a red light, because it is to do with protecting the health and wellbeing of the occupants of a vehicle.

The Convener: That is perhaps what the police have been saying to us all morning. We will take all of that away and consider it.

I have a final question, following on from Bob Doris's question about the exemption for vehicles that provide

"human habitation for not less than one night".

How could that exemption be enforced?

Assistant Chief Constable Higgins: Again, that is a difficult issue. If the vehicle was on a campsite, we would be able to see how long it had been there. If it was the cab of a lorry that was parked overnight in a lorry park, the issue would come down to assessing what we see in front of us at the time and applying a pragmatic, commonsense approach.

I should say that I was just thinking out loud there. If I came across a child camping in a lorry overnight, there might be wider issues than simply smoking. I was trying desperately to think of an example.

Brian Auld: The exemption applies to vehicles that are people's homes, such as motorhomes. It does not apply to, for example, camper vans that have been rented by people who are travelling around, as they are already covered under the smoking ban that relates to such vehicles.

The Convener: As there are no further questions, I thank all our witnesses for their attendance and the very good written evidence that they supplied.

I will now close the meeting. Thank you all for your patience and participation.

Meeting closed at 12:32.

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