The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 6 October 2015

Session 4

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HEALTH AND SPORT COMMITTEE
27th Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*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)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Alison Christie (Scottish Families Affected by Alcohol and Drugs)
Ailsa Garland (Scottish Government)
Siobhan Mackay (Scottish Government)
Petrina Macnaughton (Alcohol Focus Scotland)
Dr Colette Maule (British Medical Association Scotland)
Claire McDermott (Scottish Government)
Dr Peter Rice (Scottish Health Action on Alcohol Problems)
Chief Inspector Tim Ross (North Ayrshire Health and Social Care Partnership)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)
Maureen Watt (Minister for Public Health)
Professor Craig White (Scottish Government)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Health and Sport Committee

Tuesday 6 October 2015

[The Convener opened the meeting at 09:31]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the Health and Sport Committee's 27th meeting in 2015. As usual, I ask everyone in the room to turn off mobile phones, as they can interfere with the sound system. I point out that many of us around the table are using tablet devices instead of hard copies of our papers.

Agenda item 1 is a decision on taking business in private. Does the committee agree to take in private item 6, which is consideration of our approach to scrutiny of the Scottish Government's draft budget 2016-17, and item 8, which is consideration of our approach to our work programme? As members will know, we normally consider such papers in private.

Members *indicated agreement.*

Health (Tobacco, Nicotine etc and Care) (Scotland) Bill: Stage 1

09:32

The Convener: Agenda item 2 is our final evidence-taking session on the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill. I welcome to the committee Maureen Watt, Minister for Public Health; and, from the Scottish Government, Claire McDermott, bill team manager; Lynne Nicol, quality team leader; Siobhan Mackay, head of tobacco control team; Professor Craig White, divisional clinical lead; David Wilson, solicitor in the food, health and community care division; and Ailsa Garland, principal legal officer.

I understand that the minister wishes to make a short opening statement, after which we will go straight to questions.

The Minister for Public Health (Maureen Watt): Thank you very much, convener, and good morning, members.

Thank you for the opportunity to say a few words about the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill and why I believe that it is important. The bill covers three distinct health topics, each of which has its own important part to play in helping people in Scotland live longer and healthier lives and in safeguarding our health and social care provision. I should add that the programme for government announced a commitment to provide a right to voice equipment, and I intend to write to the committee to detail the Scottish Government's plans to lodge a stage 2 amendment on that matter.

Part 1 seeks to reduce access for under-18s to nicotine vapour products and to reduce the products' appeal to children and non-smokers in Scotland. It also seeks to place further controls on the sale of tobacco and to continue to denormalise smoking. It is my belief that in a climate of on-going debate the bill has struck the right balance in the regulation of NVPs.

As you will have heard, the revised European Union tobacco products directive, which will place restrictions on cross-border advertising of e-cigarettes on, for example, television and radio, will be implemented across the United Kingdom by May 2016. The bill builds on that by taking powers to prohibit domestic advertising, including billboards, posters and leaflets.

However, it is not the intention to ban certain point-of-sale advertising of NVPs in Scotland. It is important that current smokers are able to ask questions and have consultations about which products might be right for them.

I am aware that introducing an offence of smoking outside hospitals has stimulated debate, from those who believe that the legislation is unnecessary to those who believe that it should cover the entirety of national health service hospital grounds. The bill proposes an offence of smoking within a perimeter around hospital buildings. The perimeter will be consulted on and determined in regulations.

Preventing ill health is a major challenge for our health services now and in the future. Tobacco remains the biggest cause of preventable disease and death in Scotland. It is therefore my view that our NHS must show leadership in supporting and promoting healthy behaviours, particularly around denormalising smoking.

The provisions in part 2 place a requirement on organisations that provide health and social care to follow a duty of candour procedure where there has been an incident of physical or psychological harm. The procedure will be set out in regulations to be made using the power in the bill. The proposals have been intentionally focused on an organisational duty. The introduction of the duty will provide a further dimension to the arrangements already in place to support continuous improvement in quality and safety culture across Scotland's health and social care services.

Part 3 creates offences of ill treatment or wilful neglect, which will apply to health and social care workers and provider organisations. The offences will cover intentional acts or omissions and are not intended to catch incidents of mistake. Neglect and ill treatment occur very rarely in our health and social care system, but the criminal justice system must be able to identify and deal with those cases effectively and appropriately when they arise. The creation of the offences is intended to help secure access to justice for those who suffer neglect or ill treatment.

It is important to emphasise the difference between those offences and the unintended or unexpected incidents covered by the duty of candour. The wilful neglect offences are intended to relate to very deliberate acts or omissions.

That is all that I would like to say at the moment, convener. I look forward to the committee's consideration of the bill and the discussions to follow.

The Convener: Thanks, minister. We will go directly to questions from Richard Lyle.

Richard Lyle (Central Scotland) (SNP): Good morning, minister. You answered in your opening statement the question that I was going to ask—thank you for that—but I will ask it anyway, in order to confirm what will be the case.

I refer to smoking in hospital grounds. Most people have expressed concern that we are allowing the local health board to totally ban smoking in hospital grounds. However, in your opening statement you said that a perimeter would be set. Have you any idea what perimeter will be set? I, like many others, abhor the fact that people smoke outside hospitals, but I can understand the reasons why they are doing that—maybe they have had some bad news or have been in to see a relative who unfortunately has just died, or whatever.

I support the parts of the bill that suggest that we have to remove people who are smoking from hospital entrances. How will the perimeter be identified to smokers? Will you, as one witness suggested, consider putting up shelters, where people who are smoking could be visited by others who could explain to them the reasons why smoking is bad for their health?

Maureen Watt: No two hospital grounds are the same throughout Scotland, so it will be very much up to health boards to decide what perimeter they want. Basically, we want to get away from the situation that you describe, where people go through a wall of smoke as they enter the hospital. Something like 10m to 15m is roughly what we have in mind for the perimeter, but that will be set down in the regulations.

Richard Lyle: With the convener's agreement, I will ask you one more question.

NHS boards cannot—I repeat, cannot—ban smoking on their grounds totally. They must act within the provisions of bill when setting the perimeter in a hospital's curtilage. I would suggest that 15m is too close and that perhaps it should be double that. We might disagree on the range, but can you give the assurance that NHS boards cannot totally ban people from smoking within hospital grounds?

Maureen Watt: "Banning" is not a word that I like. It will be up to each health board to decide what its policy will be. The bill will not make it compulsory for health boards to ban smoking within their grounds.

I am very much in favour of a health-promoting health service. It is an anomaly that we allow an activity that damages people's health to take place within a hospital setting. We know already, and you will know from the evidence that the committee has taken, that different health boards are at different points along the journey. Some health boards, such as NHS Ayrshire and Arran, are much further along. The discouraging of smoking in hospital grounds is not new; it has been on-going for a long time. Health boards are on different paths along the journey.

To answer your question, the bill itself will not ban or prohibit smoking in hospital grounds. That has to be left to the policy of health boards.

Richard Lyle: Thank you for that reassurance. Again, I welcome the measure and wish it to happen.

Rhoda Grant (Highlands and Islands) (Lab): I will ask about the role of staff in policing the smoking ban around hospitals. The bill talks about the "management and control" of a no-smoking area and knowingly permitting another person to smoke there. If a member of staff is walking into work and sees people smoking outside, does that staff member have a role in trying to stop them? If there is a patient who staff believe should be allowed to smoke for their own wellbeing, and a staff member takes them outside and allows them to smoke, would that staff member be breaking the law? We need to be clear about the role that staff will play.

Maureen Watt: Staff, of themselves, would not be telling people whether they can smoke.

We are looking for a culture change. The advertising that we have done with the green curtain campaign on taking smoking right outside has been effective.

To answer your first question, we would not expect all staff to tell those people that they cannot smoke there. Dealing with people will be up to the health boards and other organisations. The perimeters will have signposting that says that smoking is not permitted in the hospital grounds. You have probably already seen that at most hospitals.

On your second question, I suspect that you are thinking of people who are in mental health wards or long-term patients who have gone on smoking. In the case of people who are going in for an operation, we are trying to make sure that they are made aware of the smoking policies at the initial appointment with their consultants and are offered smoking cessation services before they go for their operation.

Areas will be set aside for people who have mental health issues to smoke. However, the overarching policy will be to encourage people to stop smoking, because smoking does not contribute anything towards mental health and wellbeing. It actually does the opposite.

Rhoda Grant: I am thinking of a situation in which a patient is unable to get outside on their own to smoke, for example because of mobility problems, and a member of staff takes them outside to facilitate their smoking. I understand that in mental health wards there will be smoking areas, but I am thinking of normal wards.

Maureen Watt: In each individual circumstance, it will be up to the nurses or doctors, in consultation with the patient, to decide, and there will be areas set aside outside the perimeter. Siobhan Mackay or Claire McDermott may wish to comment on that.

09:45

Siobhan Mackay (Scottish Government): NHS Health Scotland published guidance earlier this year to support the implementation of smoke-free grounds across all NHS sites. It set out standards for boards, including what the roles and responsibilities of staff are. No staff member would be criminalised for assisting somebody to go out and smoke, although that would be a matter for the NHS board, and I think that the minister is right to say that the individual circumstances would have to be considered.

Nanette Milne (North East Scotland) (Con): I know that the minister is aware of a case in my region where a patient was banned from smoking in the grounds of a mental hospital. I want to clarify a point, because I will be raising the issue with the local health board soon. Is the health board still responsible? In such an instance, can it still say that the grounds must be smoke free, or could it be asked—or pressurised—to provide a shelter of the kind that the minister mentioned for such patients?

Maureen Watt: It is up to the health board to decide its policy. It is not right for me to talk about any individual case. The best course of action for that particular person should be decided in consultation with the patient and their consultant or carers. There might be something that we do not know about that case; the policy is up to the health board.

Nanette Milne: That is helpful, as it clarifies the point for me. Thank you.

The Convener: How will exemptions be clear to people and not just to the health board? If there are many different hospitals in a region and one has a 15m exclusion zone and another has a 50m exclusion zone, and if there are exemptions at one hospital but not at another, how can there be a clear message if such an ad hoc approach is taken?

Maureen Watt: The situation will be roughly the same as that under the Smoking, Health and Social Care (Scotland) Act 2005 regarding residential hospitals and residential properties that are in and around hospitals. We are on a journey and we want to ensure that people who visit hospitals and go into hospitals are absolutely aware that our aim is to make hospitals and hospital grounds smoke free.

As we have in the past, we are relying on people realising that we want to make hospitals health-promoting places. Smoking damages health, so why would we allow smoking in an area that people are in to get well? It is very much a journey for people to realise that we really do not want people to smoke in hospitals and hospital grounds, and I think that that message is already getting through. The green curtain campaign has had a great deal of success and, in the run-up to implementation of the bill, there will be more advertising and leaflets to make people aware of what we want round our hospitals.

Dennis Robertson (Aberdeenshire West) (SNP): My question is about the advertising and promotion of nicotine vapour products, which are more commonly known as e-cigarettes. The policy memorandum states that you are looking to retain point-of-sale advertising, but what is not particularly clear is what other types of advertising you might consider acceptable and how you will restrict other forms of advertising for NVPs. Will you clarify that?

Maureen Watt: Shops that sell NVPs will be allowed to advertise the products so that people know which one will particularly suit them given what they want the product to do. Much of the other advertising will be covered by the European Union tobacco products directive, but we want to ensure that there is no advertising at events on billboards, posters, screens and so on.

Dennis Robertson: It seems to be accepted that e-cigarettes can be useful in getting people to move away from smoking. Community Pharmacy Scotland suggested that, while we would not necessarily want to encourage people towards e-cigarettes, we should ensure that they are aware that such products are freely available.

Is there no intention to extend advertising away from the point of sale in order to encourage people to use NVPs, given that there is a preventative health message? I think that we all accept that NVPs are a good way of getting people away from tobacco smoke.

Maureen Watt: On the point about pharmacies, NVPs are not medicinal products and are not regulated or licensed as such. The manufacturers and sellers are not—as far as I can see—interested in having their products regulated as medicinal products.

Dennis Robertson: I am sorry, minister—I am not suggesting that e-cigarettes are medicinal products. I am simply saying that Community Pharmacy Scotland sees the benefit in having e-cigarettes available to people in pharmacies and other outlets. I am trying to establish whether there will be any additional advertising other than that at the point of sale.

Maureen Watt: Claire McDermott may want to come in on that.

Claire McDermott (Scottish Government): The bill recognises that NVPs may act as cessation devices. Point-of-sale advertising will still be allowed in pharmacies under the regulations—that is the intention, at least—but we do not envisage any advertising beyond that.

The licensing of medicines is a matter for the Medicines and Healthcare Products Regulatory Agency. If the manufacturers got a licence for e-cigarettes, they could advertise under separate regulations.

Dennis Robertson: So there will be advertising only at the point of sale and there will be no further advertising of the benefits of NVPs.

Maureen Watt: There is a fine balance to be struck with NVPs. We are not totally aware of their effects, as there has not been much research into that. We would not want them to be advertised to the extent that people who would not even think of smoking were encouraged to start using NVPs. We recognise that, for many people, NVPs are part of the process of stopping smoking, but we would not want their use to be advertised as a thing to do.

Dennis Robertson: That is reasonably clear. The advertising will be at the point of sale—full stop.

Maureen Watt: Yes.

The Convener: Does anyone else want to come in on that theme?

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): The Government is treading a fine line. The evidence that we have heard has emphasised differing—I was going to say conflicting—aspects, and I have over the past few weeks noticed differences in medical opinion on the subject.

This is one of those areas that are a bit confusing for the public, but I think that most people are reasonably happy with the line that you have trodden, minister. However, do you feel that there is room for a slightly more positive attitude to e-cigarettes from the Government? There might be some disagreement and uncertainty about whether there is a degree of harm from e-cigarettes, but surely everybody is united in the belief that they are massively less harmful than cigarettes. I think that Cancer Research UK and—if I am not misrepresenting her—Professor Linda Bauld, who gave evidence to us, take that view. Should a clear message be sent out to that effect?

Maureen Watt: I am aware of what Linda Bauld and Cancer Research UK said. As I said in answer to Dennis Robertson, we recognise that people

are using NVPs as a method of stopping smoking, but it is also recognised that they are more effective in helping people to cease cigarette smoking if they are used in conjunction with smoking cessation services that are already available.

My worry is that we simply do not know enough about the long-term effects of NVPs. I have been reading about something that is called popcorn lung. In drafting the legislation, we felt that we needed to be very cautious and to tread a very fine line between promoting NVPs as healthy products for stopping smoking and promoting them as things that people can use as a recreation. We debated the issue long and hard, but I hope that the bill strikes the right balance.

Malcolm Chisholm: In that sense, do you disagree with the guidelines that Public Health England has issued?

Maureen Watt: I have seen Public Health England's guidelines. I suppose that the short answer is yes—at the moment, we disagree with them. We do not want to be behind the curve, but NVPs are not licensed as medicinal products and not much research has been done on the long-term effects. We recognise that people are using them as a way of stopping smoking. That is a good thing, and the rates of smoking are coming down. However, I am very cautious.

Malcolm Chisholm: You are to be commended for not going down the route that has been taken in Wales, where e-cigarettes have been conflated with cigarettes when it comes to smoking in public places. However, some hospitals in a particular location in Scotland have banned the use of e-cigarettes on hospital grounds, which is an example of the Welsh approach. Do you have any views on that?

Maureen Watt: I think that NHS Lothian has decided not to allow e-cigarettes to be used on hospital grounds. Each health board has the ability to decide how it wants to progress. It will be interesting to see how NHS Lothian fares with that approach in comparison with other health boards.

This is very much a new area of legislation. We hope that what we are proposing in the bill strikes the right balance.

The Convener: To flip back to the exemptions, different health boards have made different decisions on the use of NVPs. As Malcolm Chisholm suggested, the Scottish Government is almost in the middle—it is still making up its mind—in that its position is between the position south of the border and the position in Wales.

There is a bit of an issue when health boards are treating those who use NVPs almost as smokers. We got some evidence that, if that approach continues to be adopted, people who use NVPs might think that they might as well be smokers if they have to leave a building or be treated like smokers. Perhaps that could be reflected on when guidance is issued, particularly in relation to exemptions and no-smoking zones around hospitals.

10:00

Maureen Watt: We have made it very clear that the bill does not ban the use of NVPs, but—as we have seen—each health board has already decided on its own policy. Some people have said to me that they do not like walking through the vapour from NVPs—some asthmatics do not find it helpful. I hope that what we have proposed in the bill is the right course.

The Convener: If someone was using an NVP in hospital grounds, how would a ban be enforced if NVPs are not covered by the bill? It would not be enforced, would it?

Maureen Watt: That would be up to the health board's policy rather than the provisions in the bill. We are not banning NVPs in hospital grounds, but the position will depend on the health board's policy. Health boards are entitled to make that decision; that is devolution of power.

Malcolm Chisholm: We have heard that one before in relation to health boards, but fair enough.

I turn to the duty of candour and wilful neglect, which we can perhaps look at together. Some people have suggested that the new offence of wilful neglect could undermine the duty of candour. We might come on to that issue.

My first question is on the origins of this. I take it that the origins are in the Francis report. To what extent have you looked at the legislation in England and decided to vary your approach, or have you not been very much involved in that?

Maureen Watt: Are you referring to the duty of candour or to wilful neglect?

Malcolm Chisholm: Both of them.

Maureen Watt: I know that people try to conflate the two.

Malcolm Chisholm: I am not conflating them; I am saying that they are related.

Maureen Watt: We have tried to keep them separate, because they are separate.

The provisions are obviously a result of the Francis report, and I have looked at the legislation in England. I am sorry, but I have forgotten the thrust of your question.

Malcolm Chisholm: I am trying to get the background to where the bill has come from. In

general, I support the provisions, so I am not necessarily putting this forward as my own view, but some people argue that the provisions deal with problems that have not arisen in Scotland. One way of asking you about that is to ask whether, in relation to wilful neglect, for example, you can give an example of a past case that has not been adequately addressed within the existing avenues for redress.

Maureen Watt: Off the top of my head, I cannot give an example.

I will deal with the two aspects separately. A duty of candour is part of the existing professional arrangements of several health professions, but we want to extend the duty to cover all health and social care professionals, which is not the case now. The duty will support disclosure and—I hope—learning and improvement after incidents when there is unintended harm.

Wilful neglect and ill treatment—as I think it is called—are terms that have been around for a long time. The provisions are about ensuring that people understand what they are.

Malcolm Chisholm: I was encouraged that you were clear about this in your opening statement, but is the fact that the bill does not define wilful neglect or ill treatment a problem? Some of the criticisms have come from fears that the offences may extend more broadly than you intend. You were clear in your opening statement that the offences should cover only

"very deliberate acts or omissions."

Does that need to be spelled out more clearly in the bill to reassure people?

Maureen Watt: Offences already exist and the form of the proposed offences is intended to reflect the existing offences. The existing offences use the terms "ill-treatment" and "wilful neglect". We did not think that further definition was necessary, because it might be counterproductive if it casts doubt on the meaning of the existing legislation.

Malcolm Chisholm: I expect that even what you have said today could be taken into account when the legislation is being interpreted. However, we might need to think about whether those could be defined more closely.

My last question is about the duty of candour and concerns an issue that was raised when we visited Ardgowan hospice, although it could have been raised in various places, because I imagine that quite a few individuals are in this position. Will the legislation take account of people, some of whom may be in an end-of-life situation, who do not wish to receive information about any harm or potential harm?

Maureen Watt: Some health professionals have a duty of candour, but the issue is really one that concerns organisations and has not been covered before. Craig White has done a lot of work on the issue, so he could answer the question.

Professor Craig White (Scottish Government): I read with interest the note of your visit to Ardgowan hospice and the research article that was mentioned. If one takes the research that was referenced in the context of cancer, one sees that even the roughly one in 10 people who say that they prefer the doctor to make decisions about what they are told still want specific information. One of the articles that is referenced says that failing to disclose information out of a belief that patients prefer not to know is not a tenable position.

In the context of a duty of candour and the outcomes that are defined in the bill, if someone dies as a result of a systems and processes failure, their loved ones are aware of that, so the issue does not come into play. Similarly, most people are already aware of some of the other outcomes around severe and significant harm. In the context of the duty of candour procedure, health professionals will, of course, make an assessment of the circumstances.

With regard to what you have said about the English legislation, the bill also includes provision to support people who are affected. Part of those supportive conversations would involve determining what level of information the person wants, what questions they have and how they want to receive the information. That is how that would be addressed. The other main differences between the bill and the English legislation are that our proposals include the requirement to provide training for staff involved, and there is also publication of an annual report that outlines the changes in policy and procedure as a result of a review.

Malcolm Chisholm: I am sure that we welcome the training. That is an improvement on the English legislation.

Is there any provision to ask the patient whether they want to receive the information?

Maureen Watt: The duty of candour is not about whether a patient wants to know what their diagnosis is; it involves situations in which there might have been an unintended harm incident, with the aim of ensuring that people learn from that.

With regard to being open and honest, we acknowledge that it might not always be in the best interests of the individual for them to be told about something that happened to them, but the organisation will be required to consider the issue carefully and to ensure that they do not have a

one-size-fits-all approach to disclosing information. The development group will consider the issue as part of its remit when we come to formulate the guidance.

Malcolm Chisholm: I was not asking about the diagnosis. Will there be any provision to ask the patient whether they want to know about harm or potential harm that has been caused to them?

Professor White: Section 22(2)(c) refers to

"the actions to be taken by the responsible person to offer and arrange a meeting with the relevant person",

and section 22(2)(d) refers to

"the actions which must be taken at, and following, such a meeting".

That meeting would usually be where that sort of conversation would take place, with the person being asked how often they wanted an update, whether they wanted to be involved in the review and what information they might require. Those are the sorts of issues that are being discussed around the guidance process. The conversation is very much tailored to the outcome but also to what the person's preferences are for that information.

Malcolm Chisholm: Is that before or after the initial information has been disclosed?

Professor White: I guess that that depends on what we mean by information. If we are talking about a change in the structure of a person's body or the wrong surgical procedure being performed, most people will already be aware of that initial information. Certainly health professionals will, as part of their professional duties, take that into account in their on-going relationship and assessment of the individual.

Malcolm Chisholm: I am sure that we will explore the matter when we come to that part of the bill.

The Convener: I think that Bob Doris and Rhoda Grant have questions on this theme.

Bob Doris (Glasgow) (SNP): I thought that Malcolm Chisholm followed a really interesting line of questioning. I do not want to put words into their mouths, but I suspect that if you spoke, as I have, to the Scottish Infected Blood Forum, Haemophilia Scotland and others, they would tell you that the duty of candour should be almost absolute. After all, how can when one should or should not disclose be defined? Those groups have given significant examples of individual clinicians not disclosing significant aspects of people's health. I simply leave that sitting there, because the groups will be following this process and will want that point to be mentioned.

I suppose that the question is where we draw the line in relation to the duty of candour. Are we talking about a corporate or individual duty of candour? The groups that I have spoken to were very interested in, for example, the apology that the First Minister and the health secretary gave to those who had been given infected blood and so on. However, although they certainly got something from that, they really felt that they were getting something when the Scottish National Blood Transfusion Service started to give apologies. Sometimes the more distant the place the apology comes from, the less meaningful it can be, and it would be quite helpful if you could provide some more information on who would give the apology or who would provide information via the duty of candour. Would it be someone corporate, if you like, or someone at a more local level?

Maureen Watt: The reason for introducing a duty of candour on organisations is that there is still wide variation across Scotland in health and social care organisations' response to incidents of unintended or unexpected harm. It is very much about ensuring that organisations take responsibility for what has happened as well as individuals, but the detail of the extent to which that will happen will be set out in regulations.

Bob Doris: Could there be both? What about an individual who is close to patient care—be that health or social care—who gives information in relation to the duty of candour? They could have been under stress or strain; no wilful neglect might have been involved; and what happened, serious though it was, was just an unfortunate incident that could itself identify a systems issue, in which case you might want a corporate duty of candour and apology. Does this have to be a matter of either/or? Could it be both and, if so, could that sort of thing be teased out in regulations?

Maureen Watt: It could absolutely be both, because the situation that you have just highlighted could well occur. That is why making the duty of candour the responsibility of organisations as well as individuals is absolutely necessary.

Bob Doris: As we know, the statistics show that the health service has become significantly safer in recent years, particularly as a result of the patient safety programme, so I put my next question in that context. Each week, seemingly small-scale incidents could trigger the duty of candour, and the question is whether or not it is triggered. Quite a lot of my constituents want a culture of candour as much as a duty of candour, and the issue is about openness, transparency and being able to say about an individual receiving social care—in fact, social care would be a very good example—who, say, has had a wee fall, "We really should have had two people to move and handle them, but the second staff member was overstretched. The patient was really keen to be

moved, but we got things a little bit wrong. We've now put processes in place, and this is what has happened." I think that a lot of families would very quickly get something meaningful from that approach. The question is whether that would be part of a culture of candour or would result from a legislative duty of candour, because they could be two separate things. How do we promote a culture of candour that exists even when the duty of candour itself is not triggered?

10:15

Maureen Watt: You are right—it is about promoting a culture of candour. However, it is also a continuous improvement process. We learn from mistakes and, in the example that you cited, a mistake was made, but we know what should have been done. The focus is on learning from what has happened and on the organisation providing support, training and staff development. As you say, we need to ensure that the culture is that people learn from what has happened—that there is a development and learning culture across the service.

Ailsa, did you want to say something about the legal aspects?

Ailsa Garland (Scottish Government): Yes. I want to add to what the minister said and say something about whether the duty applies to organisations or individuals. The duty in the bill is placed on organisations but it is not intended to usurp the role of individuals. It is just that the organisation will be under a requirement to follow the duty of candour procedure, which will be set out in the regulations. There have been concerns that people close to the incident will not then be able to provide information. The bill requires that a different health professional makes the judgment that the incident has caused the outcome that is listed in the bill, but that does not mean that the professionals close to the incident cannot be involved in the information giving. That is something that we can look at in relation to the regulations and when we set out the detail of the procedure to be followed.

Bob Doris: I am sure that I read somewhere in my notes that if the duty of candour is implemented and an apology given, it is not necessarily an admission of neglect—it is not a corporate admission. If the duty of candour were used at a more local level, could it empower health and social care workers to provide information to individuals and be more open and transparent? They might be keen to do that now but they might think, "If I disclose this information to this person, what will happen in relation to me, in my practice?" Is protection built in for individuals who work in health and social care to allow them to be as open and transparent as they would like to be without compromising their position? Someone might say, "We got this wrong. The duty of candour has been invoked here", and apologise at a local level. Would we be likely to see more of that if it were entrenched that that is not necessarily an admission of neglect? Would that be teased out in regulations or is it in the bill?

Maureen Watt: That is where we need to separate the duty of candour and neglect. Situations in which there is ill treatment or wilful neglect are dealt with separately. Under the duty of candour, we want to foster a culture of openness and transparency in the health service, in which people learn from their mistakes. However, the bill does not provide an exemption from disciplinary action when someone reports an unintended or unexpected incident, if indeed disciplinary action is required. That situation will not change. We want the whole organisation to learn from incidents and for the service to, and care of, an individual to be better.

Craig, did you want to come in on that?

Professor White: Yes. Section 23(2) states:

> "An apology or other step taken in accordance with the duty of candour procedure under section 22 does not of itself amount to an admission of negligence or a breach of a statutory duty."

Health and social care professionals have discussed that and commented on the importance of making it clear that an apology is part of this procedure and that any decisions that might be made in the legal process, for example on negligence and liability, are completely separate procedures.

Bob Doris: I have no more questions, convener, but I want to say that I support that approach. Those providing health and social care directly to our vulnerable constituents get things right nearly all the time. We are all human; sometimes we get things wrong. We need to empower people to be able to say, "Look, we got that wrong. That doesn't make our member of staff a bad worker, but in terms of transparency and a culture of candour, we're giving you this information." That is about reassuring people that organisations will learn from any incidents, but the individuals involved will not necessarily be hauled over the coals. It is about getting the balance right.

Maureen Watt: As MSPs, we have all had cases where people—in a care home, for example—think that things could have been done better. They do not necessarily want any reparation; they want to make sure that lessons are learned. That has certainly been my experience. We have to follow up the cases and make sure that the organisations learn from the incidents, which is often all that the relatives want.

The Convener: From previous inquiries and from our own involvement in such matters, we all know the power of an apology. We can therefore appreciate the minister's comments, which take us on to another wee stage that follows on from Professor White's comment about the definition in the bill that an apology or other step taken in accordance with the procedure would not be an admission of negligence.

The committee is also aware that the Parliament is considering the Apologies (Scotland) Bill, which is Margaret Mitchell's member's bill. The Justice Committee's stage 1 report broadly supports that bill's general principles. It is almost identical to what is in the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill, although it extends the remit to all public service organisations. The Scottish Public Services Ombudsman said in a submission that the provision in the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill should be removed altogether and included in broader legislation, or at least be extended to the whole public sector.

We have had a lot of comment about that. Should the duty of candour be part of broader apologies legislation and taken out of the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill, or should Margaret Mitchell's Apologies (Scotland) Bill be amended to exclude health and social care, which should be left to the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill to pursue?

Maureen Watt: My understanding is that the need for apologies offered as part of the duty of candour procedure should be exempt from the Apologies (Scotland) Bill. That point has been emphasised. I will bring in Craig White to clarify the position, because he gave evidence to the Justice Committee on the Apologies (Scotland) Bill.

Professor White: The Scottish Government's position is that the need for apologies offered as part of the duty of candour procedure should be exempt from the Apologies (Scotland) Bill.

The Convener: Fine. That is now on the record, if it was not already on it.

I call Mike MacKenzie, to be followed by Rhoda Grant.

Mike MacKenzie (Highlands and Islands) (SNP): The area that I was hoping to explore has been fully covered, convener.

Rhoda Grant: I have a question about the duty of candour. It is obvious from the bill that any incidents that trigger the whole process must be serious ones. Should the bill emphasise an overarching duty of candour in all situations, so that medical professionals tell patients what is going on, regardless of whether the issue is serious? Surely people should be entitled to information about their own care.

Maureen Watt: Given that we want an open and transparent health service and that we are talking more and more about patient-centred treatment, it is important that all health professionals discuss the patient's care and treatment with them while they are in a care setting. The duty of candour will, I think, ensure that systems are in place, both for the organisation and for the individuals concerned, in order to make that happen more often than it has perhaps happened to date.

Rhoda Grant: Should an overarching duty of candour be in the bill?

Maureen Watt: The description of what we mean by "duty of candour" is well set out in the bill.

Rhoda Grant: The bill uses the term "serious incidents".

Maureen Watt: Does anyone have any thoughts on that?

Professor White: The international evidence on the sort of outcomes that we have been talking about, such as death and significant harm, suggests that the professional duty of candour should apply—as Rhoda Grant has hinted—across the spectrum, at all levels of incident.

The evidence also suggests that we need to focus our thinking on what an organisation does to ensure that there are in place other policies and procedures around the review and around learning across the organisation, and that there is a systematic approach to providing support where there has been significant harm. The level of training required to enable and empower professionals to discharge their professional duty is quite specialised, given the nature of the incidents involved. That is the context in which the policy was developed, in terms of there being additional requirements for an organisational duty, relative to what is specified in a professional duty.

Rhoda Grant: That does not really answer my question. I understand that, and I understand why those things are there.

The minister said, either in her opening remarks or in answer to a question, that some professionals have a duty of candour in their code of conduct. Not all professionals do, however. Would it be appropriate to put the duty on the face of the bill so that anyone who is dealing with a patient has a duty of candour, full stop, and regardless of the outcome of the incident?

Professor White: I am sorry that I did not answer the question. Most regulated professionals have a professional duty of candour, and in some professions, such as medicine and nursing,

additional guidance is provided. Under the UK legislation that supports the regulation of health and social care professionals, those professional duties are reflected in their codes of conduct.

Rhoda Grant: That is what I said, but what about the professionals who do not have such a duty in their code of conduct?

Maureen Watt: They will be covered by the duty of candour in the bill. It is important to put in place within organisations the infrastructure to ensure that all health professionals are covered by the duty of candour.

Professor White: I appreciate that it is not for me to determine who should respond, but I know that Ailsa Garland has been looking at the issue from a legal perspective.

The Convener: It would be helpful to hear from her.

Ailsa Garland: Any discussion of the regulation of health professionals gets a little bit tricky because of the reserved-devolved split. We do not have the power to make provision in our legislation across the board.

We are talking about the fact that some professionals have a duty of candour in their code of conduct, whereas others do not. The policy in relation to setting out the various levels of harm is to set out a range of outcomes in section 21(4). However, we have to set a bar, as far as that is helpful, so it will not cover every incident of harm that may occur.

It would be fair to say—I am straying into policy here—that we hope that the bill encourages a cultural change. Even though a particular incident might not fall within the duty of candour procedure in the bill, we would hope that, over time, the bill might encourage a cultural change towards organisations being more open—even in relation to smaller incidents—with patients and those who receive social care.

The Convener: I would like some clarity on the role of the independent health professional. I note that the duty of candour will be triggered by the opinion of a health professional who has not been involved in the care of the person in question.

How will an independent health professional be identified? Why does the bill refer only to healthcare professionals when the duty will cover other settings, such as social care and social work?

Maureen Watt: It will be someone who has not been involved in the person's care up to that point. Somebody will come in to independently look at what happened to see whether the proper procedure was not followed and whether there was a lack of care in that person's treatment.

10:30

The Convener: Who would the independent health professional be, and why would they have to be a health professional if they have to cover all these settings?

Professor White: Perhaps I can make two points in response to your question. First of all, taking an example from a health context, I do not think that this would preclude individual health professionals from being involved in discharging their professional duty and the organisation's procedures. However, as I think the General Medical Council and Royal College of Nursing acknowledged in evidence to the committee, the independent health professional would be the independent person in the organisation who made the final decision whether a situation related to the outcomes that are defined in the bill. The reason why it would be a health professional is that, as you will know, some of the outcomes are health related. The bill contains a requirement for the decision to be made that the outcomes are not directly related to the course of the person's illness or their condition, and we propose that such a judgment be made by a health professional.

The Convener: And it would always be a health professional who would make that judgment.

Professor White: Yes.

The Convener: Could there be any variance? In some instances, the issue could be about health outcomes but in others, it could be something else.

Professor White: I know that in your evidence-taking sessions you considered the integration of health and social care. It is possible that a social care professional in an organisation might report that they believed that one of the outcomes had occurred, and it would then be for the organisation responsible for the duty of candour procedure, in deciding whether to report it under that procedure, to have it confirmed by an independent health professional that the outcome was not related to the course of the person's illness or their condition.

Maureen Watt: After all, we are talking about an adverse event in relation to their medical condition.

The Convener: As this is our last evidence-taking session on the bill, I want to go back to the issue of enforcement. Are you confident that the ban on smoking in NHS grounds can be adequately enforced, given comments from witnesses that local authority officers are choosing not to enforce other areas of legislation due to resource constraints?

Maureen Watt: When we introduced the legislation that banned smoking in public places,

local authorities used their enforcement powers. We do not expect a local authority officer to travel, say, a mile to a hospital to issue a fine, but the bill requires local authorities to get involved in cases of persistent breaches. I point out, however, that most people obeyed the legislation on smoking in pubs. We have been working on the matter with local authorities, the Convention of Scottish Local Authorities and environmental health officers, who already enforce the current smoke-free legislation across the whole of a local authority area, including hospitals.

The Convener: So the local authorities are helping you with this.

Maureen Watt: Well, we are having discussions. [*Laughter*.] We know that the public are largely law abiding and we expect that, if they know that the bill is coming in and if our communication on it is good, the levels of compliance will be as high as those for other such pieces of legislation.

Richard Lyle: At the end of the day, this is all about education. When the ban on smoking in public places came in all those years ago, people said that it would not work. However, it did work, because there was steady progress on the matter. I advocate a continuation of that approach by removing smokers from hospital entrances. I am convinced that if we progress steadily with educating people, they will, in years to come, not smoke anywhere near hospitals. I agree with that approach.

Maureen Watt: An awareness-raising campaign is vital, but I simply note that the recently introduced drink-driving regulations have been accepted by the public to a huge degree. I think that the same will happen with the provisions in the bill.

The Convener: As members have no other questions, I thank the minister and her colleagues for attending this morning and for their helpful evidence.

I suspend the meeting for a changeover of witnesses.

10:35

Meeting suspended.

10:41

On resuming—

The Convener: Because of a delay in our witnesses arriving for the next part of the meeting, we have agreed to move agenda items around. The next item will be our discussion of the evidence that we have just heard, which will be in private session.

10:41

Meeting continued in private.

10:57

Meeting continued in public.

Alcohol (Licensing, Public Health and Criminal Justice) (Scotland) Bill: Stage 1

The Convener: Agenda item 3 is our first evidence session on the Alcohol (Licensing, Public Health and Criminal Justice) (Scotland) Bill. I welcome to the committee Alison Christie, policy officer, Scottish Families Affected by Alcohol and Drugs; Dr Peter Rice, honorary consultant psychiatrist, NHS Tayside, and chair of Scottish Health Action on Alcohol Problems; Dr Colette Maule GP, BMA Scotland; Tim Ross, chief inspector, Police Scotland, and North Ayrshire health and social care partnership; and Petrina Macnaughton, research and policy co-ordinator, Alcohol Focus Scotland. Welcome to you all.

Before we begin the questions, I make the witnesses aware that Richard Simpson MSP, who is the member in charge of the bill, has joined us today. Richard will have an opportunity to ask questions at the end of our session. Welcome to you, too.

No opening statements will be made, so we will move directly to Malcolm Chisholm, who will ask the first question.

Malcolm Chisholm: As there are 10 different proposals in the bill, it is quite difficult—in fact, impossible—to deal with them all simultaneously. I have read all the submissions, which were extremely useful—thank you very much. I thought that it might be useful to start with the areas on which there is unanimous agreement. There might be more such areas, but I think that everyone is agreed on the minimum price for packages containing more than one alcoholic product—I am sure that I will be contradicted, but my impression is that everyone agrees on that; community involvement in licensing decisions; and restrictions on alcohol advertising. Those are certainly the areas on which there is broad agreement. There is a measure of disagreement on all the other areas, even if just one organisation disagrees with what is proposed, but I wondered whether the witnesses had any issues in the three areas that I have mentioned, on which it looks as if there is a lot of agreement. I am sure that people will tell me that I am wrong if that is not the case.

The Convener: Can we take it that there is broad agreement on those areas? Thank you. Right, Malcolm—now for the hard stuff.

11:00

Malcolm Chisholm: Oh, right—I had expected to hear some comments on that. Well, Richard Simpson will be pleased because he has three proposals in the bag and only seven to go.

There might be some merit in taking the proposals one by one. Perhaps we can start with the issue of alcoholic drinks with caffeine, because people know the background to that. Such drinks are related in many people's minds to antisocial behaviour, but there might also be health issues with them. There are different opinions, however, so it might be useful to kick off on that issue.

The Convener: Petrina, were you attempting to come in earlier and I cut you off? I am sorry if I did.

Petrina Macnaughton (Alcohol Focus Scotland): I think that there is broad agreement about restrictions on alcohol advertising, tightening up the quantity discount ban and community involvement in licensing. However, Alcohol Focus Scotland believes that the measures need to go further than what the bill proposes. I do not know whether that constitutes broad agreement, but we definitely think that marketing restrictions, for instance, need to extend beyond what is proposed.

The Convener: Would it be helpful to ask the basic question? Do you believe that the bill is likely to have a noticeable impact on reducing alcohol consumption?

Petrina Macnaughton: Voluntary agreements are already in place for each of the measures in the bill to restrict marketing. There is a voluntary agreement not to advertise around schools and a voluntary agreement not to have alcohol sponsorship of sporting events that primarily involve young people and children or where they are the audience. If such restrictions are made enforceable through legislation, that will add something, because we know that the voluntary agreements are breached in some cases—for example, in relation to advertising around schools; a few instances of that have been noted in Wales.

The bill's proposals will provide an additional element, but that will not make much of a difference because voluntary restrictions are already in place. To make a difference, we should consider extending the restrictions to prevent children from seeing advertising, because we know that they do. Our research has found that children as young as 11 or 12 have a high level of awareness of alcohol brands and advertising. We would advocate a ban on alcohol advertising in more public spaces and an extension of restrictions on advertising in cinemas, on television and in other broadcast media. There is support for such measures among the population. For instance, there is widespread support for a

ban on alcohol advertising in cinemas for under-18 films, which is a much clearer and simpler measure than what is currently in force.

Dr Peter Rice (Scottish Health Action on Alcohol Problems): Just to add to that, the measures in the bill would undoubtedly be a step in the right direction, but I agree with Petrina Macnaughton that there is still more to be done. As has been quoted in some of the evidence, we have 10 and 11-year-olds who are more familiar with lager brands than they are with ice cream brands, which is not a happy situation and not the way we would like things to be.

There are discussions going on in Europe about this issue but, at the moment, the requirement is to prove that the marketing is targeted at young children, not that they are exposed to it. If a young person goes to see their football team and the team jersey has a beer logo on it, that is substantial exposure to brand advertising but, because it is not targeted at the child, it has proved very difficult to regulate it. That is just one example of the further steps that we need to take. These are good steps to address marketing that targets young people, but most of the marketing that young people see is targeted at the wider population rather than young people, but young people see it in the general run of things. We need to take steps to address that, but the bill is a move in the right direction.

The Convener: Does anyone else want to comment?

Alison Christie (Scottish Families Affected by Alcohol and Drugs): For the Department for Work and Pensions review, we had responses from 70 family members, and the constant comment was that alcohol is everywhere. For example, if you take your children to the deli for breakfast on a Saturday morning, its shelves are lined with wine. It is about the marketing but, as Peter Rice and Petrina Macnaughton said, the bill has to go further on the exposure to alcohol.

The Convener: I can see that no one else wants to comment at the moment, and I am aware that I interrupted Malcolm Chisholm earlier.

Malcolm Chisholm: No, that was useful, because it is clear that people want to add to the list of proposals, not take away from it. It is up to you how to proceed, convener, but I suggest that we move to the issue of caffeine, if there are seven other issues that are more controversial.

The Convener: Can we have a response to Malcolm Chisholm's original question about caffeine?

Dr Colette Maule (British Medical Association Scotland): From a personal perspective, when I see patients in my surgery who are having problems with alcohol, it tends to be because it is lower priced rather than because it has caffeine in it. I would not like to concentrate on one area of low-priced alcohol; we have to take into account all the other types that are out there. At times, there is not a lot of discrimination between which alcohol people take. It is really the price that is the problem.

The Convener: Is that a generally agreed position?

Alison Christie: All the data that we have is about the quantity of alcohol. We do not have any families who are concerned about particular brands or products. It is about volume and how accessible it is to buy it cheaply.

Petrina Macnaughton: We certainly agree that price and affordability are the key drivers that increase consumption and harm. There is research that shows that a high proportion of young offenders drink caffeinated alcoholic drinks. Considering that the caffeinated alcoholic drinks that are sold in the country make up only about 2 per cent of the total alcohol market, they figure quite high in alcohol-related offending, so we take a precautionary approach. There is some evidence to indicate that caffeinated alcohol can exacerbate alcohol-related offending, and on that basis we would advocate for a restriction to be considered and implemented, and then we could evaluate the results. The evidence is indicative, not conclusive, but I am not sure whether the cost of implementing a restriction on caffeine content would be high. I do not know whether it would be costly to implement a measure about putting less caffeine into a drink, but the effect of doing so on alcohol-related offending could be evaluated.

Dr Rice: We feel that it is not a priority action, on a number of grounds. One is that, as has already been said, most of the harm that we see in clinics comes from low-cost alcohol, and the tonic wines and caffeinated drinks tend not to be low cost. The evidence about the relationship between caffeinated alcohol and offending is restricted to quite a limited part of Scotland, and even the McKinlay report had no tonic wine consumers from the east coast, which is an interesting phenomenon. That report showed that the same high numbers of people were consuming spirits, cannabis, benzodiazepine and ecstasy, and only 30 per cent of that sample reported that their alcohol-related offence was purely caused by alcohol; it was caused partly by other drugs. We should not pick out caffeine from that cocktail of drugs, as it is not the priority drug.

A further element is the emerging neuroscience, which indicates that the immature male brain—and the male brain stays immature for quite a long time, probably into the mid-20s—has an alerting reaction to alcohol, and our response to alcohol

becomes more sedative as we age. Some of you might even know people to whom that has happened. The alerting effect of alcohol in young men, which is often attributed to caffeine, may in fact be an intrinsic effect of the interaction between alcohol and the still-developing male brain. Putting all of that together, our feeling is that, although we understand the public concern, restricting caffeinated alcohol is not a priority action.

My final point is that suggestibility is a very important effect in intoxication. When people become intoxicated, they behave in the ways in which they expect to behave. The belief that a drink will make such and such happen is a strong predictor of what is going to happen. My view is that the discussions around tonic wines may in fact have made things worse. They may have established a reputation for a particular product that will become a self-fulfilling prophecy, and what might have been a short-lived craze has become more long lived. We have never drawn attention to caffeinated products, because we think that some of the public attention to them might be detrimental.

The Convener: Are you okay with that answer, Malcolm? Did you just want some of that on the record?

Malcolm Chisholm: Yes. That was interesting.

The Convener: Bob Doris has a supplementary on the caffeine issue.

Bob Doris: I will be brief, because there are other substantial parts of Dr Simpson's bill that I would like to ask questions on.

In relation to the point that Dr Rice made, if the bill were to go through and a ban on caffeinated drinks imposed, what is the likelihood that the young people who are involved in social disorder or who put themselves at risk with those drinks would stop drinking? Would they not just switch to another form of drink that might be lower cost? Would someone not just market the next big thing that would become the magnet for young people to drink? I want to be sure that the ban would actually have a positive effect.

Dr Rice: My view is that if people are setting out to become intoxicated and expecting to become violent and disorderly as part of that, that will still happen.

The question about caffeine is very legitimate. Does caffeine have a neurochemical effect that enables people to keep drinking when otherwise they would have collapsed and passed out? Does the alerting and stimulating effect of caffeine allow people to keep going, keep drinking and get more intoxicated with alcohol, leading to more disorder? That is a very legitimate question that is, to an extent, unanswered. I think that a recent meta-analysis has shown that the effect of caffeine in keeping people drinking is not powerful—it does not happen. As I said earlier, there is evidence that the alerting effect in fact happens even without caffeine.

It is likely that people who set out to drink with the intention of becoming violent, and who see that as part of the experience, will still become violent.

The Convener: Chief inspector, do you want to respond?

Chief Inspector Tim Ross (North Ayrshire Health and Social Care Partnership): I have a similar point. The fact that such behaviour exists in areas outside the west coast where those types of drinks are not so prevalent suggests that there would be alternatives and that the issue is more to do with cost and availability. Although we are supportive of the ban as a step, we would like to see the research that shows whether the effect of caffeine augments the effect of alcohol and to have that considered more fully before we take decisive action on it.

Richard Lyle: I have a question about alcohol advertising and then would like to move on to container marketing and off-sales.

Although I am not a football supporter, I know that in the past we have had sports events that were sponsored by Tennent's, we have had the Carling cup and we used to have the Martell Grand National. Dr Rice, a couple of moments ago you mentioned that quite a number of football teams have the logos of drinks brands on their jerseys and so on. Do you feel that alcohol advertising, particularly sponsorship by alcohol brands, should be banned at sporting and cultural events that principally target those under the age of 18?

I go to a sports centre with my grandson and see kids of five or eight playing football, but there is no advertising of beers or wines there. If I take my son or my grandson, when he is older, to a football match, there will be a Tennent's cup or a Carling cup and advertisement boards will be flashing up different brands of alcohol. Do you think that what is proposed in the bill is workable?

11:15

Dr Rice: I think that it is workable. One of the first things that I did on alcohol policy was to run a campaign to get the drinks logos removed from child-size football strips. That was eventually successful, although it took some years. The Welsh research shows that the issue that you raise is undoubtedly a major part of young people's exposure to alcohol brands, with the one

that was most recognised by young people being the company that sponsors the rugby union competitions in Wales. It is a big channel for exposure.

Many countries in Europe do not allow that sort of sponsorship. In two of Celtic's three away games in Europe so far, they have not been able to wear their cider logos on their shirts, because they were playing in Azerbaijan and Iceland, which do not allow that. Other countries, such as France, have made such a restriction work perfectly successfully. It is not a proposal that is on the table today, but my view is that that type of sports sponsorship is inappropriate.

There are shades within the issue, and you would not want to interfere with a situation in which, say, a local hotel was sponsoring an amateur team. However, I am opposed to big corporate sponsorship of major sporting events by alcohol firms.

It is a big business. FIFA forced the Brazilian Government to change the law in order for it to stage the world cup, and the Russian Government just agreed to do the same in order to have the alcohol sponsors selling their product in the football grounds. National Governments come under pressure from sports associations and have gone along with what has been asked of them. They are powerful forces, but I think that such sponsorship is inappropriate and I would like it to be removed.

Petrina Macnaughton: It comes back to what Peter Rice said about the rule that advertising and sponsorship must not appeal particularly to children. However, that distinction is quite meaningless, because children are targeted by all the advertising that adults are targeted by. All the advertising and sponsorship that appeals to adults appeals to children, too—humour, depictions of social and sporting successes and so on all influence children's attitudes. It has been shown clearly that that influences their intentions to drink, when they start to drink and how much they drink. That needs to be addressed in all our rules regarding the marketing of alcohol. We must recognise that, to protect children, we have to consider all advertising. There is no such thing as advertising that does not appeal to children. It all does, so that has to be addressed.

Richard Lyle: I want to move on to deal with the issue of container markings. My question is for Chief Inspector Ross.

The Convener: I am sorry to interrupt, Richard, but I thought that you had another question about advertising.

Richard Lyle: I said that I was going to move on to container markings.

The Convener: I must have misheard you. Other members want to come in on the back of your first question. I am sure that that is in the interests of everyone.

Colin Keir (Edinburgh Western) (SNP): I have a couple of questions about the influence of alcohol companies on sporting competitions. Has there been an assessment of the amount of money that is involved? I am sure that the sporting authorities might complain if a massive amount of sponsorship money suddenly left because we happened to change the law on sponsorship.

As I was coming into the meeting today, it was put to me that a lot of sports clubs, golf clubs and so on receive preferential loans and things such as that through alcohol companies—Belhaven beers are quite prevalent in golf clubs, for example. Has there been an assessment of how much money might be taken from sporting organisations and events if we changed the law?

Petrina Macnaughton: I do not think that there is a recent assessment. Ireland was considering phasing out alcohol sponsorship of sport. For its public health bill, it might have done an impact assessment, but I have not seen it so I do not know for sure.

Beer companies have preferred beers at events, with sponsors' beer and so on. However, there are alternative models for funding sport. Heart of Midlothian Football Club has led the way on that; it requires a different ethos.

We recognise that alternative sources of funding would be required. If we were to go down this road, we would advocate a phased removal to allow other funders to come on board.

At the moment, a lot of funding of football is related to addiction—to betting, alcohol and payday lenders. It attracts those kinds of funders. If we were to move away from that and get more congruence in funding and more family-oriented funders of football, we would have to phase out that funding. Such a change would need to be planned, and a change of ethos would be needed.

Colin Keir: Before we try to find a way to get out of such funding, would it be appropriate at least to work out the financial hit on sporting events and clubs? As we all know, funding can be difficult to find.

Petrina Macnaughton: This is about a principle. We are not talking about introducing a law to ban such funding overnight. It would be a phased removal, which would allow people to source alternative funders and to allow other models of funding for games. We live in quite a rich society and there are a lot of businesses that are not alcohol related that can fund sport and sporting events. That is not impossible.

Colin Keir: If there is no financial assessment, how can we tell what the hit will be?

The Convener: Other members of the panel want to come in.

Dr Rice: I will try to keep it brief. I am a football supporter and one of my arguments has always been that this might mean that Scottish football was dragged down to the level of French football. As France functions perfectly well without such advertising, I could live with that.

We did some work at the UK level on sponsorship of sport. In the English Premier League, which is very financially successful, only one football team is sponsored by a beer company, and that is a far eastern beer company. It seems that English football has become too big for the beer market. In fact, the biggest club that is sponsored by an alcohol company in the UK is in Scotland.

The argument that we will hear is that sport is hooked into that money and cannot live without it. I do not think that the evidence supports that. Colin Keir is absolutely right, though. If a ban on such advertising was a firm proposal, there would need to be appropriate analysis of it.

The Convener: The restrictions on alcohol advertising that are described in the bill might be much more limited. You have argued that such restrictions should be extended. What is your understanding of the limits of what is being proposed?

Dr Rice: What has been proposed is a group of good ideas, but one of the limits is that they work on the presumption that advertising is targeted specifically at young people around schools and so on, when in fact most of the exposure is not there.

Another issue is that billboard advertising is becoming a smaller and smaller part of the advertising industry. The real prize is social media, which is very difficult to legislate for. Finland is trying to do that.

The measures in the bill are useful, but there are bigger fish to fry, if it is possible to construct legislation on that. The social media issue in particular is not easy, but it needs to be taken on.

The Convener: Does anyone else have questions before I go back to Richard Lyle?

Dennis Robertson: Just a quick one.

The Convener: On advertising, surely.

Dennis Robertson: I will be brief, convener. We probably want to ensure that advertising is more ethical and perhaps moral. If alcohol advertising were to be removed and the advertising instead related to—as Petrina Macnaughton said—payday lending or betting, we would create another problem and perhaps an even bigger problem in terms of people's wellbeing and addictions. How do you suggest that we control advertising to ensure that we do not create a bigger problem? Alternatively, Dr Rice suggested that perhaps we should not allow such advertising at all.

Dr Rice: I will have another crack at that one. The first thing that we need to do is stop advertising being self-regulated. That would be a big change. My profession used to be self-regulated and now it is not: the majority of the membership of the GMC is now non-doctors. Somehow, the advertising industry has retained the right to self-regulate. The number 1 priority on my list would be to change advertising regulation.

Richard Lyle: My question is for Chief Inspector Tim Ross. Most of the complaints that we receive locally are about the fact that, when police catch an under-age drinker, they do not know or cannot find out where the person bought the container. The bill proposes that there should be an identification mark—it would be interesting to find out later how that would be done—on each container to show where it was bought. Is that workable?

Although the proposal in the bill refers to off-sales premises, my view is that every place where alcohol is sold, including supermarkets or wherever—as someone said previously, some local shops and eating places sell alcohol—should have a specific code or identification mark. Is that workable? Would that help the police to establish where alcohol had been bought by, say, an under-age drinker?

Chief Inspector Ross: Container-marking schemes are workable, as they have been undertaken before voluntarily, although they have not been widespread. I understand that the proposal in the bill is that such a scheme would be established by order of a licensing board in a particular area, so we are not looking at population-wide schemes. The schemes are workable on a local basis and they enable us to track containers back to premises. The proposal relates to off-sales because we are trying to address the sale of alcohol to young people in off-sales premises.

Nevertheless, such schemes have limits. The licensing environment has changed since bottle-marking schemes were first used, which was before the introduction of the current licensing legislation. The likes of the challenge 25 scheme and test purchasing perhaps give us stronger options when we are dealing with premises that sell drink to under-age people. The strength of bottle-marking schemes is in developing

intelligence to allow more targeted enforcement to take place.

The schemes have worked in the past and I would not say that they could not work again, although they have had varied success in different areas. I fully appreciate that there are difficulties, as the fact that somebody has a drink that came from certain premises does not mean that the premises committed an offence in selling it—that depends on who the third party was who bought the drink.

Bottle-marking schemes have worked and if there is community support for such a scheme and—perhaps more important—support for it among the premises in the area that might wish to take part in it, it could well be a success. As I said, such schemes might be more about informing future work on the management and operation of premises.

The Convener: Are you saying that such a measure could or should be available to a licensing board in a given area?

Chief Inspector Ross: That is an interesting question. I am certainly not against the measure. I should point out that I am at the meeting as a representative of North Ayrshire alcohol and drug partnership rather than as a representative of the police, but never mind that, because I am of course a police officer.

I am certainly not against such schemes. The environment has changed slightly in recent years. On what such schemes deliver, it is good if the premises licence holders take part in the scheme voluntarily, because we need that buy-in.

On the evidence that that provides, the outcome and the impact on drinking in the area, we would have to take that case by case. As I said, perhaps its greatest potential would be in providing the evidence or intelligence base to allow further action.

11:30

Rhoda Grant: I turn to the section of the bill that deals with notifying GPs about offenders. It seems counterintuitive that GPs and the BMA have concerns about that provision. I want to get those concerns on the record, because it appears to me that that requirement would give GPs a full picture of their patients. We talk about treating the whole person and their circumstances and the like. If a piece of information from the jigsaw is missing, I do not understand why someone would not want to have it.

Dr Maule: I start by saying that the piece of the jigsaw probably is not missing—GPs are probably aware of the alcohol problems that their patients are suffering with. We have to accept that the medical record is fundamentally there for treating patients. Bringing in information across the board is probably not the way that we want to go.

We have to look at the doctor-patient relationship. We spend a long time over our careers building up a relationship with our patients. It is a relationship of trust that what we discuss and have in the records is something that we have both consented to, which we have spent a long time dealing with.

If a patient presents daily in the surgery with anything that suggests an alcohol issue, I will address the matter with them. If they do not raise the issue but I suspect that they have an alcohol problem, I will raise that with them. I will investigate it and bring them back in to discuss the outcome of the investigation with them. I would not like to jeopardise that relationship by the patient having—or possibly not having—consented to me being given information about a criminal offence that alcohol might have played a part in.

There would be an issue with data coming into the record. I am the data controller of the record. I would have to know that the patient had been appropriately counselled and informed. The patient would have to have been told exactly what would happen with the information coming into their record, and what would happen to the information should the patient leave my practice and move on to someone else, which often happens when people have chaotic lifestyles in which alcohol plays a part.

I am particularly concerned about receiving information on spent convictions, because that would require GPs and their practices to spend considerable time following up the information that had been placed on the record. How would I be informed about that? What would happen between the patient being convicted and the conviction becoming spent? How would that information be passed to a GP who the patient had moved to?

Consent is a big issue. I want patients to be fully aware of the information that is part of their medical record. I do not perceive that the system is foolproof enough to ensure that that would happen for their medical record for their entire life.

A large administrative burden would also be placed on GPs and patients. I was slightly disappointed to note that no impact would be expected on a GP consultation from placing the additional information in the record. If I had to deal with something because it was there—the GMC clearly states that, if something is put into a patient record, I have a responsibility to act on it—that would impact on my personal relationship with the patient and the time that I could spend dealing with other aspects of their health in the consultation.

In the practice, a lot of my staff's time would be taken up with bringing in the information and sending it to a doctor to be actioned. That would also be the case in doing the opposite, when information needs to be taken out at the other end.

The doctor-patient relationship is critical. It must be accepted that general practitioners have a very good idea of their patient's health problems. Even if a patient is not forthcoming, we are trained to tease out the information from them. I am perfectly content that I would be able to deal with the possibility of an alcohol problem with any patient who presents in the practice.

Alison Christie: One of our concerns about the proposal came from family members. The ones who spoke to us were unclear and therefore hugely anxious about what would happen next, because they immediately started to think that that simple statement would lead to social work, the police and so on getting involved. The families already face a huge amount of shame and stigma, and the family members who spoke to us felt that this was just another layer that would be added to what they already have to carry.

The Convener: How does that square with what we just heard from Dr Maule? Families do not want doctors to know the information and want it withheld, but Dr Maule said that she knows all the people in her practice who have a drink problem.

Alison Christie: There are families who will go to their GP, but we have found that on average a family member will cope with someone's problem alcohol use for seven years before they seek help—partly because of the fear of the unknown, particularly if children are involved. I agree that a GP is likely to know their patient's history, but the situation is different for family members, who will hide things and try to cope for a long time.

The Convener: Families will live with the problem for seven years without seeking any help.

Alison Christie: Yes. We already knew that anecdotally from our family members, but research that we have recently completed with the University of Edinburgh is likely to provide evidence of that.

The Convener: In that case, could intervention happen earlier to prevent the eventual crisis?

Dr Maule: I imagine that, if a patient of mine was attending court or whatever, the ideal time for intervention would be when they were being dealt with by those who were raising the alcohol problem with them. I think that Ms Christie is saying that relatives are more loth to come forward with the information, which is certainly an issue.

When a patient comes to my surgery, I have a one-on-one relationship with them at that time. It would be rare to have a consultation at which a GP would not address the possibility of alcohol as a factor. If a patient were to present at the surgery in a way that gave me concern, I would intervene at that point.

The proposal might be that I would not have to do anything if I received information that one of my patients had a drink problem, but the GMC says that I have to. That would just lead to confusion. I would not ignore the information, but the question is whether I would be tasked with bringing in a patient to address it. More often than not, I am absolutely aware that a patient has issues with alcohol.

The Convener: I do not know whether you have already alluded to this, but do you feel that the justice system provides support to and helps to identify and track those who are being dealt with for drink-related offences?

Dr Rice: As I worked for 20-plus years as a specialist psychiatrist in alcohol problems, I know that there was a common route of referral, sometimes from criminal justice services and from courts for, say, people on probation orders, and sometimes from people going voluntarily to their GPs, precipitated by an offence. It was a common pathway for people to get into specialist treatment through criminal justice routes.

The Convener: You said that it was common.

Dr Rice: Yes.

The Convener: Is that still the case?

Dr Maule: Yes.

Dr Rice: I have been out of clinical practice for a couple of years, but I do not think that things have changed much. You can take it that that is still a common route for people to get into specialist services. The GP is often, but not always, involved in the process; sometimes, the referral comes from criminal justice probation teams and so on.

Rhoda Grant: That is interesting, because I am not awfully sure where the difference lies, apart from ensuring that this sort of thing happens routinely when there is a problem with alcohol, instead of someone having to take the additional step of referral to a GP, counselling services and the like. If that was happening, health professionals could intervene earlier, get support for the person and perhaps deal with the problems long before they got worse and people found themselves in prison because of their offending behaviour.

Dr Maule: The first intervention should be at the earliest possible time. If we were informed down the line when a conviction had happened, rather than the patient being in the system and alcohol having been perceived as a problem, there would be a delay.

Patients are still referred to us by probation officers, counsellors and addiction workers. The bill does not need to be put in place to ensure that that system exists. I would certainly rather see the patient two to three months before their conviction than wait until it had happened, as I could then intervene at the right time. I think that the current informal system works.

Rhoda Grant: But people will be missed.

Dr Maule: People will be missed, but that must be balanced against all the other issues that I have raised that are to do with the loss of the doctor-patient relationship, the potential impacts on families, the administrative burden, the data controller procedure and the GMC opinion. I do not think that the proposal would help my relationship with my patients.

Bob Doris: I wrote down a couple of phrases—"trust" and "patient buy-in"—that relate to the discussion. If I am being honest, I am not sure that the provisions in the bill facilitate either of those things.

On patient buy-in, I think of my constituents. Let us imagine that one of us around the table gets involved in an offence in which alcohol has been consumed, irrespective of how major or otherwise that offence is, and is convicted. I do not know how any of us would feel about that being flagged up to a GP in terms of trust, or how we would feel about part of a criminal record being kept in our medical records. I think that we would all be thick-skinned and worldly wise enough to get on and deal with the matter, but for a number of my constituents—particularly those in hard-to-reach groups—it is a significant achievement to go to the doctor in the first place. I am concerned that those who are least likely to seek medical help for a variety of conditions and who are most likely to need support from GPs might be those who take greatest umbrage at the breach in the trust relationship. I would welcome comments from the witnesses on whether they agree with that.

I also wrote down the word "targeting". I am delighted that it looks as if the quality and outcomes framework is on the way out from 2017 onwards. If politicians were to say to medical professionals, "Pick the 100 people in your practice who you think are most at risk of alcohol abuse, and we'll give you more time to spend with them in a targeted way," would you pick the 100 people who had committed an offence during which they were intoxicated, or would there be another way of doing things? Is targeting the GP's time the most effective way to get the outcome that Dr Simpson quite understandably wants to achieve?

Can you say a bit more about the hard-to-reach groups whom you struggle to get to make and keep appointments? In particular, would Dr Simpson's proposal dissuade them from going to the GP? Is it the best approach? Obviously, it would take up GPs' time. Is targeting at-risk groups of people who abuse alcohol and damage their health the best use of clinical time?

Dr Maule: I agree with your first point. I definitely agree that those patients are difficult to reach and that any barrier that is put in the way will have only negative consequences. As you say, those consequences will relate to not just alcohol-related problems but all the other medical conditions that can go with them.

On the second point, the first thing that would have to be decided is whether the GP was best placed to deal with the initial presentation. The GP possibly is best placed to recognise initially that there are problems, but who is best placed to deal with the long-term effects of those problems and has the time and expertise to go along with that? As members know, we essentially have 10-minute consultations, during which it is very difficult to achieve anything. The impetus is lost if you bring someone back a week later. GPs see most patients most of the time, but we would probably be best placed acting as a route to someone who has the time and expertise to deal with the on-going problems.

11:45

Bob Doris: I am trying to get at the issue of targeting. Dr Simpson obviously wants to target at-risk groups where alcohol is a contributing factor to offending—although I suspect that it is a public health initiative rather than a criminal justice initiative. If you want to target those who are most at risk of a public health hazard due to alcohol abuse, is Dr Simpson's proposal the way that you would like to use your time as a GP, or can you think of other ways of using that time?

Dr Maule: That is a difficult one. I do not think that I can answer it just now without having more information. I would have to know the balance of who had been convicted and whether what happened with an individual was a one-off or whether they had a long-term alcohol problem.

As GPs, we have embraced that sort of work in the past. We have done brief interventions and we have targeted patients, but generally time is of the essence in the consultation and we really rely on having a support network that we can send people on to. We target anyway, because we tend to ask most people who come in with a medical problem whether they smoke or drink and we assess whether they are overweight. We do public health promotion in every consultation anyway. Taking that next step is where we get the best support.

Chief Inspector Ross: I have scribbled down a few points to make. From a health and social care partnership point of view, we want to be really clear about the exact purpose of the bill. On the face of it, you might think, "I can see why that's happening", but we would have to be really clear about the purpose. For example, is there anything to facilitate patient buy-in or patient engagement in the process? If somebody does not want to engage with their GP, albeit that their GP may well know that they have an issue, how do they buy into the process?

It would also be interesting to see the scale of the issue. There is a degree of subjectivity in a police officer assessing the role that alcohol plays in the commission of an offence. It would be interesting to see the scale of referrals to GPs and the obvious knock-on effect on resourcing.

We talked about earlier schemes. Various police offices throughout Scotland have undertaken pilot alcohol referral schemes, which have been more about giving offenders who are in custody brief interventions. That might be something to look at as well.

The point about targeting is valid, because it comes down to resource issues. How do you choose between the person who committed an offence because they were drunk—but they do not normally drink—and the long-term alcoholic in the community who perhaps does not come to the attention of the police?

I am not saying that what Dr Simpson proposes is a bad thing to do, but maybe we have to consider whether it would be the best way to use our limited resources.

Bob Doris: I might come back in later, convener. I found Dr Maule's final comment on alcohol brief interventions helpful. Let us take the fictitious 100 alcohol brief interventions that Dr Maule is going to do. I know that it would be wonderful if she was given lots of additional time to do them. This might be a difficult question to answer, but do you think that interventions would be more likely to have an impact if you identified the patients in your caseload who would be most likely to benefit, based on your current relationship with them? Alternatively, would it be more effective to do interventions for 100 people who have been up in court as they come forward? What would be more likely to produce an effective brief alcohol intervention and produce the positive health outcome that you are looking for? That is what I am trying to get at.

Dr Maule: Do you have an answer to that, Dr Rice?

Dr Rice: I will take that one, having been involved in the development of the alcohol brief intervention programme. It is important to put this into context. The Scottish programme, which has been up and running since 2008, is the first national programme of its type in the world. It has been a big success numerically, mostly due to its take-up in general practice. A good structure was established, with good software and all that, to make it easy to do. The programme has outperformed its target every year. People are coming to look at how that has been achieved. It has also coincided with considerable improvements in alcohol-related health in Scotland. The programme has been a big success and primary care has really bought into it. That is part of the context of the discussion. There is lots of very good practice in Scottish general practice, and the ABI programme supports that.

Your question on targeting relates to my previous day job in Tayside. Although things have improved in Scotland, there is still a shortage of treatment—there is unmet need for treatment for alcohol abuse.

The people who were most likely to benefit, and whom I most wanted to see, were those who most wanted to be there. There were various ways of rationing treatment—we need to use the word "rationing", because that is the reality. I always felt that putting rationing in the hands of the patient seemed to be the fairest way to do it. The people who wanted to be there got there, often via their general practitioner.

That is what I took from your question about targeting. If we have limited resources—we would love to have unlimited resources, but we do not have them—who is it best for us to target? My answer is that we should target resources at the people who really mean business.

Dr Maule: The difficult part is getting people who want help to seek it and to go forward from there. We do that in the surgery, day in, day out. We discuss alcohol—in fact, I discuss alcohol in probably about 60 per cent of my consultations—no matter why the person is there. We try to get the network that is around us to support the patient and their family.

Bob Doris: That is helpful—thank you.

The Convener: That takes us on to another part of the bill, which is on alcohol awareness training as an alternative to fixed penalties.

I do not know exactly what is meant by the specific word "training", but the idea of directing and supporting people rather than imposing a criminal sanction relates to what we have been speaking about. The training could include some sort of counselling support or referral, or it could even just be about asking people whether they have thought about those things or discussed them with their GP.

I wonder what people's views are on that provision, under which training would be offered—as I said, I do not know about the word "training", but that is what is in the bill—as an alternative to a fine when someone commits an offence under the influence of alcohol.

Chief Inspector Ross: We would welcome that approach. We recognise that education and awareness raising are generally more effective in many cases than enforcement—and certainly if enforcement is in the form of a fixed-penalty notice. If we had training as an option in circumstances in which we felt that it would be appropriate for the offender to be offered it as a means of negating the requirement to pay a fine, that would be very welcome. A fine is quite often punitive for the people whom we deal with and does not assist them in their situation.

The early and effective intervention programme for younger people has been really good. We looked at whether it would be possible to do that in Ayrshire. At the time it was not, because the procedures did not allow us to do it, but we would certainly welcome training as an option.

Dr Rice: We have just completed a pretty large trial in England, funded by the Department of Health, which looked at brief interventions in a number of settings such as primary care, criminal justice and accident and emergency. Primary care came out as by far the best setting in which to deliver brief interventions.

Brief interventions that were delivered by probation staff in a criminal justice setting also came out well in evaluation. The problem was in getting departments to do those things. The general practitioners were quite well behaved and did the work, but we had a job getting criminal justice services organised so that they actually did it—although those that delivered it did pretty well—and keeping them engaged.

There is merit in the idea of training, but we would need to look at the structure of criminal justice services and at how they can get themselves organised to deliver such training reliably.

Chief Inspector Ross: Looking at the available models, I think that there are definitely resource implications. The work that we have done in North Ayrshire around trying to improve peer involvement and raising awareness of alcohol issues has been very successful. We could adopt some innovative and exciting approaches that might not be too resource intensive but which would allow us to deliver some really effective interventions.

Petrina Macnaughton: We definitely support the provision of awareness training and support. The only question in our minds concerns cost effectiveness and what happens if people do not have the motivation to change. If they simply think that they will get out of paying a fine and are not ready to change their behaviour, such an approach may not motivate them to change, and that raises the issue of whether the training would be cost effective. That would have to be evaluated, I guess.

Bob Doris: I am trying to go through each of the bill's provisions. Alcohol education policy statements are an aspect that seemed fairly reasonable initially but, on looking at the bill, I began to wonder a little bit. If we go down that road, my thinking is that people would lobby me about having substance abuse education policy statements, healthy diet education policy statements or physical exercise policy statements.

We absolutely agree that there is need for better education and information to allow people to make informed choices, but the issue is whether we should single out alcohol from the areas that I just mentioned. I am open-minded about the matter. I do not know how it would work in relation to Government and to reporting back. I am not so hung up on the process, which is something that we could look at, but should there be stand-alone alcohol education policy statements?

Petrina Macnaughton: I am not quite sure what the purpose would be of alcohol education policy statements, what they would include and what they would be aimed at, hence my reservations in supporting their introduction. If more information was provided to help us understand what they set out to achieve, we would be open-minded about their introduction.

I can see a clear need, or a context, for policy statements in licensing. When implemented at the local level, they provide communities with the broad framework in which licensing decisions are made. Licensing is often about the individual application, so I can see that they would have a place in meeting the overall objective of the licensing system. However, I am not sure how they would work in an education context, given local authorities' control over education policy. In addition, would they be national and local? I do not know. There is not enough information for me to come to a decision on that.

Bob Doris: That is helpful. Does anyone else want to comment?

Dr Rice: I am aware that the preferred approach in education is to see alcohol as a general life skills or personal, social issue. The old-style approach of getting in the doctor or the nurse for half an hour to speak to the kids is not what happens now—I think that the general approach is that teachers incorporate such education in the curriculum.

Many of the submissions have called for caution in being overoptimistic about the effect of education, partly for reasons to do with marketing. As has been said, young people get many messages about alcohol, and education is only a drop in quite a big ocean. It is important to understand that context when you look at the issue. Education can do useful things, but we should not overestimate its effect. In answer to your question, the preferred educationist approach is to focus on general life skills.

Dr Maule: Again, it is about evaluating the effectiveness of the approach. Would we be moving resources from a more effective area? Obviously, we need much more information about the policy's effectiveness, its cost and the balance that we might lose from other areas.

Bob Doris: That is helpful. Are there no more comments on that?

The Convener: They shook their heads; they said no. [*Laughter*.]

Bob Doris: I know, but—

The Convener: I have a question.

Bob Doris: I was going to ask again the other part of my question, which was whether anyone has any concerns. If the concern is only in my head, it does not matter. Is there no concern about compartmentalising health education into alcohol, substance abuse, healthy lifestyles or whatever? That was the main part of my question, but thank you, panel, for not answering it, which is why I came back in. [*Laughter*.]

The Convener: The question that I will raise is for the sake of completeness. We are dealing with lots of issues in the bill. What about the age discrimination in off-sales? Licensed premises may voluntarily apply an age limit higher than 18, and we have received mixed responses to that. Section 3 would remove that flexibility and voluntary code. Are people relaxed about that and content with it?

12:00

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Convener—

The Convener: You will have an opportunity to come in, Richard, but you must be patient. You are not a member of this committee any longer, so you will need to wait until we are finished.

Dr Simpson: I am trying to be patient.

The Convener: Yes, and we are trying your patience.

Dr Rice: I will have a crack at this one, convener. I realise that there is more to the bill than public health, but I really do not see the public health gain in removing the flexibility. I understand that the flexibility has not been used; I am not aware of any licensing board using it. However, there was pretty full discussion of the issue when it was aired in an earlier consultation process, probably about five or six years ago. The idea did not find favour and there was some pretty active lobbying against it. I still think that a split age limit is an interesting idea, with people being able to buy alcohol in a pub or restaurant at the age of 18 but not being able to do so in off-sales until they are 21. It has not found favour in public policy, but I do not see that there is any public health benefit in removing the option for licensing boards to have such flexibility if circumstances demand it.

The Convener: Are there any other responses?

Chief Inspector Ross: The apparent absence of any licensing board that exercises the power in question suggests that there is no evidence base for it being required. Therefore, our take on the issue is that we are not sure that there is an evidence base that would suggest that persons aged 18 to 21 are particularly involved in disorder in any area, and it would be quite difficult to measure.

The Convener: Okay. Malcolm?

Malcolm Chisholm: I think that there is only one of the 10 proposals in the bill that we have not covered, but it is the one that covers the most sections in the bill and concerns drinking banning orders. There are differing views on that proposal, so I am interested in hearing what the witnesses think of it.

The Convener: We are looking to you, Mr Ross.

Chief Inspector Ross: As an alcohol and drug partnership and a health and social care partnership, we welcome the drinking banning orders as an option. There would be two routes to obtaining the orders, and we can see circumstances in which they would be very useful. However, more work needs to be done on exactly how they would work and how effective they would be, because undoubtedly there would be problems attached to them.

They would provide a phased approach. There are elements of the Licensing (Scotland) Act 2005 that allow us to deal with violent offenders linked to licensed premises. The drinking banning orders would maybe allow a bit more of a stepped approach for those who do not reach that threshold and who we can try to influence.

In terms of linking the orders to an approved training course, we have talked already about the benefits of education and awareness for those who are ready and willing to undertake that. It

would be good if such training was an option, because it could indeed start to impact on the public's use of alcohol.

Malcolm Chisholm: I suppose that you are the person who might be able to answer this question. Would the orders add anything to the options that are already available in criminal law?

Chief Inspector Ross: Yes, I think that they would. It would be interesting to see exactly what the impact would be in terms of policing, because such an order would, in effect, be a civil order, a breach of which would be a criminal offence. Would that be easy enough to police reactively? Yes. Would there be an expectation of some proactive policing around that? I am not entirely sure how we could do that. However, I certainly think that the orders could fill a gap that exists just now and could be a useful option.

Dr Rice: My clinical patch was in Tayside and I had some experience of the same goal being achieved, mostly by sheriffs in smaller towns. A sheriff in such-and-such a town would say to someone "I don't want you to be drinking any more", and the police would know that. My observation is that that seemed to work quite well in smaller communities.

We should also acknowledge the fact that we are no longer a pub-going nation. In 1994, 51 per cent of alcohol was sold in pubs; 20 years on, that figure is heading for less than a quarter. The big shift from pub drinking to drinking at home has been a big part of the challenges that we have faced, and if the thinking behind a drinking banning order is based on a model of risky people going into pubs, I have to say that that battle has already been lost among the very heaviest drinkers. Indeed, the survey from Glasgow and Edinburgh makes it clear that only 3 per cent of the alcohol that the heaviest drinkers who come to our clinics consume is drunk in pubs. They are almost exclusively home drinkers, and the drinking banning order needs to be thought about in the context of that reality and where we are at the moment.

The Convener: That was helpful. I should say that we have until approximately 12.15 for this session. As members of the committee do not seem to have any more questions, I will now turn to Richard Simpson.

Dr Simpson: I will go through my points in order, convener.

First of all, I thank the witnesses for their input on the issue of advertising. We are limited in what we can do; after all, we cannot introduce the loi Evin here. Sarah Wollaston tried to do so in England, but she was blocked by the UK Government. There is certainly a problem in that respect, but I wonder whether the witnesses think that we should extend the provisions to include sporting events for adults. Under the bill as drafted, such adverts would not go on screens or on the thing that goes round the football pitch at under-18 matches. We are limited in our legal opportunities, but should we go further at this point in time?

Dr Rice: I am all for that.

Dr Maule: Me, too.

Alison Christie: I know that we were talking about children earlier, but not only children but adults are very much exposed to alcohol. We work with the over-18s and we get many calls from people saying, "It's everywhere." How can we stop that kind of exposure? When you get off the subway in Glasgow, the first thing you see is a bollard advertising an alcoholic drink. We need to protect adults as much as children.

Dr Simpson: That is fairly clear, and the Government might need to consider the matter, particularly in the context of minimum unit pricing. After all, if the courts decide in favour of that policy—which they might well do, given that it is a public health issue in Scotland—the additional profits, particularly for the supermarkets, will amount to more than £100 million a year, some of which might well go into more advertising. I do not know whether the witnesses agree that, even if the bill goes through with its limited scope, the committee should consider recommending such a move in its report.

The Convener: I think that that was a statement, Dr Simpson. Do you have any questions?

Dr Simpson: On container marking for off-sales, there seemed to be a suggestion in response to Richard Lyle's questions that the scheme would be universal when in fact the provision in the bill is limited with regard to the licensees who would be affected and the period for which it would operate. Do the witnesses think it appropriate to keep that as a temporary measure?

Chief Inspector Ross: In my experience, these schemes have been most effective and have worked best where there has been buy-in from communities and local premises. From that localised point of view, it is absolutely important that the measure is not universal. I suppose the question is about having a statutory power and whether things would still happen on a voluntary basis. I am not entirely clear whether a statutory power is required.

Dr Simpson: On notification of GPs, I have to say that I put in this provision even though in the consultation the BMA and GPs were against it; indeed, the courts were against it, because of the

costs. In my 30 years as a GP, the only people who were referred to me were those with really serious offences while those for whom alcohol was only a small part of their offence were not referred.

Given that GPs now deal with 400 brief interventions per full-time equivalent post a year, the objective of the proposal was to provide focus. Notification would be voluntary; the offender would not need to give the GP's name. The process would be to say, "Look, you got into trouble through alcohol, and we would like to inform your GP. Is it okay for your GP to be informed?" Is that not a reasonable approach? We are talking about relatively low-level offenders, when the police have said that alcohol is involved in the offence.

Dr Maule: I cannot agree with that approach. Notification would impact on the doctor-patient relationship. A part of the proposal suggested that they would not need to consent, and part of the problem would be the ability to consent at that time. I feel that brief interventions are to be performed at the time rather than later when the GP might be informed.

We also have to accept that there would be an administrative burden and workload implications, when GPs currently are failing daily because of the workload that we undertake. We have to prioritise what is important to each patient and we have to go on the doctor-patient relationship that exists. I do not feel that the proposal would bring anything to my practice.

Dr Simpson: Okay. The courts estimate that 150,000 cases come before them at the moment. How many have you been informed of? How many of your patients have come to you and said that they have been to court and have had a conviction? I am talking about low-level offences, because high-level offenders are referred to a specialist. As a specialist addictions doctor, I had referrals from the courts, as did Peter Rice. Among that low level, how many patients have come to you and said that they have just been done for doing something and got into trouble because of alcohol?

Dr Maule: I cannot give you a figure off the top of my head, but in my practice it is not an uncommon occurrence for patients to come either when they accept that they have some form of alcohol issue or when something like that has happened that has a real impact on their lifestyle.

Dr Simpson: Okay.

The last proposal that I want to raise is the one on caffeine. I accept that it is a very small area of sales, but it is a particular problem in the west of Scotland. What do you feel about the fact that in America the Food and Drug Administration has effectively persuaded producers to suspend production of premixed alcoholic drinks and that at least two, if not three, European countries have limited it? Do you think that they have acted in a way that is not evidence based or that is unreasonable? Have they done it for some other reason? Why would they do it if it was not for a good reason?

Dr Rice: My response both today and in my written submission is about priorities. If there is lots of time and scope for legislation, the proposal in the bill might be something that we should look at.

The American situation is interesting. In the American evidence, the perceived trouble with caffeine was to do with sportsmen in universities—they are the people who were thought to be causing trouble because of caffeine—which is quite a different group from the one that was described in Scotland. It fitted with my notion that caffeinated alcohol was a kind of craze, if you like, among a sub-population.

It was interesting that the FDA was able to approach the issue by shutting the market down. It might have been able to do so because the products were only part of those companies' portfolios, so they could live with it. It was an interesting development.

I have not followed the Danish story too closely, but I am aware of it.

In my view, the issues are whether it is a priority and, as I said earlier, that excessive focus on one type of drink might be detrimental to addressing wider problems. Some of our large producers and large retailers are quite happy to see those products in the spotlight, because it suits them quite well. That worries me.

Dr Simpson: Okay. Thank you very much.

The Convener: I thank all the witnesses, who have been with us for quite a while now. All the evidence that you have given has been very helpful, and I hope that you will see it reflected in the committee's final report.

12:14

Meeting continued in private until 13:15.

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