OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 1 March 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

9th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Alison Douglas (Alcohol Focus Scotland)
Professor Niamh Fitzgerald (University of Stirling)
Lucie Giles (Public Health Scotland)
Elinor Jayne (Scottish Health Action on Alcohol Problems)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 1 March 2022

[The Convener opened the meeting at 09:40]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the ninth meeting in 2022 of the Health, Social Care and Sport Committee. I have received no apologies from members.

The first item on our agenda is a decision on whether to take item 8 in private. Do members agree to take item 8 in private?

Members *indicated agreement.*

Tackling Alcohol Harms

09:40

The Convener: Our second agenda item is an evidence session on tackling alcohol harms in Scotland. We have four witnesses, who all join us remotely. I welcome to the committee: Alison Douglas, chief executive, Alcohol Focus Scotland; Professor Niamh Fitzgerald, from the institute for social marketing and health, University of Stirling; Lucie Giles, public health intelligence principal, Public Health Scotland; and Elinor Jayne, director, Scottish Health Action on Alcohol Problems. I thank you all for your time this morning.

There are figures out there that, at first, make it look as though consumption of alcohol has gone down during the pandemic, but that is not the whole picture. Starting with Alison Douglas, I will go round all the witnesses to get your views on what the consumption of alcohol and alcohol harms during the past two years really look like.

Alison Douglas cannot hear me, so I will bring in Niamh Fitzgerald.

Professor Niamh Fitzgerald (University of Stirling): I think that you are right that the fall in consumption is not the whole story. We have done some work to look at ambulance call-outs during the pandemic and, in particular, alcohol-related ambulance call-outs. Although when the bars and pubs were closed, alcohol-related ambulance call-outs were falling, even before bars and pubs reopened, there was a rise in ambulance call-outs to people who were drinking at home. Paramedics and other colleagues in the licensing system have expressed a lot of concern about a rise in home drinking in particular groups. Even as researchers, we were surprised that those call-outs to pubs and bars in city centres were replaced so quickly by call-outs to people's homes. In that indicator of alcohol-related harms through the Scottish Ambulance Service, we see a fairly even split between harms that relate to short-term use of alcohol—in relation to parties and city centres—and chronic, long-term use of alcohol, whereby people are drinking heavily on a regular basis and often have alcohol problems.

Elinor Jayne (Scottish Health Action on Alcohol Problems): Other people on the panel—in particular, Lucie Giles—will be able to speak in detail about the figures and data around consumption levels and death rates due to alcohol during the pandemic. It really was a mixed picture. Although overall consumption went down, we believe that that was a reflection of the fact that places where people go out to drink, such as pubs, clubs and restaurants, were closed.

The increase in the amount of alcohol that was consumed at home was a continuation of a trend that had been going on for years, and it was a massive acceleration of that trend, because people consumed virtually all their alcohol at home. That is a concern in itself, but the increase did not quite equate to the drop in consumption as a result of the closures of pubs during various lockdowns. However, that masks changes in consumption. Although various bits and pieces are going on, we think that the heaviest drinkers were potentially at more risk of consuming more alcohol during the lockdowns, and we might see an increase in health inequalities as a result of that.

There is a real risk that we will see a difference between more affluent communities, who were consuming less alcohol, and the heaviest drinkers in some of our more disadvantaged communities, who were drinking more. Obviously, that happened during the pandemic and we do not know what the long-term implications will be. However, we need some policy response to reduce those inequalities and those really harmful levels of consumption; we cannot just accept the situation.

09:45

Lucie Giles (Public Health Scotland): The data that you are referring to in relation to an overall reduction is probably the data that we published last week. We use alcohol retail sales data to monitor alcohol consumption at a population level. However, it is important to stress that that is an average for the country; it masks some of the differences in different sub-groups. As Elinor Jayne has alluded to, other sources of data indicate that, throughout the pandemic, some people have possibly reduced their consumption; some have not changed their consumption at all; and some have increased it. As Elinor said, those who have probably increased their consumption tend to be those who were already drinking at the higher end of the scale.

Essentially, we have seen a big shift towards drinking at home. Over the past couple of decades, we have seen a shift from on-trade sales—sales through pubs and clubs—towards off-trade sales, but that shift has increased quite significantly. Typically, in the immediate years before the pandemic, about three quarters of alcohol was sold through the off-trade. That rose to about 90 per cent in 2020 and then increased further in the first part of 2021 because virtually the whole country was in a full lockdown.

There is a mixed bag of data; what is of more importance is the harms data that we published. At the point of the strictest restrictions, we saw a big decrease in the number of people who were accessing hospital treatment for alcohol-related conditions. At the same time, we saw an increase in deaths from alcohol-specific conditions. That data is of more concern and points towards that polarisation of consumption as well, which held particularly true among men and those who were aged 45 and older. Those are the primary findings from that work.

The Convener: Lucie, you have been looking at the data, including the different demographics and what the patterns are. Was there anything notable in the statistics in terms of rural areas in particular?

Lucie Giles: We did not look at rural areas specifically. We used sales data to monitor population-level consumption, but the data is not available to enable us to drill down by demographic group in that way. We would have to look to other data, such as survey data, to be able to do that.

The Convener: Our other panellists might have something anecdotal to add from the work that they do. Is there anything of interest in terms of alcohol harms and consumption in urban versus rural areas, particularly in the past couple of years?

Elinor Jayne: Although, as Lucie Giles says, we do not have any data in relation to the impact of the pandemic on consumption and harms in rural areas, we know that the infrastructure and culture around alcohol in rural areas are very different. Previous research that we carried out demonstrates that there is very limited access to alcohol-free spaces in rural areas and, because the rural economy quite often relies on tourism and hospitality, alcohol is quite central to a lot of the social interactions in rural communities.

Although we do not have anything specific on the impact of the pandemic in rural areas at this point in time, it is important to bear in mind the cultural difference in our rural communities when we talk about different responses and how to build back from the pandemic and address some of the harms that have occurred, especially when it comes to isolation and loneliness. Last week, the Scottish Government published data about levels of isolation and loneliness going up, and it is obvious that, in rural communities, there will be a deeper impact. Those things need to be borne in mind. We cannot assume that rural communities are experiencing the same problems as urban communities are. We need to think of different ways to build back, and we need to make sure that we take action to reduce harm in a different way in our rural areas.

The Convener: Thank you. I am now able to bring in Alison Douglas. Alison—I hope that you were able to hear at least some of what has

happened and that you can comment on the issues from your perspective.

Sadly, we cannot hear Alison. You should not have to do anything, Alison. We should be able to hear you. We will get someone from broadcasting to get in touch with you and maybe sort out some of the problems. I am seeing a nod from our colleagues in broadcasting. Sorry about that, Alison. I will go to Niamh Fitzgerald next, and then my colleague Sandesh Gulhane has a question.

Professor Fitzgerald: If you are interested in geographic differences and differences in urban and rural areas and areas of deprivation, ambulance call-out data could be looked at in more detail. We have not done that yet, but call-outs go to a specific location, so it is good data for making those comparisons, although it is not something that we were originally funded to do.

Sandesh Gulhane (Glasgow) (Con): There are a couple of things that are really concerning when it comes to alcohol harms in Scotland. We need to be absolutely clear that the average is not the average, because those people who are harmful drinking will skew the average. Also, I found it really concerning that, even though we have that overall reduction in the amount of alcohol that has been sold, the average is 18 units per person per week. That is huge; that is over the recommended maximum amount that we should be drinking, which is 14 units.

What assessment can you give us on the effectiveness of the steps that we have taken?

Professor Fitzgerald: In terms of alcohol harm reduction, the three key policies are to make alcohol less affordable, less available, and less attractive. Those are the World Health Organization's "best buys". When we look at what Scotland has done in relation to those best buys, we have addressed price, albeit that our minimum unit price for alcohol is quite low and has stayed low for some time, so that is something that we could look at.

I believe that plans are under way to look at the marketing of alcohol. Other countries have done more on that, so we can learn from them. We know that in other countries, for example, they have found that it is easier to take bigger and broader action on alcohol marketing than it is to take piecemeal action. One of my colleagues has recently looked at marketing regulation in several countries.

On alcohol availability, our research and our practitioners are telling us that the licensing system, as it is currently set up, cannot reduce availability; it is not possible to take licences away. There is a limit to what can be achieved on availability in terms of reducing alcohol-related harms. That is not to say that good cannot be done through that system. A lot of people are working very hard on that. However, although Scotland is very much viewed as a leader in alcohol policy worldwide, there is still a lot that could be done on all three of those best buys.

Elinor Jayne: In response to what Dr Gulhane was saying, the 18 units average masks an awful lot because a proportion of the population does not even drink. That means that a lot of people will be drinking way in excess of 14 units, which is the minimum risk guideline—it is not a safe amount to drink, it is just what the chief medical officers have agreed is the minimum risk limit in terms of what adults should consume as a maximum each week.

As Niamh Fitzgerald has said, there are the WHO best buys. The Scottish Government is very supportive of those and has bought into the WHO recommendations on alcohol policy.

One of the fundamental measures that the Scottish Government has brought in is minimum unit pricing. The whole context of MUP is that the affordability of alcohol is directly related to the consumption of alcohol and the consumption of alcohol is directly related to the number of harms experienced across the population. If you reduce affordability, you reduce consumption and then you reduce harms. There is clear evidence around that and it is what the WHO recommends, which is why that measure has been taken in Scotland.

The MUP was introduced at the level of 50p per unit in 2018. The level of 50p was proposed when the legislation was first mooted, in 2012, but there were delays due to the legal challenges to the legislation and, when it was finally introduced, six years later, it was introduced at the same level that had been proposed six years earlier. Although we were supportive of that, we would argue that the level should definitely be increased if we are genuinely going to talk about reducing the affordability of alcohol.

In 2020, alcohol was 73 per cent more affordable than it was in 1987, which demonstrates why we have seen alcohol harms increase so much in that period. Although MUP is a very positive measure, we want to see it being uprated to 65p in order to give the measure a few more teeth and to impact on affordability a little bit more.

We would also like the MUP to be automatically linked to inflation so that we do not have to go through regular reviews and legal processes to uprate it each time. It should be automatically linked so that its level of affordability is maintained. That is one measure that we would like to see taken further.

There are lots of other measures that could be taken. Marketing and sponsorship are a really big area, and the Scottish Government is committed

to introducing restrictions in that area. It is our view that there should be total regulation of all alcohol marketing in Scotland, especially marketing that may affect children and young people, as well as people who are in recovery from alcohol problems, who are regularly exposed to marketing around alcohol and find it really difficult.

In particular, we would like to see an end to alcohol sponsorship in sports because we feel that it is totally incongruous to have alcohol, which is intrinsically a harmful product, involved in a healthy participatory activity. For instance, in the 2020 six nations broadcast coverage, alcohol was mentioned every five or six seconds in the broadcast of the Scotland-England match. That is the sort of thing that we would really like to see restricted, to make alcohol less like a normal commodity and more like the commodity that it is, which is one that comes with health risks attached. There are a whole lot of different measures that the Scottish Government should take forward in that regard.

The Convener: Some of my colleagues are going to drill into particular aspects of what you have brought up, but we will turn to Lucie Giles next and then I will bring in Alison, as I think her technical issues are now resolved.

Lucie Giles: To go back to the original question about the effectiveness of the policy that is in place, I just want to reflect on the fact that we have shown, in the first year since MUP—[*Inaudible*.]—that it had an impact, with a reduction in total consumption of around 3.5 per cent. Again, that is population-level consumption, so that comes with a caveat that it masks the consumption level across different groups.

However, there has been that reduction of 3.5 per cent in comparison to England and Wales, where we saw an increase in total consumption. We will be publishing data later this year that looks at the longer-term impact of introducing MUP, but there is also evidence there from other studies. For example, a group in Newcastle University has published longer-term data looking at what the impact has been and it found that the impact was—[*Inaudible*.]. It showed an impact of around 7 to 7.5 per cent reduction in consumption based on purchasing data and that has been sustained over the longer term. As I said, we will be publishing three years' worth of data later on this year.

In terms of how that then translates into harms, we have not yet published that data. We will be publishing a study next year that looks at the impact on not just alcohol-specific and directly alcohol-attributable conditions but on a wider range of both wholly and partially attributable conditions. We are looking at the impact of MUP specifically on health harms but we do not quite have that data yet.

The Convener: That is great. We will hear from Alison Douglas next.

The Convener: We come now to Alison Douglas.

10:00

Alison Douglas (Alcohol Focus Scotland): Thanks, convener. Can you hear me now?

The Convener: We can hear you perfectly, thank you.

Alison Douglas: Brilliant.

Lucie Giles spoke about the reduction in consumption and, in the first full year of implementation of MUP, we saw a 10 per cent reduction in alcohol-specific deaths. Obviously, we cannot take one year's data as evidence of a trend, but that gave all of us hope that we were seeing the effect on consumption starting to translate into a reduction in harms. There is also some evidence that liver hospital admissions reduced slightly. Therefore, there were some preliminary indications of positive effects on harm, but the pandemic has really set us back, and the substantial increase in deaths that we saw in 2020 was really shocking to all of us.

To go back to the first question that was asked, what deeply concerns all of us who are working in this area is that Scotland already has death rates that are 60 to 70 per cent higher than those in England. If we are seeing this really significant impact on heavier drinkers in terms of their drinking patterns as a result of the stress and anxiety of the pandemic, we could be looking at a really terrifying trajectory for Scotland in relation to its alcohol problem.

We had seen a tripling of the number of deaths in the 1980s. Although there have been some reductions over the past number of years, or a broader trajectory from the early 2000s, we have absolutely no room for complacency. That is why we need really bold policies; we need to be following what the WHO is telling us will have an effect on preventing alcohol harm by reducing alcohol consumption. That is why we need MUP but, as Elinor Jayne has said, we need to think about how we optimise that policy.

What I take from the evidence so far on MUP is that there is cause for confidence that the policy can and does have the effect that we hoped it would have when we implemented it and that it is not having any of the unintended consequences that people were concerned about. We are not seeing droves of people driving to England to buy their alcohol; we are not seeing people turning to

drugs; and we are not seeing the industry being driven to the wall. We are, however, seeing that we need to increase the price in order to get a more positive effect.

Let us not forget that the original modelling showed that setting MUP at 60p per unit would deliver double the benefit of setting it at 50p per unit, and that a price of 70p per unit would deliver triple the benefit of a price of 50p per unit. It is about both matching inflation and optimising the policy.

The Convener: My colleague Stephanie Callaghan is going to come back specifically on minimum unit pricing, but I think that Sandesh Gulhane has a quick follow-up question. Sandesh, you might just have to direct your question to one person so that we can move on.

Sandesh Gulhane: Absolutely. My question is really about the fact that the most deprived parts of Scotland have alcohol-related death rates that are eight times the rates in other areas. Are we doing enough targeted support in those areas? I would like to hear from Lucie Giles on that.

Lucie Giles: The data is really stark in that regard. We have much higher rates of alcohol hospital admissions and alcohol deaths in the most deprived areas compared with the rates in the least deprived areas.

That is not all down to consumption. It is not a straightforward case of people in those areas drinking more; there are bigger, more structural elements at play that need to be addressed in order to address inequalities more widely. By addressing those inequalities more widely, you will start to address some of the inequalities that are specific to alcohol.

I was quite heartened to see that you have a call for evidence specifically around inequalities. I ask the committee to take heed of what comes out of that and to start to really implement some of those measures, particularly those that relate to things such as income inequalities, employment and housing. All those things play a part in terms of the structural elements that sit behind the data.

The Convener: Thank you. We move on to questions about some of the Scottish Government policies that are in place.

Emma Harper (South Scotland) (SNP): Good morning. Dr Gulhane has covered some of what I was going to ask about, but I am interested in the health inequalities where we have made the best progress, and those where we maybe have not.

Elinor Jayne said that if we affect affordability, that will directly relate to consumption, and if we reduce consumption, that will reduce harm. I am interested in what we should do to continue implementing the best progress and where we need to change tack, especially when it comes to pandemic work.

Elinor Jayne: As I said, I think that we want to build on the success of the introduction of minimum unit pricing in Scotland. As Alison was saying, the data suggested that the policy was having a positive impact in the year after its introduction, but then the pandemic came along and changed absolutely everything in terms of consumption and, therefore, harms. Sadly, we saw deaths increase quite dramatically in 2020. That is why, although we saw that initial positive impact, we are now asking for minimum unit pricing to be uprated so that affordability is directly impacted once again and harms are therefore reduced.

The World Health Organization recommends that we take action on attractiveness and availability as well. In those areas, there is probably quite a lot that can be done in Scotland in terms restricting alcohol marketing. That could be marketing where alcohol is bought, but, much more generally, it could also be marketing that is online, in the street or in the different types of media that we consume. In addition, labelling could be much clearer and could provide health information to consumers.

In terms of availability, there are measures such as restricting the hours when alcohol can be sold. If those were reduced, availability would be a little bit restricted.

We could follow in the footsteps of Ireland, for example, which has introduced in shops what is colloquially known as a “booze curtain”. Alcohol is treated similarly to tobacco products, in that it is put behind a curtain so that children, for example, cannot go into that area. Alcohol is then seen not as part of your normal or everyday shop, but as a slightly different product that you have to go out of your way to buy and consume.

Measures could be taken across all those areas, and I think that the harms that we are now seeing as a result of the pandemic make all those options more urgent. We need to see action across those areas, or the Scottish Government start to bring forward proposals quite quickly, in order to ensure that we do not see increasing inequalities as a result of the pandemic.

Alison Douglas: As has been mentioned, there are real structural drivers of inequalities, and it can be quite difficult to identify interventions that can help reduce health inequalities if some of the fundamental issues around poverty are not dealt with. Interestingly, however, when it comes to alcohol, interventions do reduce inequalities.

We are looking at the fact that people are four times more likely to die an alcohol-specific death if they live in our poorest communities than if they live in our richest ones. Although that is an

appalling statistic, that difference is significantly lower than it was 10 years ago, when people overall were even more likely to die an alcohol-specific death.

When we reduce consumption and harm in the population overall, it has a disproportionately beneficial effect on our poorest communities—those that suffer the greatest inequalities. That is also true of the minimum unit pricing policy. It will deliver greater benefits to those suffering the greatest inequalities. That is something positive that we can take from alcohol interventions.

Just to build on Elinor Jayne's point about the availability of alcohol, work that we did with the University of Edinburgh showed that there were 40 per cent more places to buy alcohol in our poorest communities than there were in our more affluent communities, and that areas with a higher density of places to buy alcohol experienced twice the level of harm of those with a lower density. Again, we are seeing inequality playing out and, frankly, our poorest communities are being targeted by those who promote and sell alcohol to the detriment of the health of the people in those communities.

As has been discussed, availability is one of the three best buys for alcohol policy, yet we have a licensing system in this country that does not allow local licensing boards to reduce the number of places where alcohol can be bought in those areas. Covid notwithstanding, we have seen a year-on-year increase in the number of places where we can buy alcohol to more than 16,000 in Scotland.

We have also seen some diversification in the type of place that sells alcohol. Cinemas are now licensed, as are many coffee shops. We even have licensed hairdressers. We really must stop and ask ourselves why we are allowing that to happen and whether we need a more effective system for controlling the availability of alcohol in Scotland.

Professor Fitzgerald: The other thing to add to what Alison Douglas said, which was on point, is that not only are we unable to address the issue of physical premises in communities, but we saw a large increase in the amount of online sales throughout the pandemic. In the work that we are doing in England, we are also seeing an increase in the number of rapid delivery grocery services that rely heavily on alcohol for their profits. That has not become endemic in Scotland in the same way as it has in London, but we are losing the battle to contain availability, never mind reduce it, because of how easy it is to buy alcohol through apps and online.

The licensing system is locally organised, so if a large online retailer opens a very large warehouse to serve the whole of Scotland, the decision on that warehouse is made only by the local licensing board for the area in which the warehouse is located. The licensing board cannot take into account any harm caused to the rest of the country when it is making that decision. As designed, the system does not address deliveries from other places or online and remote deliveries. That is a key gap.

There are gaps in our ability to control physical outlets, but there might be an opportunity to close the barn door before the horse bolts—if it has not bolted already—on online sales.

Emma Harper: Public Health Scotland has a number of documents to support healthcare professionals to deliver alcohol brief interventions. They are also available on NHS Education for Scotland's Turas e-learning platform. Are we tracking the uptake of those by healthcare professionals—whether they are nurses, doctors or other professionals—especially those who work in primary care and accident and emergency? Are ABIs a good thing that is working?

The Convener: That might be a good question for Lucie Giles.

10:15

Lucie Giles: ABIs are not really part of my area in Public Health Scotland. I used to work in an alcohol and drugs partnership, and we tracked ABIs because there was a health improvement, efficiency and governance, access and treatment—HEAT—target around them. It is not an area that I am involved in now, so I cannot answer your question directly or comment on ABIs specifically. However, I can endeavour to find out the information you ask for and get back to you.

Professor Fitzgerald: Scotland has made good progress on the delivery of ABIs. I would say that it is a world leader in terms of that national programme. However, the programme has not changed much since it was originally started. Similar to the situation with minimum unit pricing, what we really need to look at now is how we can build on that success and what else needs to be done. I believe that ABIs are still tracked—there is still annual reporting of delivery, but there is an issue in terms of the new general practitioner contract. Under the new GP contract, in which prevention is not as big a priority as it was previously—care of chronic illness is now more of a priority—the delivery of brief interventions by GPs has fallen in many areas.

We know that there are many people who attend health services with conditions and problems that are caused or worsened by alcohol but who are not asked about alcohol consumption

at that time, so their awareness of the issue is not raised.

There are issues around how effective those conversations are. We need to do more to understand the best way to manage those conversations in order to help people to make changes and give them the best opportunity to do so. The research has moved on since the original programme in Scotland, and it could probably be drawn on to improve the situation. However, there are more fundamental questions to be addressed. We need to have those conversations, but what is the best way to have them so that they have the best effect?

There are still issues that could be addressed. Any programme of that nature relies on continued momentum, leadership and training, and that is hard to sustain. A lot of people were trained to train health professionals in the programme, but that training for trainers has not continued.

There is certainly more that could be done, but it is important to remember that, although people should be informed about alcohol when they appear with conditions that are affected by alcohol, the evidence on the effectiveness of alcohol brief interventions as a solution to alcohol-related harms is not as strong as it is on pricing, availability and marketing interventions.

The Convener: Sue Webber has a supplementary question.

Sue Webber (Lothian) (Con): I have a question for Niamh Fitzgerald. Alcohol-related deaths increased by 10 per cent in 2020, but fsligthe number of alcohol brief interventions declined by 28 per cent between 2013-14 and 2019-20. We have heard about some of the challenges and the number of issues that exist. What value do you attach to the alcohol brief interventions, and what should the Scottish Government do to reverse that decline in uptake?

Professor Fitzgerald: One of the issues is that that figure relates to recorded alcohol brief interventions. Previously, there was greater incentivisation of delivery, and when people are being paid to deliver an intervention, they are more likely to fill out the form that says that they delivered it. Therefore, we cannot really be sure whether fewer conversations about alcohol are happening or there is just less recording of those conversations, because people are not, to the extent that they were previously, receiving payment when they deliver an intervention. I would, therefore, be a bit cautious when talking about the trends.

The question about what value I place on ABIs is a good one. I do not think that we should view reducing one of Scotland's biggest health problems as an either/or situation. Although I said that there is stronger evidence for the effectiveness of interventions in pricing, availability and marketing, I also feel quite strongly that people who are suffering from conditions and are visiting health services should be given the information that is relevant to those conditions. For example, people with depression or people who are not sleeping have a right to know that alcohol might be playing a part in their depression or affecting their sleep, but they are not always told that. That feels like quite an easy win, and the approach is not terribly difficult to get across to health professionals, if we make it simpler.

There are other advantages of raising awareness among health professionals in that way and in enabling them to have those conversations. It generally creates a trickle-down effect. Back in the day, when the programme was first rolled out, I was involved in training health professionals. What we often found was that not only did the training change their practice, but when they went back to the surgery or their homes, they had lots of conversations with colleagues and family members about what they had learned and how their awareness of issues around alcohol had been raised. Such programmes have that kind of transformative effect. However, that is more resource intensive than simply operating a minimum unit pricing policy, which can be done easily. Rolling out a programme of brief interventions requires a greater resource commitment than banning marketing or addressing pricing.

The Convener: Stephanie Callaghan will ask about issues around minimum unit pricing, specifically.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Good morning. I picked up the same point as Emma Harper, which is that affordability relates directly to consumption, which relates directly to harm. That is an important point.

We have heard quite a lot of figures; clearly, the pandemic has created an issue around evidence. That said, I ask Lucie Giles this: how effective has the minimum unit pricing policy been in addressing alcohol harms and how strong is the case for continuing it beyond the five-year period?

Lucie Giles: I refer back to the evidence that I have already shared. We have demonstrated that there has been a reduction in population-level consumption in the first year following implementation. We have evidence from other studies outwith Public Health Scotland; for example, Newcastle University has, essentially, triangulated the evidence and demonstrated a sustained impact of minimum unit pricing on total purchasing at household level. We have yet to demonstrate the impact on the harms that we have been talking about—hospital admissions and

deaths—but we will produce the data from that study in approximately a year.

As Alison Douglas said, some of the unintended consequences that people talked about appear not have been realised. For example, none of the studies have shown that people have turned to more harmful substances such as drugs or non-beverage alcohol as alternatives. That is not to say that we have not seen any instances of that at all, but they have been in the minority of cases and have definitely not been widespread. The same applies to cross-border purchasing: we are not seeing that people are trying to circumvent the policy by travelling to England to buy cheaper alcohol.

On continuation, the Newcastle University data has shown that there has been a step change. Alcohol consumption has fallen, and that level has been sustained. The evidence suggests that the policy does not continue to reduce consumption; it simply brings about a step change. If you want to see further improvement in that regard, further action would be needed.

Alison Douglas: Obviously, Lucie Giles is taking a rigorous view of what we can and cannot say about the evidence. You will have heard me talk earlier about the 10 per cent reduction in deaths in 2020. Quite rightly, Lucie is not putting that forward as proof of, or a robust basis for thinking that, the minimum unit pricing policy has achieved the results that we want, and it would be accurate to say that, in the past, there have been one-year reductions in deaths that were simply noise in the system and were not sustained as trends. It is therefore quite right of her to be robust that what she is saying is clear evidence of the impact of MUP, but it is also fair that the rest of us who are closely interested in the policy should remind people that that did happen in 2020, and that it might be an indication that MUP is having an effect on harm. However, we will have better evidence of that in the future.

This is often about comparing Scotland to England or Wales as control countries, so that we can identify what is and what is not likely to be attributable to MUP. It is also worth remembering that alcohol causes a wide range of conditions. When the modellers were originally looking at how many lives MUP would save, some of the deaths that they looked at were caused by cancers or liver disease, which can take 10 to 20 years to manifest themselves. That is why they talked about it taking 20 years for the full effect of MUP to show up. Part of the problem is that absence of evidence about the harms is not evidence of their absence. The fact that consumption has reduced significantly gives us all cause for optimism that we will, in time, see that reduction in harm.

The Convener: Niamh Fitzgerald wants to come in.

Professor Fitzgerald: It is also important to remember that the fundamental relationship between the price of alcohol and how much people buy has not changed since minimum unit pricing was introduced. The case for increasing the price of alcohol through taxation and minimum unit pricing still stands, and it is not so different from many other commodities in that respect. When something is more expensive, people purchase less of it. Although the pandemic has made it difficult for us to assess trends because it has made such a ripple in the data and trends, it has not changed the fundamental relationship, which is the law of economics that applies worldwide—when prices go up, people tend to purchase less.

It is also worth adding that, in relation to the economic impact of minimum pricing, not only did we not see unintended consequences such as the collapse of the industry, as Alison Douglas mentioned, but we have evidence from a study of smaller retailers and communities that they have welcomed the policy and that it benefited them and their ability to survive as businesses. There has therefore been support for minimum unit pricing from some unexpected quarters; I am sure that the support would be even greater with a higher level of MUP.

Stephanie Callaghan: Thank you. It was great to hear Alison Douglas talk about the longer-term effects of the policy over 20 years or so, as well as all the ripples from it, such as the impact on children and their lifestyles.

I have a question on data for Lucie Giles. Will we have a strong enough evidence base for the policy? Will it be difficult to ascribe improvements to minimum unit pricing because of everything that has happened, or are you expecting that levels of hospitalisation and the number of deaths next year will support the policy?

Lucie Giles: I will not speculate on what the results will show; I will wait until we have done the work and have the hard evidence. However, the pandemic happened bang in the middle of our post-intervention period. We are looking at the impact on harms during the three years following implementation and when the pandemic started in earnest in the UK in March 2020. That will have an effect.

We are implementing measures so that we will be able to say confidently what has been the impact of MUP. For example, we will look at just the post-MUP pre-Covid period—data for the time until the end of February 2020, when Covid was having no impact. We will also look in the longer term and use data up to the three-year point, when

we will apply measures to account for and adjust for the fact that the pandemic happened when it did.

10:30

None of that is perfect. We have to remember that this is essentially what we call a natural experiment. A multitude of things can impact on how well we can tell what the true impact of an intervention is when it is being implemented at whole-population level. However, we are applying the most robust methods that we can apply in order to enable us to do that.

We must also bear in mind that there is not just one result to be considered; we are looking at the impacts across a broad range of outcomes. We are concerned not only with consumption and health harms, but with crime and with children and young people and other specific groups in the population. There is no single answer to the question whether the policy has been effective; a multitude of impacts and effects must be weighed up as part of the final report that we will put before Parliament in 2023.

The Convener: David Torrance has questions on this area.

David Torrance (Kirkcaldy) (SNP): I think that my questions, which were on minimum unit pricing being index linked, have been answered.

The Convener: Okay. Emma Harper wants to come in.

Emma Harper: The alcohol industry is a big part of Scotland's economy. How do we support that business in Scotland while supporting the industry to take responsibility for the issue and helping it to do what it can to support alcohol-harm reduction?

The Convener: Alison Douglas might have some thoughts on that.

Alison Douglas: Again, it is helpful if we are guided by the WHO on the matter. The alcohol industry should not have a role in public health policy, because there is a fundamental conflict of interests there. The industry exists to make profit for shareholders, and we know that a significant proportion of its profits come from people drinking at a level that is above the lower-risk guidelines. I will give an English figure, because we do not have the figure for Scotland, but it is estimated that the heaviest-drinking 4 per cent of the people who drink are responsible for 30 per cent of the revenue of the alcohol producers. That shows that, although the industry might say that it wishes to reduce alcohol consumption and alcohol harm, that is a conflicting thing for it to do, because doing so strikes at its profitability.

We must be realistic and principled and not have the alcohol industry participating in public health policy. Instead, we must root that policy in international evidence and independent sources of evidence and advice.

We must also root policy in something that we have not touched on this morning, which is evidence about what the public want. Public Health Scotland has published the results of an independent survey of people's support for minimum unit pricing that shows that almost half of Scots support it and another 20 per cent are neutral. There is strong public support, which has increased since the policy has been in place.

Similarly, when we talk to people who are in recovery, they talk about how they see alcohol everywhere and how, when they are in the early stages of their recovery they cannot even go into shops—they have to get other people to shop for them—because alcohol is so present and attractive.

Children and young people are telling us the same thing. Through work that we have done with the Children's Parliament and work that Young Scot has done, we know that they want alcohol marketing to be restricted. They see a lot of that marketing in their lives—they are aware of sport sponsorship, for example—and they want it to stop, because they do not feel that they should be subjected to that in their daily lives.

We need to prioritise what people in Scotland want and the place that they want alcohol to have, and we need to protect their interests, rather than enabling the alcohol industry to influence things. As we saw, the alcohol industry postponed the implementation of minimum unit pricing by almost six years through its legal action. It will say that it was perfectly entitled to do that: technically, it was, but morally—given that Parliament had voted for MUP and the public supported it—I question what it did. The industry was self-seeking in trying to protect its interests and to prevent the policy from being implemented.

The Convener: After we have heard from Elinor Jayne, we will move on to questions from Gillian Mackay.

Elinor Jayne: There are a number of things that the alcohol industry does and says that can confuse issues when it comes to public health. For example, one of the main actions that the alcohol industry promotes is alcohol education, but we know from the WHO that, in improving health, education is one of the less-effective interventions and that we should be talking about interventions on price, availability and attractiveness, because they are much more effective in reducing harm.

We also know that when the alcohol industry takes voluntary action in lieu of regulation by

Government on, for example, labelling, although it might put information on labels, it does so in a way that downplays the risks, or in such a way—for example, by using slightly see-through colours—that the information is very illegible compared with other information on the label. It is important that there be regulation of the industry on labelling and marketing, because the industry's voluntary approach is not rigorous enough. In the world of academia, many peer-reviewed articles have looked at what the alcohol industry has done and have shown how ineffective it is in conveying information to consumers.

An academic review of health information that has been put forward by the alcohol industry, and by industries including the tobacco industry and the gambling industry, shows that when the industry puts out messages about the risks to do with alcohol and cancer, it can downplay those risks or present them in a confusing way, so that when a normal person like me reads them, they come away thinking, "I'm not quite sure of the risks." If they were to read information from a health body, they would be quite clear about the risks to their health from alcohol. Therefore, I think that the public health issues around alcohol need to be kept very separate from the alcohol industry.

The Convener: I said that I would bring in Gillian Mackay, who wants to dig into the issue a little deeper, but first I will bring in Sandesh Gulhane. I completely forgot that he has a question about minimum unit pricing.

Sandesh Gulhane: Thank you, convener. We have heard a lot about minimum unit pricing and the potential benefits of increasing the price, given the benefits that have already emerged. However, the World Health Organization has three themes: affordability, advertising and availability. I do not want to touch on advertising, because that will be a theme of later questions, but I want to ask directly about availability. I was offered a drink when I got my hair cut and when I went into a cafe, and I am offered drinks when I go and watch a film. Alcohol is ridiculously easily available—it is everywhere. What can we do to reduce its availability? Do you agree that we need to reduce that?

The Convener: Do you want to direct that question to anyone in particular? Maybe we could hear from Niamh Fitzgerald on that, as she mentioned the issue earlier.

Professor Fitzgerald: I am happy to answer that. We are completing a very big review of public health involvement in the licensing system in Scotland and England. We have compared the two systems and looked at whether we can achieve reductions in health and crime harms from alcohol through the licensing systems. I do not want to pre-empt papers that have not been published yet—I will share them with the committee when they come out later this year—but it will not come as a surprise to you that there are huge challenges in the system in relation to addressing availability. However, there are things that could and should be done.

We do not have a strategic national approach to licensing in Scotland or England, so we do not know what the trends are or what progress has been made with regard to availability. We do not have a live and accurate register of premises that sell alcohol with their opening hours and their capacity, which means that we cannot monitor the trends. However, we know that availability is increasing. I agree with you on that.

We do not have routine national analysis of what is happening locally. Alison Douglas will be able to say more about Alcohol Focus Scotland's work on that, but work is not resourced nationally to compare local licensing policy statements and licensing data; that is something that is done on a voluntary basis at the moment.

We also do not have sufficient support for local public health teams or the work that they can do. For example, there is an issue around legal advice and legal support. One of the barriers to stronger action on licensing is that local authorities and public health teams are concerned that, if they take strong decisions that are based on, for example, objections that have been raised, they will be challenged on them. As Alison Douglas said in relation to other legal challenges, the applicant for a licence has the right to challenge the decision, but they often have access to considerably more resources for legal advice and support than others do.

There are other things that we could do. We know that the public health teams are engaging effectively with local licensing systems to try to make the case around health data and health harms, but the realistic expectation can only really be that that will change practice slowly. Even within that, it is difficult for licensing boards and local authorities to decline licences. The system is set up as a permissive system. More could be done in guidance, but that is not the same as a change in the law. If we really want the licensing system to be able to achieve the licensing objectives, the matter probably needs to be looked at in a more fundamental way.

Picking up on what I said earlier, I note that the licensing system is not at all set up to deal with online sales and online availability. At the moment, that accounts for only a small proportion of sales, but the trend is only going in one direction, and it is much harder to reduce availability once it has reached a certain level than it is to prevent it from increasing. That is something in the system that needs to be looked at as a matter of urgency.

In relation to things such as people being offered a drink when they go for a haircut, we cannot take a licence away once it has been granted, as the system does not allow that. Changing that would involve fundamental reform. At the very least, however, we should look at strengthening the system to enable it to do something that it is supposed to be able to do, which is to contain availability in areas where it is already high.

The Convener: I will briefly bring in Lucie Giles on that question, and then I will bring in Gillian Mackay.

Lucie Giles: Niamh Fitzgerald talked about the data. I am involved in a piece of work on alcohol surveillance systems, in which we are bringing together a range of data sources in order to monitor a range of indicators at local and national levels. Niamh highlighted some of the issues that we have in that regard. If we do not have the data, we cannot tell how we are impacting with different policies and local interventions. I support what she said about the need to have good quality data so that we can monitor where the problems and issues are and make progress against them.

The Convener: I will now bring in the long-trailed Gillian Mackay.

Gillian Mackay (Central Scotland) (Green): Thank you, convener. As we have already touched on various issues to do with marketing and sponsorship, I will squish some of my questions together so that we can try to cover everything.

The SHAAP report on alcohol marketing during the six nations championship has been referenced. Do you believe that there should be a full ban on alcohol sponsorship of sport? Given that it can be lucrative and many sports clubs are facing challenging financial circumstances, do you have views on how we can encourage clubs to move away from such sponsorship? Would it be best to achieve a full ban through legislation? If not, what mechanism should be used?

10:45

Alison Douglas: It is interesting that the prevalence of alcohol sponsorship of our football clubs has changed over time. There was a time when it was more dominant. When we researched the prevalence of such sponsorship in premier and first division clubs, we found that those that have it were in the minority. However, where it existed, it appeared to represent significant income for the club. It is difficult to get figures on that, but we could tell from the prominence of the sponsors that that was the case.

We need to consider our experience with tobacco. Tobacco advertising and sponsorship of sport have been banned for some time and other sponsors have got involved. I do not want people to rely on betting companies for sponsorship either, but they have become more prominent. Information technology companies, finance companies and the like are also providing sponsorship—there is a broad range of sponsors.

One way to manage the transition is to phase out alcohol sponsorship. Another approach, which Australia has looked at, is to create a fund to help clubs out in the short term, as they transition. There are ways to make the change. The experience with tobacco sponsorship has been good, as it shows that clubs do not necessarily fail because sponsorship has been withdrawn.

Elinor Jayne: I applaud Scottish Women's Football, which has rejected alcohol and gambling sponsorship. That shows that it is possible to take such action on a purely voluntary basis. However, I recognise that it puts women's football under greater pressure compared with men's football, because it does not have the same access to sponsorship money, funding or partnerships.

Rather than encouraging sports clubs, leagues and competitions to reject alcohol sponsorship, the fairer approach is to introduce a ban. As Alison Douglas said, we can be reassured by the fact that the ban on tobacco sponsorship has not led to any club going under or to competitions suffering. Other industries have stepped in. I do not think that there will be anything that we need to worry about if we decide to introduce a ban.

We should create an independent body to oversee the change and take it forward in the round so that we ensure that the measure will be comprehensive. France has a ban on alcohol sponsorship and marketing in sport, but a grey area has been introduced, because the alcohol industry still gets into competitions and can be seen on television through alibi marketing. I will give an example of that. In the six nations championship, instead of "Guinness" being emblazoned on hoardings, shirts and suchlike, a different word is used, but the branding is clearly Guinness branding. If we decide to introduce a ban in Scotland, we must learn from other countries where restrictions have been put in place in order to ensure that the measures will be as effective as possible.

Gillian Mackay: What are your views on other preventative measures, such as a social responsibility levy on retailers? The Scottish Government has stated that it will take action to improve alcohol labelling. What impact could mandatory alcohol labelling have on alcohol harm? What changes would you like to see in that regard?

Professor Fitzgerald: In relation to a levy on retailers, it is largely shops that have profited from the pandemic, at the expense of bars and pubs, so there has been a windfall from the harm that we have talked about—the increased deaths during the pandemic due to alcohol—and there probably is a strong moral argument for clawing back some of that windfall.

If we uprate the minimum unit price, that will create additional profit in the system that will largely go to retailers. There is a strong argument that we should look at what we could do with that funding to address other measures. Minimum unit pricing does not cost much to implement as it largely uses existing systems for enforcement and compliance. Other measures would perhaps be more expensive, particularly those around treatment and brief interventions, as we have discussed. There is a strong argument that we should look at some way of redressing the balance on that.

Alison Douglas: The social responsibility levy is on the statute book, but it has not been used. It was in part motivated by the fact that minimum unit pricing would potentially result in significantly increased revenues. Some people have said, "Aren't we better with tax, because it means that the money goes into the public purse rather than into the pockets of retailers or producers?" I have a lot of sympathy with the point that we do not want the supply chain to make more money out of selling less alcohol. That is unhelpful because it creates an incentive, particularly for retailers, to promote the sale of alcohol, as they make more money out of it. That does not help with our longer-term objectives.

The Scottish Government estimated that the minimum unit price would result in increased revenue for the supply chain of £34 million. We do not know how much of that is pure profit but, obviously, a proportion of it will be.

We advocate an alcohol harm prevention tax, which would apply to retailers that sell alcohol. The money would go into the public purse and be used to offset the harms that are caused by alcohol. It could be used at the local level. That would be like the public health tax that we had a few years ago. Preferably, it would be linked to the quantity of alcohol that retailers sold. That relates to the point that Niamh Fitzgerald made about availability, because it is important that we create a condition on all licence holders in Scotland to provide data on how much alcohol they sell. That would help to inform local licensing decisions and the national strategic approach to controlling availability that we have talked about.

On labelling, consumers have a right to know what is in their drinks. At the moment, alcohol is an exception to the legislation that requires every other food and drink item to have details of ingredients and nutritional content. That does not apply to alcohol. We have a carcinogenic product that has fewer mandatory labelling requirements than apply to any other food or drink item, which is just ridiculous and unacceptable. We are therefore calling for comprehensive labelling, which should include mandatory health warnings.

The Convener: Before I bring in my colleague Sandesh Gulhane, I have a question for Alison Douglas. I have always been quite surprised that we do not have calorie information on alcohol labelling. Would having information on how many calories are in alcoholic beverages have an impact?

Alison Douglas: Alcohol represents an average of 9 per cent of the calorie intake of people who drink. That is pretty significant and we know that it motivates people to cut down on their alcohol consumption when they are trying to lose weight.

Calorie numbers should be on labels, as is required for other food and drink items. In recent research that we did, we analysed 30 different types of wine—white, red, rosé, sparkling and fruit wines—and we showed that people can have absolutely no idea how many calories or how much sugar they are consuming based on the type of wine that they drink. Sometimes, those things are inversely related.

People might think that they are making a healthy choice by picking a lower alcohol wine, but they might end up consuming significantly more sugar because of that inverse relationship. One bottle of red wine that we looked at contained 600 calories. Wines can be highly calorific and they can contain a lot of free sugars. Two glasses of one wine contained the equivalent of the 30g of sugar that a person should consume in any one day.

If people do not have the information, they cannot make informed choices. That is why such labelling needs to be mandated—the industry will not do it unless it is required to.

The Convener: Sandesh Gulhane has a quick question about something that Alison Douglas mentioned.

Sandesh Gulhane: Alison, I am staggered by something that you have just said. I did not realise that this was the case. Let us say that we have increased the price from, say, 30p to 50p—they are arbitrary numbers, but let us say that it has gone up to 50p. The extra cash does not go to the national health service or rehab programmes—it goes back into the supply chain, perhaps back to the manufacturers. Is that correct? Is that what you said?

Alison Douglas: That is correct. The policy is meant to improve public health. That is what the modelling told us would happen and what we think the early evidence is showing.

However, the increased profit from that is going back into the supply chain. Not surprisingly, the industry is not willing to reveal where that money is going and whether the retailers are pocketing it or whether it is going to the wholesalers or the manufacturers themselves. It is difficult to get under the skin of that, but companies are certainly making increased profits as a result of the policy. That is exactly why we think that there needs to be an alcohol harm prevention tax so that the money goes back into the public purse and is used to prevent or tackle alcohol harm.

The Convener: Thank you. Sandesh, do you want to continue? You were going to ask some questions about Brexit and the United Kingdom Internal Market Act 2020.

Sandesh Gulhane: The UK Government has specifically amended the internal market act to carve out pricing policies in relation to the sale of goods. The act now makes it crystal clear that pricing policies in relation to the sale of goods, such as minimum unit pricing, are out of the mutual recognition principles. Considering those changes, do you have any further concerns about the act?

Alison Douglas: We have significant concerns about the impact of the internal market act on public health policies in general that go way beyond alcohol. Our colleagues who work on tobacco and unhealthy food have expressed similar concerns. Those concerns go wider, obviously, but in terms of public health, there is a strong risk that the act could curtail the Scottish Government's and the Scottish Parliament's opportunities to take action.

The difficulty is that we are dealing with new legislation and an evolving situation. Work is being done on common framework agreements. I believe that there are three frameworks on labelling, so we can already see that it will be complex to navigate what that means for the Scottish Parliament's opportunity to legislate on alcohol labelling. In relation to minimum unit pricing, the UK Government explicitly excluded minimum unit pricing from the mutual recognition elements.

11:00

However, it is not clear what would happen when the price increases, for example, which is what we are asking for. As I understand it, the internal market act indicates that extant legislation would not be affected, but if there is a change to that legislation—as there would have to be to uprate the minimum unit price—what would that mean? That would at least open the possibility of another legal challenge by the industry, which is a very real risk. We saw the industry's determination when it took the Scottish Government all the way to the Supreme Court about the initial legislation. The industry could well challenge the Government on uprating under the new internal market act, which is a new test in comparison to the European context in which the original case took place.

Sandesh Gulhane: As I understand alcohol supply, the alcohol will go from the manufacturers to wholesalers, which then supply shops. Many wholesalers are in England and supply Scottish shops. Surely labelling has to have a four-nations approach, because otherwise Scotland might be in danger of not having access to other wholesalers, which was one of the big issues with the deposit return scheme. Is it not a good thing for there to be a four-nations approach to labelling, so that we get it right for everyone?

Alison Douglas: Absolutely, but it has been more than 10 years since the Scottish Government recognised that the labelling of alcoholic products was inadequate. For two years, we have been waiting for a UK four-nations consultation on a narrow improvement to labelling, specifically on calories. I believe that there will also be a consultation on including the chief medical officers' low-risk drinking guidelines. That is only part of what we would want to see in a more comprehensive labelling regime. Even though we understand that there has been an agreement to have a UK-wide consultation, we have been waiting for it for two years and it still has not come out.

The Convener: Is it not also the case that, when it comes to labelling and product marketing, there could be differential labelling for Scotland—for example, during the world cup? That can be done in other cases, including for marketing aspects.

Alison Douglas: That is absolutely right. Companies will complain about the cost and the difficulties, such as the amount of room that they have on labels, yet it is interesting that there is plenty of room on product labels for information where they perceive there to be a commercial advantage to talking about how many calories there are, that the product does not contain gluten or is low carb. It needs to be mandated because, to be honest, the devil is in the detail when it comes to labelling. At the moment, many products have a "Do not drink during pregnancy" logo, but in many cases it is so tiny that it is almost indecipherable, which is what the public are telling us. When research has been undertaken with focus groups, participants say that they are not surprised that the industry does not provide that

information, and that the information that is available is barely legible and certainly does not get people's attention.

For health information, the industry is directing people towards a website that it funds, which provides questionable information about alcohol harms or provides information in a way that plays down the health harms. We need independent information mandated, so that when people pick up a bottle or a can they can make an informed choice about whether they want to drink and whether they want to drink that particular product.

Professor Fitzgerald: I support what Alison Douglas has said. I also make two observations. First, over the years, we see a pattern across public health measures in that, when there is an effort to address harms, prior to the implementation of any measures there are all sorts of predictions about how difficult it will be for the industry, and yet when we evaluate the implementation after those measures have been introduced, we find that most, if not all, of those difficulties are small or non-existent. In general, in this country we have law-abiding companies which, if the law changes, will find a way to implement it.

Secondly, when we consider the economic effects of the public health policies, we need to look beyond the alcohol industry: if people are not spending money on alcohol, they are spending money on something else in the economy. That spending often benefits their local community, unlike the tax on alcohol, which goes to the UK Government and is not necessarily being reinvested back into the local community. It is not that people hoard that money—they still spend it and contribute to the economy, but perhaps it is not spent on something that harms their health as much as the alcohol would.

The Convener: We will move on to treatment of alcohol harms.

Sue Webber: A recent study that was conducted in South Korea—you may not be aware of it—revealed that a therapeutic community-oriented day-treatment programme resulted in continuous abstinence rates after six months that were nearly eight times higher than those seen in the control group. What I found interesting was that both the treatment group and the control group were women. When it comes to treating alcohol use dependency, what different needs do men and women have and is there more that we can do to address the needs of women specifically?

I am not sure who might have insights into that. I have scribbled down "Elinor", but I am sorry if that puts Elinor Jayne on the spot.

Elinor Jayne: I am not sure that there has been a lot of research into the differentiation of services for men and women. I know that, once people have accessed treatment services and embarked on their individual recovery journey, those recovery communities are shaped by the individuals. There will be recovery groups in there that will be specifically for men or for women. It is well evidenced that such peer support is crucial in people being successful or having a positive recovery journey.

You may be interested in something that is related to that: we are about to publish some research that has been carried out by Glasgow Caledonian University into alcohol treatment services and the LGBTQ+ community. Like many other minority groups, that community will experience more alcohol harms than the general population as a result of the stigma that they experience—in this case, because of their sexuality or gender identification. However, accessing treatment and services can be more difficult for those groups because those services are not set up or designed to be inclusive of people from different backgrounds.

The research that we are yet to publish will show that people from the LGBTQ+ community can feel excluded from treatment services because there is sometimes a lack of recognition of how important their sexuality or gender identity is to their alcohol problem. There is a whole lot of work that needs to be done on inclusivity—

Sue Webber: I am sorry, but can I interject? My question was specifically about women. Some of the graphics show us that, for example, after MUP started, there was a drop-off in the hospital stays of males but not in those of women. I am trying to drill down on the women element of things, if that is possible.

The Convener: It is important to let our guests finish their sentences, though, Ms Webber.

Does any other colleague who is online want to add anything to the aspect that Ms Webber wants to address—on the treatment of males versus that of females?

Alison Douglas: Like Elinor Jayne, I am not aware of much research in that area. However, one thing that can act as a barrier to women's access to support is concerns about their children and worries that their children may be removed from their care if they disclose that they have an alcohol problem. We need to take that seriously and to ensure that we work with and support individuals, rather than have them feeling that coming forward for support is going to result in their children being taken into local authority care.

Sue Webber: Thank you, Alison. Can I have another question?

The Convener: Yes.

Sue Webber: We recently published a proposal for a bill on the right to recovery, which would ensure that every individual seeking treatment for addiction or substance misuse—

The Convener: "We" is not the committee.

Sue Webber: Sorry. It is the Conservative Party.

That includes alcohol. What are your thoughts on that proposed bill, and have you fed into the consultation process on it?

Alison Douglas: We very much welcome the intention behind the proposed bill, and absolutely recognise some of the concerns that drive it. However, services are not available to the degree that they ought to be for people with drug and alcohol problems. No estimate has been made in recent years of the ratio of people who can obtain support for an alcohol problem. The most recent data is from 2014. I think, and it showed that about one in 4 people with alcohol dependency was able to access a service. We therefore have concerns that the availability and accessibility of services needs to be addressed.

The scale of the problem that we are dealing with is significant, as we heard at the beginning of the session. There are concerns that those who were drinking most heavily prior to the pandemic have been at greatest risk of increasing their drinking during it. We need investment in services, and we need to tackle stigmatising attitudes and behaviours, in order to ensure that people feel welcome and supported in their recovery.

That said, Alcohol Focus Scotland thinks that incorporation into the Human Rights Act 1998 represents a better opportunity to protect and promote the rights of people who have alcohol and drug problems, rather than a separate piece of legislation.

There could be an inadvertent risk of increasing stigma in specifically focusing on people with alcohol and drugs problems, rather than seeing the issue as part of the wider promotion of human rights. We also worry that it could damage the therapeutic relationship, which is so important in recovery, between the person who is providing the support and the individual who is trying to recover, by potentially creating a risk of litigation, which we think would be unhelpful.

We absolutely welcome the intention behind the bill, but we believe that there is a better way of achieving those ends.

11:15

Elinor Jayne: Similarly, we totally understand the motivation behind the bill. The number of people with alcohol problems accessing alcohol treatment services has gone down, which is strange, considering the increase in alcohol problems, general speaking. In 2016-17, more than 28,000 people were accessing alcohol treatment and support services; by 2020-21, that number had gone down to just over 19,000. Obviously, there is a problem that needs to be addressed, but we are concerned that introducing such a technical legal right would serve as a bit of a distraction from the most fundamental things that need to happen with the system, which are about resources, direction and ensuring that enough people are in our services with the right skills to support people to access those services.

As Alison Douglas said, there is a risk of further stigmatising a group of people who already experience an extensive amount of stigma by introducing a right for that specific group, who would then be treated slightly differently from how other people who access healthcare and treatment services are treated. Although the intentions are laudable, the implications could distract from what we need to do, which is, fundamentally, to increase access to services.

We think that, if the forthcoming UK alcohol treatment guidelines are introduced—they have been delayed—and implemented in Scotland, they will be an opportunity to see real change in services in Scotland, if they are backed up by meaningful quality of care and access standards.

Emma Harper: I have a quick question on the families and women issue. I know that the Scottish Government has a framework that has been created for families who are affected by drug and alcohol use in Scotland. That is a framework for a whole-family, holistic approach that is inclusive for families. Women might need to be supported because they might have families to support and they might be carers for family members. I would be interested to hear your thoughts on that framework, which has been implemented, and on progress on its delivery.

Alison Douglas: It is very welcome that we are taking a whole-family approach. In the past, we have talked about the hidden harm of alcohol. People will often say that it is an individual's right to choose how much they drink and that they are not harming anyone but themselves, but the reality is that many other people are affected by somebody's drinking. I guess that most of us in this meeting have known someone or have a friend or family member who has been affected by alcohol, and have seen the direct consequences on those around them. It is not just the drinker who suffers; family members and friends suffer, too. The people around the drinker have too often been neglected, so it is extremely welcome that we recognise that there are wider impacts and that

those people are very important in supporting the recovery of the person with the alcohol problem.

If somebody does not have support around them, their potential to recover will be much less, so recognising the importance of that makes a great deal of sense, not only to tackle that wider impact and harm but to enable and support recovery.

The Convener: Thank you. I will pick up on something that Elinor Jayne mentioned about the work that her organisation is doing on specific demographics—for example, LGBTQ+ people—having specific needs when it comes to treatment. I am interested in the fact that a lot of people find it very difficult even to get themselves through the door for treatment—you mentioned some of the barriers for that community. Is there on-going work and thinking about other cultural demographics? For example, people from ethnic minority groups might find the same issue with not having treatment services specifically dedicated to them. Has that come up?

Elinor Jayne: That has come up. We have not been involved in research around minority ethnic groups, but I am aware of research that shows that they are vastly underrepresented when it comes to alcohol treatment and recovery communities, so there is obviously something going on there. People from a minority group can experience a double level of stigma and shame. That is worth looking at; it is a real difficulty and there is a lot more work to be done to make treatment services and recovery communities work better for the groups that are doubly affected.

When it comes to alcohol treatment and services, it is very important to see people as people and not just as people who have an alcohol problem. Obviously, their alcohol problem can be tied up with many other issues, including childhood trauma, mental health issues or housing problems. For women, it could be tied up with their relationships. Alcohol problems can be the cause of those other issues in their lives, and vice versa.

It is important to think of the services that people access as being not just about treating an alcohol problem but about them being integrated with all the other services or types of support that people might need. There is a really positive model in Aberdeen, where a specialist alcohol service is provided by the alcohol and drug partnership, which links to a huge range of other services, including the police, housing services and social work services. The person is assigned a key worker, who can work with all those services.

To go back to Sue Webber's previous question about the support that women might specifically need, I note that that type of service can really work if other services are properly integrated and see the person as an individual who might need a vast range of different types of support, some of which might not be specifically about alcohol, but are related to the alcohol problem. We need to see that approach being taken more commonly across the country.

The Convener: Thank you. It is always helpful when people give examples of good practice that we can look into further.

We move to questions from Evelyn Tweed about funding.

Evelyn Tweed (Stirling) (SNP): Good morning and thank you for all your contributions so far; it has been a really helpful session.

What are your views on the split of resources between alcohol treatment services and drug services? Do you feel that the split of resources is appropriate? That question goes to Lucie Giles.

Lucie Giles: I am not specifically involved in funding, so I am not well versed in that. Someone else might want to step in.

The Convener: We will look for volunteers. Does anybody want to come in on funding? Niamh Fitzgerald is nodding. If people give me the slightest inkling, I will single them out. [*Laughter*.]

Professor Fitzgerald: Actually, Elinor Jayne and Alison Douglas have typed R in the chat box.

The Convener: I am sorry—I was not looking at my screen, so I was not doing my job. We will hear from Elinor.

Elinor Jayne: The funding split between alcohol services and drug services is not necessarily clear. There are various ways of looking at the matter. The funding for ADPs is used for both alcohol and drug services, but there is also funding that the NHS, local authorities and integration joint boards might be using for those services separately. As I said, the split is not totally clear.

As for the emphasis in respect of resource, the Scottish Government said in the budget documents that it published towards the end of last year that it recognised the twin public health emergencies of drug deaths and alcohol harm, but that is not necessarily being reflected in a focus on, or attention being given to, alcohol services. We have seen lots of progress with regard to investment in and focus on the services that are provided to people who use drugs, with particular emphasis being placed on rehabilitation and focus being placed on lots of other aspects, including the medically assisted treatment standards, but there has been nothing similar for alcohol issues.

As, I am sure, you will agree, the data for Scotland is not good. Deaths went up in 2020; we know that alcohol harm is a real problem for

Scotland and we need a bit more urgency and focus on it. We argue that the Scottish Government should do something ahead of the alcohol treatment guidance that we are, as I said earlier, expecting at UK level, so that we start to make inroads and get investment in services that are specifically for people with alcohol problems.

Alison Douglas: I agree with Elinor Jayne that it can be quite difficult to understand exactly what is going on with budgets. There has been a very strong focus on drug deaths—for completely legitimate reasons, because the situation is tragic and shocking and requires a response.

However, we must also recognise that there needs to be capacity in the system to respond to the challenges that we face. I am concerned because I am hearing from the local level that—because alcohol and drug partnerships cover alcohol and other drugs—the focus on drugs, the demands that are placed on partnerships by the Scottish Government in that respect, and the time and effort that are spent on addressing drugs issues are diminishing the capacity to do anything about alcohol. Instead of increasing the effort that is being made on drugs at the expense of what is being done on alcohol, we need an overall increase in capacity. I am hearing anecdotally from public health and alcohol and drug partnership colleagues that they really do not have the capacity to do much about alcohol at the moment, which concerns me when we might be facing a period of increasing problems.

Evelyn Tweed: Thank you for that. I know that you have touched on this in your previous answers, but how can the effectiveness of public spend on alcohol services be assessed? What information is required to allow that assessment to be made, and how can we do it better? The question is for Alison Douglas.

Alison Douglas: That is really difficult. Elinor Jayne has alluded to this: the funding that the Scottish Government specifically gives to alcohol and drug partnerships is not meant to be the sum total of investment at the local level in alcohol and drug services and related work.

In practice, there have been instances of health boards top slicing for statutory NHS services money from the Scottish Government, although the ADP is meant to make decisions, as a collective, about where the money should be invested. However, speaking as somebody who used to work in the Scottish Government and was responsible for the investment in alcohol services, I point out that it is very difficult to understand in detail what is going on at the local level. Therefore, I wonder whether it would be better to come at the matter from the other end and consider the outcomes. Perhaps, rather than trying to follow the money, we should look at the impact at local level and improve reporting on that.

11:30

Elinor Jayne: As an aside, I point out that some modelling has been carried out in England about the impact of alcohol care teams. That broad term is used to describe specialist nurses, usually addictions nurses, who work in hospitals. When someone has been identified as potentially having an alcohol problem, the nurses work with them and put them in touch with services in the community through assertive outreach, or they put in place support to help the person to address the problem. That model has been shown to work and to be cost effective. We would like such a model to be implemented more consistently across Scotland. It is done to varying degrees in various places; it could be more consistent.

Lucie Giles: Focusing on outcomes and the impact that services have in an area is the right approach. However—I call on my experience of having previously worked in an ADP—it can be difficult for services to do that.

There are a number of tools that can be used to measure and monitor outcomes at individual level, but it can be difficult to collate that information. There have also been tools such as the Scottish drug misuse database—SDMD—which was not particularly user friendly for services, which found it quite difficult to use. We have moved on to the drug and alcohol information system—DAISy. It would be a real step forward were we to maximise use of national systems that are already in place, such as DAISy, or implement a single outcome system that all services could use.

Paul O'Kane (West Scotland) (Lab): I will follow on from many of the points that have been made. Alison Douglas talked about the importance of reporting. Other witnesses talked about knowing what is working. In September, I asked the minister about alcohol and drug partnership reporting. Previously, we broke down information on the granular spending for ADPs by IJB. That certainly happened in 2016-17 and 2017-18, but we have not had that level of detail since, so is there enough certainty on funding to measure how effectively approaches are working?

Alison Douglas: I am sorry, Paul. Can I ask for clarification? Do you mean certainty about what money is going in or how it is being spent?

Paul O'Kane: I mean certainty that funding is available and that we are not seeing gradual cuts or more top slicing, which has been referred to. From that, how can we measure the effectiveness of the interventions that the spend pays for? Does that make sense?

Alison Douglas: You will be aware that, some time back, there were cuts in alcohol and drug funding. At that point, we tried to do a bit of work with the alcohol and drug partnerships to understand what that meant in practice and how it affected the services.

It is really difficult to get a clear picture of that, because, ultimately, the people who act as the co-ordinators and the facilitators for alcohol and drug partnerships are usually employed by the health board or the local authority, so it is very difficult for them to be open and honest about the situation in public. We have found it really difficult to get a handle on that in a systematic way. We tend to hear that a service has gone or that a contract is not being renewed. Such contracts are usually with the third sector, because statutory services have tended to be more protected than third sector services. That is of concern not just because of the loss of services, but because third sector services sometimes take a more progressive and recovery-oriented approach. That is part of the challenge.

Alcohol and drug partnerships have a responsibility to try to prevent problems as well as to respond to existing problems. I am concerned that the capacity to be active in preventing alcohol harm tends to get pushed to the side when there is a need to deliver services to people who are in need now. It has been 10 years since the Christie commission, but we have still, in all sorts of spheres, not made real progress on prevention; we have not made the progress that we had hoped to make in relation to alcohol.

Elinor Jayne: I refer back to what I said earlier about the importance of alcohol treatment services being integrated with, or linked to, the wide array of other services and supports that people might need. We could invest all the money in the world in alcohol treatment services to treat alcohol problems, but the other factors in people's lives also need to be addressed. People's mental health needs to be supported through community mental health services, and support is needed for people who live in poverty or who live in inadequate housing that is cramped, damp and so on. We cannot isolate alcohol problems from the wider picture and all the other areas in which investment is needed to ensure that the best possible support is available for people.

The Convener: We are running out of time. Emma Harper will ask a very short question to round off the session.

Emma Harper: We might not get the answer to my question today. I am aware that there are different models of ADPs. Some have independent chairs who work only three days a month, whereas some have full-time employees, lots of co-ordinators and administration support. I am interested in whether we are looking at examples of best practice in ADPs that have good outcomes, so that such practice can be reflected in other areas.

Elinor Jayne: I do not know enough about all the ADPs across the country, but I urge you to look at the model that is used by the Aberdeen city ADP, which is one of the few whose drug support is separate from its alcohol support. The model that it uses involves being as inclusive and proactive as possible, and it engages with all the various services in the area. That is really positive, and other areas could learn from that model.

The Convener: I thank all four witnesses for their time. It has been a very useful session. What you have told us has certainly given us a lot of food for thought about what targeted work on the subject we might do in the future.

11:39

Meeting suspended.

11:45

On resuming—

Subordinate Legislation

Forensic Medical Services (Modification of Functions of Healthcare Improvement Scotland and Supplementary Provision) Regulations 2022 [Draft]

Forensic Medical Services (Self-Referral Evidence Retention Period) (Scotland) Regulations 2022 [Draft]

The Convener: Items 3 and 4 on the agenda are consideration of two affirmative instruments. We have an evidence session with the Cabinet Secretary for Health and Social Care and his officials, who are all joining us remotely. Once all our questions have been answered, we will have a formal debate on the motions.

I welcome Humza Yousaf. He is accompanied by Scottish Government officials: Vicky Carmichael, acting unit head of the chief medical officer task force; Greig Chalmers, head of the chief medical officer's policy division; and Jacqueline Pantony, solicitor, and Carole Robinson, implementation team leader, who were both on the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill team.

Cabinet secretary, with your agreement, given that the underlying subject matter of the regulations is similar, we intend to ask questions on both of them in a single session—I believe that we have already let you know that. I invite you to make an opening statement.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Good morning. I am absolutely fine with that approach and I welcome the opportunity to make some opening remarks. First, let me say that I hope that everyone on the committee is keeping safe and well.

Thank you for the opportunity to give evidence on two instruments under the Forensic Medical Services (Victims of Sexual Offences) Scotland Act 2021. When commenced on 1 April, the act will create a clear statutory basis for health boards to provide forensic medical examinations for victims of sexual crime. Health boards will also be required to provide consistent access to self-referral services. Self-referral will enable someone who is aged 16 or over to access healthcare and request a forensic medical examination without first having to make a report to the police.

First and foremost, I am extremely grateful to the survivors whose courage, bravery and honesty helped to inform the key principles of the act. I know that I can safely speak for my predecessor, Jeane Freeman, when I say that it was a moment of tremendous pride when the act was unanimously passed in December 2020.

I also thank the chief medical officer, Professor Sir Gregor Smith, for his leadership of the national task force for the improvement of these services, and I put on record my thanks to his predecessor, Dr Catherine Calderwood, for her efforts to improve forensic medical services across the country.

The task force has made significant progress against the five-year high-level work plan that was published in 2017, which was supported by a Scottish Government funding commitment of £11.7 million over four years. That investment has helped health boards to get ready for the commencement of the act. One of the most significant improvements is that victims no longer need to go to a police station for a forensic medical examination. Those now take place in an NHS healthcare setting known as a SARCS—a sexual assault response co-ordination service.

Healthcare Improvement Scotland has published national standards and quality indicators. There has been tangible improvement in health board performance against those. In the final quarter of 2021, 87 per cent of examinations were carried out by a female doctor, supported by a female forensically trained nurse. Nurse care co-ordinators are in post in every health board to help ensure the smooth pathway of onward care and support.

National clinical pathways for adults and for children and young people have been published and are followed by health boards. A national clinical IT system has been developed to ensure consistent recording and collation of data, and the system will go live on 1 April.

Task force officials are liaising closely with health boards to ensure that they are all ready to provide self-referral forensic medical services nationally from 1 April. Boards have been provided with detailed guidance and training, as well as additional funding to support implementation and readiness.

I turn first to the Forensic Medical Services (Self-Referral Evidence Retention Period) (Scotland) Regulations 2022. Section 8(1)(b) of the 2021 act enables the Scottish ministers to set, by regulation, the length of time for which health boards will be required to store evidence that is gathered during a self-referral examination. That is known as the retention period. Any evidence that is stored will be destroyed at the end of the period, unless the person examined has requested destruction of their evidence prior to that or has reported the matter to the police, in which case the

police will request that the evidence be transferred to them.

The regulations, if approved, will set the retention period at 26 months. That period is based on the outcome of the Scottish Government's public consultation and on evidence and best practice from across the UK and internationally. Just over half of the responses to the consultation agreed with that period, which seeks to strike the right balance between ensuring that evidence is held for a reasonable timescale and taking into account the practical considerations for health boards.

The Forensic Medical Services (Modification of Functions of Healthcare Improvement Scotland and Supplementary Provision) Regulations 2022, makes amendments to the National Health Service (Scotland) Act 1978 using the powers in sections 13 and 19 of the 2021 act. This technical instrument will give Healthcare Improvement Scotland functions similar to those that it currently holds in relation to wider health services. The functions include a general duty of furthering the improvement in the quality of services that are provided under the 2021 act and the provision of information to the public about the availability and quality of those services.

The instrument will also extend the inspection power of HIS to any service that is provided under the 2021 act. That serves as a backstop power that is likely to be used only in the event that a significant issue of continued concern has not been resolved through existing health board governance and assurance processes. However, the Government considers it prudent for it and HIS to have those powers in reserve, as is the case for other healthcare services.

In summary, the CMO's task force has made significant progress over the past five years, and Scottish Government officials are working closely with health boards to ensure that they are ready for commencement of the 2021 act. This secondary legislation is an important anchor to that work and helps to underpin the continued improvements that we plan to deliver with our NHS partners.

As always, I am happy to take questions.

The Convener: Thank you very much, cabinet secretary. Do colleagues have any questions?

Emma Harper: Good morning, cabinet secretary. I have a quick question on the 26-month retention period. Our convener rightly mentioned that that is to do with not contacting survivors on an anniversary that is associated with a reported assault. That is part of it, but there was also a consensus on the 26-month period in the feedback from the consultation. Everybody agreed about that, which is why we have got to this point today.

Humza Yousaf: I thank Emma Harper for making those important points. She is absolutely right about why we have a 26-month period and not, for example, 24 months, which would seem a more natural time period. The reason why we avoid 12, 24 or 36 months, for example, is that those would be anniversaries of when the medical examination had to happen, which I imagine can be a traumatic period in a survivor's journey. We avoid those anniversaries for good reason. That is the feedback that we got from the likes of Rape Crisis Scotland and others.

On Emma Harper's point about consensus, it is important for me to say that, although the 26-month period was backed by the majority of respondents to the consultation—just over 50 per cent—there was not consensus on what the retention period should be among the remaining group of just over 49 per cent of respondents. Some thought that it should be shorter than 26 months and some thought that it should be longer. It would be remiss of me not to say that the survivor reference group favoured a longer retention period. However, we wrote to the reference group about the 26-month period and it has not pushed back on that.

I think and hope that the reference group understands our reasons for trying to balance important factors: retaining the evidence for a long enough period while ensuring that evidence is not held for a disproportionate amount of time, given the sensitivity of the data.

We looked at evidence from across the UK and found that in the London centres—the Havens—the average time between self-referral and police referral was three months. In other UK centres the average time between self-referral and police referral, for cases that go on to police referral, seems to be between three and six months. Therefore, 26 months seems adequate.

The Convener: No other members want to ask a question, so we will move on to items 5 and 6, which are the formal debates on the made affirmative instruments on which we have just taken evidence. Are members content to hold a single debate on the instruments?

Members *indicated agreement.*

The Convener: I remind the committee that, during the formal debate, members should not put questions to the cabinet secretary and officials may not speak. I invite the cabinet secretary to move motions S6M-03315 and S6M-03316 and to speak to the motions, if he wants to do so.

Motions moved,

That the Health, Social Care and Sport Committee recommends that the Forensic Medical Services (Modification of Functions of Healthcare Improvement

Scotland and Supplementary Provision) Regulations 2022 [draft] be approved.

That the Health, Social Care and Sport Committee recommends that the Forensic Medical Services (Self-Referral Evidence Retention Period) (Scotland) Regulations 2022 [draft] be approved.—[*Humza Yousaf*]

The Convener: I invite members to contribute to the debate.

Sandesh Gulhane: I am perfectly happy with what is proposed.

The Convener: Thank you. I want to thank the Health and Sport Committee in the previous session for the work that it did on the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill. It was a significant moment for the Parliament when the bill was passed.

I see that no one else wants to contribute and that the cabinet secretary does not want to comment further. Are members content for me to ask a single question on the instruments?

Members *indicated agreement.*

The Convener: The question is, that motions S6M-03315 and S6M-03316 be agreed to.

Motions agreed to,

That the Health, Social Care and Sport Committee recommends that the Forensic Medical Services (Modification of Functions of Healthcare Improvement Scotland and Supplementary Provision) Regulations 2022 [draft] be approved.

That the Health, Social Care and Sport Committee recommends that the Forensic Medical Services (Self-Referral Evidence Retention Period) (Scotland) Regulations 2022 [draft] be approved.

The Convener: That concludes consideration of the instruments. I thank the cabinet secretary and his officials for attending.

Humza Yousaf: Thank you.

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2022 (SSI 2022/45)

The Convener: Item 7 is consideration of a negative instrument that increases the charges recovered from persons who pay compensation in cases in which an injured person receives national health service hospital treatment or ambulance services. The increase in charges relates to an uplift for hospital and community health service annual inflation.

The Delegated Powers and Law Reform Committee considered the instrument and made no recommendation, and no motion to annul has been received in relation to the instrument. I invite members' comments.

Sandesh Gulhane: I would be interested to know how much money has been claimed back through the scheme, versus the cost of the administrative work that is involved, so that we can see what difference the increase will make.

The Convener: Okay. I take it that that is a point of information, on which you would like to hear from the Government, rather than a comment on the uplift.

Sandesh Gulhane: It is not a comment on the uplift.

The Convener: If there are no more comments, do members agree that, other than seeking the information about which Sandesh Gulhane asked, the committee makes no recommendation in relation to the instrument?

Members *indicated agreement.*

The Convener: Thank you.

At our next meeting, on 8 March, the committee will start taking evidence as part of our inquiry into alternative pathways into primary care.

That concludes the public part of our meeting today. I thank everyone.

12:00

Meeting continued in private until 12:16.

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