OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 28 June 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
24th 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)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jules Goodlet-Rowley (Scottish Government)
Michael Kellet (Scottish Government)
Maree Todd (Minister for Public Health, Women's Health and Sport)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 28 June 2022

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Deputy Convener (Paul O'Kane): Welcome to the 24th meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from the convener, Gillian Martin.

Agenda item 1 is a decision on taking business in private. Do members agree to take in private items 6, 7 and 8 on today's agenda and our next meeting on 6 September?

Members *indicated agreement.*

Health Inequalities

09:01

The Deputy Convener: Agenda item 2 is the final evidence-taking session for our inquiry into health inequalities. I welcome to the committee Maree Todd, the Minister for Public Health, Women's Health and Sport, who is soon to be joined by Michael Kellet, director of population health at the Scottish Government.

I invite the minister to make a brief opening statement.

The Minister for Public Health, Women's Health and Sport (Maree Todd): Thank you for inviting me to give evidence to the inquiry today. I am aware that, last month, my officials and Public Health Scotland took part in a private session with the committee at which they outlined the range of work that we are undertaking to support a reduction in health inequalities. I was pleased to hear that members found the session useful.

We have made many positive changes. However, I want to be up front about the challenges that we face on the issue. Scotland's long-standing health inequalities are fundamentally about income, wealth and poverty. The recent report from the University of Glasgow and the Glasgow Centre for Population Health attributes stalling life expectancy trends in Scotland directly to United Kingdom-led austerity measures. The report makes a number of key recommendations, including protecting the real incomes of the poorest groups, especially with the currently escalating inflation rates. The evidence strongly suggests that implementing such measures would reverse death rates and reduce the widening health inequalities that we see.

We are doing all that we can to mitigate the impact of such policies. The introduction of the Scottish child payment of £20 per week is just one of the measures that we are taking to mitigate the adverse impact of UK Government-led reforms and to put money back into the pockets of the people who have been hardest hit. We have more than 200 community link workers across Scotland playing a vital role in supporting people with issues such as debt, social isolation and housing, and our welfare advice and health partnerships are now well embedded in 150 general practice surgeries in Scotland's most deprived areas. However, we simply do not have all the levers at our disposal to tip the balance and change the trajectory on life expectancy.

I have stressed in previous debates and evidence sessions that the Parliament needs to be a public health Parliament in which all parties come together to consider how we work jointly to

tackle issues. Our work on child poverty provides us with an opportunity to live up to that expectation. It is a national mission and our commitment to wide-ranging action is demonstrated by the work that is taking place across portfolios to consider outcomes for children and young people. It includes a collective focus on what we are doing in childcare, what we are doing to support people into work and what we are doing to support those who are furthest away from the labour market. None of it is easy and we are learning as we go, but that is precisely the approach that we need to address health inequalities across all the social determinants of health.

As part of the strategic reform of health, our emerging care and wellbeing portfolio is creating a sustainable health and social care system that will promote new and innovative ways of working. That includes our place and wellbeing programme, which is bringing together all sectors to drive change jointly and locally to reduce health inequalities.

An example of that is our work on positioning national health service and social care providers as anchor institutions in our communities, working with others such as housing associations, local government and universities to nurture the conditions for health and wellbeing. NHS and social care providers are significant sectors across Scotland, and they are well placed to provide opportunities in local communities by increasing access to employment in health and care and making available NHS land and buildings to support communities' health and wellbeing.

Our role is to enable local change, not dictate what form it takes. The voice of people with lived experience will be crucial in guiding and shaping local action on health inequalities. To reiterate, we all have a collective responsibility to address health inequalities—it is not the sole responsibility of health and social care. I am committed to playing my role in that endeavour.

There is a real appetite for change among us all. That consensus and that support are both welcome and necessary, and I am pleased that we are having an open and honest discussion on the subject.

The Deputy Convener: Thank you, minister. We now move to questions on a variety of themes and on the issues that you have raised in your opening remarks. I will start on the progress that we are making on health inequalities.

Minister, I appreciate that you have covered in your opening remarks the progress that has been made over the past seven years, and you have pointed to some of the reasons for poor health equality in highlighting UK Government decision making and austerity. I want to broaden that out a little more. Why have we been unable to make greater progress in addressing health inequalities over the past seven years, notwithstanding the issue that you have raised? What more do we need to do to make progress?

Maree Todd: Thank you for the question. I will focus on what the Scottish Government can do, but we cannot ignore the fact that, as I have highlighted to the committee before, it feels as though I am working with one hand tied behind my back. What the Scottish Government gives with one hand, the UK Government takes away with the other.

The unwelcome reality is that health inequalities are widening, including the gap in health life expectancy. That is completely unacceptable, and we know that we need to do more, particularly on the implementation gap. We recognise that addressing the wider determinants of health such as poverty and inequality requires cross-Government working and partner-led action. The answers to health inequality do not lie simply in my public health portfolio.

Where potential levers for tackling poverty are reserved, we will continue to put pressure on the UK Government to rethink its social and welfare policies, for example, which absolutely help poverty to persist. We are introducing extra social security programmes that are well beyond anything that the UK Government offers.

We know that we have a lot still to do to tackle the determinants of health where we have control of the levers, and we are making progress in a lot of key policy areas. For example, with the child poverty delivery plan, we are putting money into the pockets of families now, helping to tackle the cost of living crisis and setting a course for sustainable reductions in child poverty by 2030. I have already mentioned the game-changing Scottish child payment, which is £20 and will increase to £25 when it is extended to cover under-16s by the end of this year. Our five family benefits, including the Scottish child payment, will be worth up to a maximum of £10,000 by the time a first child turns six and £9,700 for subsequent children.

We have extended our fuel insecurity fund by making available a further £10 million to third sector organisations to support people who face fuel insecurity. That means that we have allocated more than £1 billion since 2009 on tackling fuel poverty and improving energy efficiency. That particular policy area highlights the challenges for the Scottish Government in fully tackling those issues. My constituency of Caithness, Sutherland and Ross is the furthest north mainland constituency in Scotland, and we pay the highest prices in Scotland for our electricity. Indeed, we

pay more for our electricity than people down here in the central belt do, despite the fact that we are net producers of green energy. We are also, in large part, off the gas grid, so electricity is a really important source of energy for us.

However, the matter is fully reserved to the UK Government, which has chosen, through its policies, to continue that injustice. In my constituency role, I wrote to the Chancellor of the Exchequer about six weeks ago, but I have not even had the courtesy of a response yet. The UK Government has no interest in fixing these appalling injustices and, as a result, many of my constituents where I live in Scotland are living in extreme fuel poverty, entirely because of a UK Government policy choice.

The Deputy Convener: I want to further explore the policies and objectives that relate to addressing health inequalities. Last week, Professor Sir Michael Marmot, who has previously given evidence to the committee, provided compelling evidence about the measures that have been taken in England, particularly in Wolverhampton and Manchester, under his Marmot cities model. He uses six approaches that can make a difference—and which, on the basis of reports on those cities, have been shown to have made a difference.

Last week, I said that those things are not "rocket science"; we probably all recognise them as important things to do that make a difference. They are very often offered and supported by local government and the third sector. However, we know that their funding is reducing, which is challenging, so I am keen to get a sense of how we progress a Marmot cities agenda in Scotland, particularly in our city regions, and how we can sustain funding in the six areas that Professor Marmot has identified.

Maree Todd: The Scottish Government welcomes Professor Marmot's work. We are very interested in his approach and his thoughts on how we tackle these thorny issues, which, to be frank, are not easy for any Government to tackle and resolve.

You said that the powers are largely in the hands of local authorities and the third sector. As I mentioned in my introduction, we need to work closely with partners, because it is significantly important that we all work together on the same aim. I always think of tackling health inequalities as being a golden thread that should run through all our work in the public sector.

Professor Marmot is meeting Scottish Government officials today, and I will let my colleague Michael Kellet say a bit more about that. As we are interested in Professor Marmot's work and keen to learn from him, we have asked him to spend some time with Government officials.

Michael Kellet (Scottish Government): First, I must apologise profusely to the convener and the committee. I was here on time but I was sitting in reception.

Had I not been here giving evidence this morning, I would have been in a virtual session with Michael Marmot and fellow Government colleagues in health and social care and beyond. We will hear directly from and be challenged by him, and we will explain to him the place and wellbeing programme and the care and wellbeing portfolio that the minister has set out.

We are really interested in his Marmot cities approach. A place-based approach is fundamental to the place and wellbeing programme, as the minister has set out. It is about creating partnerships with the public sector, the third sector and, potentially, the private and independent sector in localities and thinking about how inequalities can best be tackled. We want to learn the lessons there, and there is real potential in that regard. Clearly, the context is different in Scotland, but we certainly want to take that learning.

The Deputy Convener: It is good to hear that that meeting is taking place today and that progress on that work is being made, because the committee felt very strongly about that evidence.

I want to ask about health inequalities that are driven by poverty. The committee heard evidence from many organisations that, to some extent, the only proven policy relating to poverty and its impact has been the child payment, given the progress that has been made in that regard. It has had an impact because income goes directly to the poorest families in our society. Would the minister support a further increase to the child payment in order to tackle inequalities?

09:15

Maree Todd: We have committed to further increasing the payment to £25 by the end of the year, and we are also extending eligibility and making the payment available to all children up to the age of 16 by the end of the year. That is a further increase.

I agree that that is an extremely helpful way of getting money into pockets, but a relying on social security alone is not the only thing that we can do. Again, however, I am frustrated at our not having all the levers that could be available to us. For example, we would really benefit from having some powers over employment law, because that would allow us to ensure that work paid. As we saw a few weeks ago in the Government's white paper on Scotland's place within the UK, which

compared us with a number of near European neighbours, we live in a very unequal country with a large income gap and a very large gender pay gap. Indeed, only one of our close neighbours has a larger gap. We have a high number of people—and a really high number of children and pensioners—living in poverty, as well as a high level of in-work poverty. It is extremely challenging to tackle and change some of those structural issues when you have only one effective lever. It is, as you have said, a very effective lever, and we will use it, but it has only a limited impact on the whole-system problem.

The Deputy Convener: Thank you very much. I will move on to questions from my colleague Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning, minister, and good morning, Mr Kellet. I am interested in the issue of cross-portfolio working, because, as you have said, the austerity being inflicted on Scotland is costing £770 million a year at the moment. You have also said that we do not have all the levers that we need to tackle health inequalities. As a public health minister, can you tell us what work is being done in other parts of the Government and in other portfolios to tackle these inequalities?

Maree Todd: We recognise that a cross-portfolio approach is required. If we did not know that before—which we did—the pandemic absolutely shone a light on those pre-existing health inequalities; indeed, it not only shone a light on them but worsened them. The Scottish Government recognises that.

We also recognise that the past couple of years have been a terrible experience for almost everyone in Scotland, but with our learning from the pandemic, we have found ourselves able to turn and face what are really difficult issues and have the sort of impact that we were unable to have before. For example, rough sleeping has been a priority for the Government ever since the Scottish National Party came into power in 2007, but it took until March 2020 and a national emergency for us to be able to end rough sleeping successfully, because it was a necessity for the country. We found that, in the face of that national emergency, everybody came together collectively and, as I always say, we did things that we thought were impossible. I tell you what—we have a taste for that now, and we are going to keep trying to do impossible things and things that are really challenging.

A role of the Deputy First Minister—and something that is a really key part of our Covid recovery—is to try to bust silos right across Government. It is almost a human norm that we create these silos in our work, but the Deputy First Minister's role across Government is to bust them by regularly bringing groups of ministers together and ensuring that we are all aware of each other's work, that it is all aligned and that we are getting the maximum impact from across Government in tackling the really thorny issues that Scotland faces.

Emma Harper: Those challenges are not just urban; they are also rural, and you are a rural MSP, like I am. Is specific work being done to consider housing or other wider issues to help raise awareness of health inequalities in rural areas?

Maree Todd: You are absolutely right to consider those differences. You and I, and every MSP around this table, know very well that you cannot have a one-size-fits-all approach in Scotland. We might be a small country, but there are lots of different areas with very unique factors, which is one thing that differentiates Scotland from the rest of the UK.

A number of years ago, the Joseph Rowntree Foundation looked at the level of poverty in each of the countries in the UK, and one of the things that protected people in Scotland was the quality of our housing stock and the availability of social housing. The Scottish Government has had a huge programme of investment in social housing, and we have built more social housing.

The quality of rural housing stock and the difficulty of bringing the insulation up to an appropriate grade to mitigate fuel poverty is a challenge. That is vital in relation to reaching our net zero ambition and tackling fuel poverty. We have kind of done the low-hanging fruit. Upgrading insulation is easy in large-scale modern housing in an urban setting, but it is a much tougher job in a rural setting with more dispersed housing, different types of housing and different qualities of housing stock. We will have to get into that challenge.

That illustrates the need to work together. If we are going to achieve either or both of the ambitions of tackling fuel poverty and aiming for net zero, we have to get in about the challenging issue of improving the housing stock in rural areas. I do not need to tell you about the impact of the cost of fuel in rural areas. Although there is cheaper electricity in the south than we have in the far north, the cost of fuel for cars is challenging for my community at the moment. The lack of public transport options and the need to run a car is a challenge in rural communities, however well off you are.

I had a heartbreaking communication from a constituent who is a pensioner. He lives 20 miles from his local shop, had no fuel in his car and had only £11 in his bank account. He could not heat his house because he could not afford to fill his oil tank, which was his form of heating. You will all be

aware that in many parts of rural Scotland, filling your oil tank so that you can get heat and hot water is a huge outlay, but that constituent could not afford the outlay. He was in a cold house and had to gather wood for his wood fire—this is in 2022—in order to heat his house, and he was unable to access his nearest shop to buy food. That is a disgrace, and it is absolutely about policy choices.

Reducing the VAT or making it zero on heating fuel or reducing the VAT on car fuel would relieve that situation. We can help with welfare policies, and my office directed him to all the funding that is available through the Scottish Government, but it is difficult to tackle those particularly grisly issues, and it will only get worse, which is heartbreaking.

People in my constituency—and I am sure in Emma Harper's constituency—feel that those stories are hidden, because urban deprivation is so challenging for Scotland.

Emma Harper: I have a final quick question about the delivery of anti-poverty measures and stopping folk from working in silos. I know that good work is being done in Dumfries and Galloway Council on anti-poverty approaches using participative budgeting.

Are we good at breaking down silos between local authority areas and the Government? Are people embracing that? You said that the Deputy First Minister has oversight of getting people around the table. Are we embracing non-silo working?

Maree Todd: I have grown to believe that it is a human trait to silo off and protect our own little area. We are recognising the benefits of working together, because we are in difficult times. There is absolutely no denying that. People are recognising the benefit of working together in a way that we have not done before.

Key is what you said about participative budgeting and getting the community involved. A powerful means of keeping us all working together in that way is to bring in the voices of lived experience. It is sometimes easy to dismiss evidence that is on the page, but once somebody has looked you in the eye and told you their story, it is hard to choose not to work together to make things better for that person. Having the voice of lived experience at the heart of policy making and implementation is key to ensuring that we continue to work together.

Perhaps it is just me, but I suspect that that is not a desperately natural way for people to be. Often, there are sensitivities between local government, central Government—in Scotland and in the UK—and our third sector partners. However, we will get the most powerful impact if we are able to work together. That absolutely needs to be the goal.

The Deputy Convener: Carol Mochan has a supplementary question.

Carol Mochan (South Scotland) (Lab): I am interested in that cross-departmental Government working, and I would be interested to know whether you have any examples of having done that well. You mentioned transport as being particularly important in rural areas.

I am also interested to know whether you can commit to asking the Deputy First Minister to give us some kind of plan, because it is key that the ministerial departments work closely together. Perhaps some kind of plan about how he sees the next year would be helpful, particularly in the remit of health inequalities.

Maree Todd: I am certainly more than happy to ask the Deputy First Minister to bring forward a plan of what is happening over the next year—or perhaps an outline of the type of cross-portfolio working that he does.

An area outside of public health in which we see a laser focus on tackling health inequalities is the child poverty plan. That is a national mission for the Government, and was prioritised even in the resource spending review, which was a challenging set of figures for the Government to receive, work through, share with our partners and local authorities and put into the public domain. Within that, you can see that tackling child poverty is still a priority.

Our action against child poverty is firmly rooted in evidence, with a robust evaluation strategy. Cumulative impact assessment and wide-ranging analytical materials underpin the approach that was outlined in our second delivery plan for tackling child poverty, "Best Start, Bright Futures". That plan has a sharp focus on six priority family types, who are at the greatest risk of poverty, including those from a minority ethnic background, those with a disabled household member and those with a lone parent.

We are taking that evidence-based and balanced approach to tackling poverty, focusing on increasing household incomes through social security and employment and reducing household costs. Our action will focus on drivers of poverty, balanced with a focus on the next generation, supporting children to thrive and ensuring that we support the wider wellbeing of families. We have talked about the Scottish child payment, which we have already doubled in value. We will further increase it to £25 and extend it to children under 16. In my last portfolio, we had a massive social infrastructure investment in early learning and childcare, for which we doubled the entitlement.

That is where we get the biggest bang for our buck, as a Government.

09:30

We all know and cannot deny that the impact of poverty on a child can be lifelong. Tackling child poverty will absolutely deliver benefits in tackling health inequalities. It will be decades before we see those benefits, but it is absolutely the right thing to do.

Michael Kellet might want to come in.

Michael Kellet: The child poverty example is a really good one. As a Government official, I felt part of the broader team that pulled together the child poverty strategy.

Another good example of policy is the national mission on drugs. I support Angela Constance in that work and we are using the structure of the DFM group that the minister talked about to focus on the underlying causes of addiction. The committee will know that there is a real focus on the mission for medically assisted treatment standards and on residential rehabilitation. We also need to look at the underlying causes of addiction and we are using the DFM group to think about how drugs policy officials and Ms Constance can work with ministers in education, local government, transport and in the economy and employment to tackle some of the underlying causes. That gives us a structure and, if I can be honest from an official level, a pressure, requirement and clarity from ministers that they need us to work better and across portfolios. That is significant: it feels different and is making real changes.

The Deputy Convener: We move to questions on national strategy, which will be led by my colleague Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): At our meeting on 24 May, I asked Dr David Walsh whether, because we do not have overall powers over social security, taxation or employment in Scotland, it would make any difference if we had an overall strategy to reduce health inequalities. Dr Walsh replied that, if the aim was to narrow health inequalities across society, a strategy would be great but the relevant powers would also be required. Minister, what is your view of those comments?

Maree Todd: It will be no surprise to hear that I do not disagree with David Walsh's assessment. That is why I was very keen to quickly put on record at the beginning of the meeting that, although I absolutely welcome scrutiny of what the Scottish Government is doing, none of us should kid ourselves about where the power to tackle poverty and the responsibility for the situation that we are in lie.

The UK is a wealthy country and it is a policy choice to perpetuate poverty. The Liberal Democrat and Tory coalition government made choices in 2010 and absolutely chose to pursue austerity policies. They reduced the funding to the Scottish Government and local authorities and brought in punishing welfare reform. We are witnessing the tragic consequences of that now.

That is one of the reasons why I was politicised and came into politics. In 2010, I was working as a mental health pharmacist in a psychiatric hospital and saw first-hand the impact of that welfare reform on the vulnerable citizens that I worked with. I worked mainly with people with schizophrenia and bipolar affective disorder. They had quite severe and enduring lifelong disabilities but they were put through a system that was unable to recognise that their illnesses were disabling them and that thrust them out into poverty and destitution without a second thought. I saw that first hand, so I will not deny the hand that the UK Government has in that.

It has a profound impact. We can think about some of the particular policies. There is the two-child cap, which contravenes the United Nations Convention on the Rights of the Child. A child who requires the support of the state is entitled to the support of the state, however many brothers and sisters they have. There is no conditionality in the requirement for support. Just think about the impact of that policy. It is a choice to put children into destitution. We cannot shy away from that. If the Scottish Government had a policy that academics clearly stated was life shortening, I am sure that I would be facing a great deal of scrutiny on that front. The UK Government and the coalition Government that made those decisions, for which we are now all paying the price, should absolutely face scrutiny on their consequences.

I am so mad that I have forgotten your question.

Evelyn Tweed: Would it make any difference if we had an overall national strategy?

Maree Todd: I do not think that we can excuse ourselves. I cannot be faced with this need and not take action. I am absolutely clear that the powers to tackle this fully lie at Westminster, but that does not mean that the Scottish Government cannot do anything. We have to do everything that we can. We are faced with immense need on a daily basis and we have to do what we can to rise and meet that need. There is no way of avoiding that, but there are bigger challenges at the door of the UK Government. Of course, my solution would be for us not to be subject to the whims of the UK Government, but that is a choice for the people of Scotland.

Evelyn Tweed: Do you feel that health inequalities are a top priority for other organisations outwith the health service, such as local authorities, that will need to assist with health targets?

Maree Todd: I think that it is easy to lose the focus on health inequalities, but I genuinely believe that my local authority colleagues are as troubled as I am about this. There is also amazing work going on in the third sector, which does a power of creative work in difficult circumstances—and, to be frank, insecure financial circumstances. It does amazing things.

I think that it is easy to lose focus, to take your eye off the evidence and to feel overwhelmed by the situation that we face. When we are faced with such desperate need—we hear about it on the news day in, day out from many people the length and breadth of Scotland—and there is an understanding that it is only going to get worse, it is easy to lose the focus on health inequalities. Part of my job is to make sure that we keep an eye on the golden thread of health inequalities that runs through everything.

We must remember what causes health inequalities. They are fundamentally caused by inequalities in wealth, power and status. I and all our partners who are trying to tackle health inequalities need to remember that in everything that we do. We must not disempower our communities or individuals. Every policy that we bring together should empower them and help to tackle inequalities. That is why, fundamentally, putting money into people's pockets is a far more powerful tool than giving them a box of food. It is a much more empowering experience.

Emma Harper: I have a quick supplementary question on what you have said, minister. We constantly hear about choices that are being made and we constantly talk about constraints and the mitigation of austerity. When Scotland becomes an independent country, will this Government continue to pursue the policies that will tackle the issues that affect people's lives, cause them to face poverty issues and lead to the health inequalities?

We cannot constantly talk about "mitigation, mitigation, mitigation". We need to be able to have the tools, levers and powers to do what we want. That is the bottom line for me. We will still need to make those choices when Scotland is an independent country.

Maree Todd: You are absolutely right. Those choices are not easy for any Government, and we see issues around health inequality affecting many countries around the world. However, the UK is fundamentally one of the most unequal countries in Europe. It stands out when we compare it to our neighbours—it is not a great record to have the second-highest gender pay gap or to have such high levels of in-work poverty. The policy choices that any Government makes will make a fundamental difference to the level of inequality that is experienced.

To pick up on your point around mitigation, the situation at the moment is that we are a devolved Government. The amount of money that we have is largely dictated by the Barnett formula—Scotland gets a population-based percentage of what it chooses to spend—so the choices that the UK Government makes on spending account for the bulk of our budget, which restricts how much money we have.

We have some levers over raising money in income tax but we do not have all the tax levers. We have no power over national insurance and, as some economists would say, it is pointless to have any power over income tax if you do not also have power over national insurance—the two almost always require to be balanced.

The other thing is that that money is for our devolved responsibilities. About 70 per cent of Scottish revenue spending is by the Scottish Government on devolved issues, and every time that we make a choice to mitigate a reserved issue, there is less money in the pot to spend on devolved issues. That is why the situation cannot go on forever—that pot is not limitless. We have devolved responsibilities on which we need to spend money, and we have limited means of raising extra money, should we choose to do something different from the UK. It is a difficult situation for any Government to be in.

Another issue, which came up time and again during the pandemic, is the inability to borrow. Most Governments around the world are struggling to balance their budgets now, but most Governments have the opportunity to borrow. The Scottish Government has to bring its budget in bang on the money every time.

Sandesh Gulhane (Glasgow) (Con): Good morning, minister. What is the gender pay gap in the Scottish NHS?

Maree Todd: I cannot give you that number at the moment.

Sandesh Gulhane: It is 18.2 per cent, and the Scottish NHS is fully devolved. Why have you not improved that?

Maree Todd: A lot of work goes on in order to improve the pay in the Scottish NHS. As you know, people who work under agenda for change in Scotland are paid more than their counterparts are in the rest of the UK. I imagine that the gender pay gap in the NHS arises from the fact that a great deal of women work in the NHS—more than

50 per cent of employees in the NHS are women. However, as we see reflected in many other aspects of society, the people who are in the highest-paid managerial jobs tend to be men.

You are absolutely right to draw attention to that huge gender pay gap. My own profession of pharmacy has one of the biggest gender pay gaps that there is. That gap does not start at the point where women have children, but at the point where we graduate from university. From the point of leaving university, female pharmacists tend to earn less than male pharmacists, and we need to put in place policies to tackle that.

09:45

The Deputy Convener: Our next theme is tackling the fundamentals of health inequality. Carol Mochan will lead on that.

Carol Mochan: I absolutely condemn the policies of the current Conservative UK Government. It was interesting that Dr Walsh said at a previous meeting that if we had a change in Government at UK level, that would make an enormous difference to what we could do, including as a devolved nation. However, it is important that we in this committee talk about what we can do in Scotland. I absolutely welcome your commitment to do everything that we can, and I assure you that I will do my very best to hold you to that.

I will talk a little bit about the evidence that Claire Sweeney, from Public Health Scotland, gave to the committee. If you do not mind, I will read out a few points that she made. She said:

"although we have talked about a lot of the challenges that we are facing in Scotland, the big message that I want to emphasise and get across is that we can do a lot about inequality. There are lots of levers and opportunities in Scotland to address it. It is by no means something that is intractable that we cannot address; we can address it."

She went on to say:

"Given the millions of pounds that the public sector spends in Scotland every year, there is a huge opportunity to use that money to good effect, and we see many ... things"

that we could do in Scotland. She said:

"For example, we hold public bodies to account for financial and access targets, but we do not hold public leaders to account as strongly ... That is something really clear and tangible that could be done."

She also said that she

"would like budgets and spend across Scotland to be more closely aligned to impact",

on things such as

"reducing inequality and child poverty".

and stated:

"It is about the early years, access to education and training, having good and fair work, having a good and affordable standard of living and having healthy communities in place so that people have access to green space, good transport".

Finally, she noted that

"There is a lot of agreement on what can be done",

and that we in Scotland need to

"mobilise the rest of the system"—[*Official Report, Health, Social Care and Sport Committee,* 31 May 2022; c 13-14.]

to do that.

Maree Todd: I would not disagree with anything there. I will not get into the detail of your first comment about the fact that the Government in the UK could change. Scotland has consistently voted left wing—either Labour or the Scottish National Party—for many decades, and we do not always get the Government that we vote for: we get the Government that our neighbours choose. To be frank, that is a fundamental challenge for the health of people in Scotland.

Undoubtedly, I think that, if we look at the issues in totality, Carol Mochan said much that would chime with some of the policies that the Scottish Government is developing. An example is the development of anchor institutions—I will let Michael Kellet say a little more about that. That development is recognition that we have a powerful opportunity through spending on our NHS that could be used to benefit communities. We could use that spending power to ensure, for example, that individuals who are less likely to be in the workforce have opportunities to be employed and trained, and are supported to fulfil their potential. We could use it by bringing in local procurement policies, which would mean that all the things that we have to buy to run the NHS could benefit local communities.

We could use some of the assets that the NHS has for community empowerment projects, by handing over buildings and land to support communities to do what they want. That is a hugely exciting opportunity, and if we get it right, it absolutely will have an impact.

Carol Mochan mentioned the generality of the space that we live in. Again, there is a lot of work on that going on across the board. We talk about 20-minute neighbourhoods. There are different opinions the length and breadth of Scotland about how doable that approach is in some areas, but it is a great concept to have everything you need within walking distance of your house, is it not?

Again, I highlight that it is important to consider the twin challenges that we face—tackling poverty and achieving our ambition for net zero—when we are thinking about what our environment looks like. To be honest, I would like us to think a bit

more about them in considering how we deliver our public services.

As public health minister, I am a little tormented, to be honest, by the fact that we keep centralising public services so that people have to travel some distance—often, in my part of the world, by car—to access healthcare and local authority services. We need to think a bit more about how we can deliver such services closer to home. That would be better for people's health; it would make it easier for them, and would not put in their way barriers that prevent them from accessing vital public services. That would also make a difference in respect of our net zero ambition—think how many journeys are made by people travelling for NHS appointments.

Carol Mochan mentioned early learning and childcare. It was a huge privilege for me to be involved in delivering that policy in the previous session of Parliament. I cannot tell you how significant that social infrastructure investment is; it will benefit children and their families the length and breadth of Scotland.

We found that investment in high-quality early learning and childcare has a direct impact on the individual child. It can literally close the attainment gap before it appears. We know that children from the poorest backgrounds are, when they present at school at the age of five, about 18 months behind their peers in language, literacy and numeracy. High-quality early learning and childcare can reverse that. We need the priority to be on eligible two-year-olds—about 25 per cent of children in Scotland are eligible for accessing provision early—in order to close that attainment gap.

However, the benefit does not stop there—the provision benefits not only the individual child, but their family. I have heard time and again about families who are really struggling. Many of us around the table who are parents will remember tag-team parenting, where one parent comes into the house and the other parent leaves to go to work. A lot of families are living like that, and are living under immense pressure, just to earn enough money to cover their household bills. The provision of high-quality early learning and childcare by the state gives them room to manoeuvre and to have family time, which is really important for them and for their children.

The final point, which is mind blowing—I used to get very excited when I thought about it—concerns the impact of high-quality early learning and childcare. As we see in studies from the US, the impact on the child is not only as they reach their school years and go through their education—it is lifelong. For children who have experienced high-quality early learning and childcare, there is a measurable impact on their parenting ability when they have their own children.

As a Government, how much do we love having policies that can effectively tackle some of the long-standing intergenerational challenges that Scotland faces? We in the Scottish Government are absolutely committed to tackling those challenges. That is why, despite all the economic benefits that come from ELC in Scotland, our ELC provision is absolutely focused on the beneficial impact on the child, and we are ensuring that that provision is high quality.

Michael Kellet might come in here.

Michael Kellet: Yes. Thank you for the opportunity, minister. The anchor institutions agenda is important and exciting. It relates to the point that Claire Sweeney made, and which Carol Mochan quoted, about making full and best use of the collective power of public sector institutions in particular, in order to improve the economy, wellbeing and health, and to tackle health inequalities in the communities that the institutions serve.

That has been a real priority for us. It is the top priority in the places and wellbeing programme that the minister referenced earlier, and there is a real connection with the community wealth building agenda, as well. It is really quite simple: it is about using the power of the NHS and other local partners as employers. We recognise that huge numbers of people are employed by the NHS and as contractors of services, and we recognise the huge amounts that the NHS and other public sector bodies spend on contracts, and their important role as owners and users of buildings that are located in communities.

We have prioritised that work, and we recently set up a steering group to take it forward. Carol Potter, who is the chief executive of NHS Fife, has agreed to chair the group and drive the work forward.

I will give the committee two or three examples of the benefits of the approach. First, the new north-east hub health and care centre is a development in the north-east of Glasgow that will host three general practices and a range of other public and third sector services, which means that people will be able to get the support that they need, whether it is health related, financial or just social connection. There will be a community space there, including a cafe in Parkhead library, and it will be a net zero facility. That is an excellent illustration of how an NHS facility can become an anchor in its community.

I know that the committee has taken evidence from Clackmannanshire Council as part of its inquiry. The work that it is doing in its wellbeing economy pilot project has, at its centre, a focus on

anchors. Colleagues from NHS Forth Valley and Clackmannanshire Council are part of our work.

There is also the work that NHS Education for Scotland is doing in the youth academy, where it is partnering with schools in areas of deprivation across Scotland to think about how they can encourage kids to take up opportunities to work for the NHS in a range of roles that they would not otherwise have thought about.

A really good example that is perhaps closer to Mr Torrance's heart—as you know, I used to be the chief officer of Fife health and social care partnership—is the project at Victoria hospital in Kirkcaldy to encourage and support people into working in health and social care. The project is encouraging people who were nowhere near the labour market into full-time employment with NHS Fife.

There is a wide range of such agendas across Scotland. We want to identify best practice and make sure that all our institutions, working with local partners, make the most of what exists in order to improve the wellbeing of their communities and tackle the health inequalities that we are focusing on today. I hope that that is helpful.

Carol Mochan: It is. That work is very exciting and there is plenty to work towards. However, I think that Claire Sweeney was saying that, to get the full power behind it, the Government needs to be stronger in pushing public leaders. It would be good to have some kind of commitment from the minister on that. I think that we all agree that we need to push the people at the top to really see this as a priority so that all those things are brought to the fore.

Maree Todd: I could not agree more. I am more than happy to do that and you are very welcome to hold my feet to the fire if you do not see it happening.

The Deputy Convener: Tess White has a supplementary question.

Tess White (North East Scotland) (Con): I have a question on the women's health champion, but before I ask that, minister, I want to make a comment. As a fellow of the Chartered Institute of Personnel and Development, I was delighted to hear you say that closing the gender pay gap is a really important focus for you and that you will be taking action on it. Thank you for that.

Women's groups were delighted to hear the First Minister say last week that the Government will appoint a women's health champion by the end of the summer. What steps are you personally taking to ensure that they will be in place by the end of the summer?

Maree Todd: I am confident that the women's health champion will be in place by the end of the summer. In "Women's Health Plan: A plan for 2021-2024", which was the first such plan to be set out in the UK—I was really privileged and proud to launch it last year—are a number of short, medium and long-term outcomes that we hope to achieve. There will be an update to Parliament in the autumn, but we are very much on track to achieve and surpass all our short-term outcomes. We have made huge progress in improving the information that is available to women on a variety of conditions including endometriosis, menopause—

10:00

Tess White: You have not answered my question, minister.

Maree Todd: But I have not finished yet, Tess—

The Deputy Convener: I am sorry, but could you direct your comments through the chair?

Tess White: Convener, I just want to know what steps the minister is taking. We have done a lot of work on this, and we know about the role of the women's health champion, which we fully support, but what steps is the minister taking to ensure that the women's health champion will be in place by the end of the summer? I would just like an answer to that question, please.

Maree Todd: So you are clearly not interested in the steps that we are taking to implement the women's health plan.

Tess White: I am very interested. I just want to know what steps you are taking on this matter.

Maree Todd: We are working with officials to ensure that the specification for that recruitment is absolutely where we want it to be. As you will know, the national women's health champion will have to liaise with the individual board champions who will also be put in place, and will, I think, make a significant difference with regard to the women's health plan. We have set that out as a medium-term ambition. As I have said, we are working on the job specification and we are looking at how it will be funded and what the level of funding will be. We are considering what sort of people we think might apply and are tightening up what will be required before we advertise the position. As the First Minister set out in Parliament last week, we expect the person to be recruited by the end of the summer.

Tess White: As a fellow of the Chartered Institute of Personnel and Development, I know that such things can take longer. The First Minister has committed to putting the person in place by the end of the summer, but if the job and person specs have not yet been drafted, is the minister

saying that she thinks that it is unlikely that the role will be filled by then?

The Deputy Convener: The committee can perhaps take the issue up with the minister after the evidence session. I am conscious of the time.

I call Sandesh Gulhane for a brief supplementary, after which we will move on to our next theme.

Sandesh Gulhane: Minister, you have mentioned the provision of 1,140 hours of ELC, but what is the position for a child who turns three between March and August? Is it the case that no funding will be available for those children during those six months? You have talked about the importance of being able to parent and about the policy allowing that to happen, so why is it that, if a child turns three between March and August, no funding will be available?

Maree Todd: That is actually a standard way of delivering all sorts of education—there is an intake on certain dates of the year. It is how education works in Scotland: if your child turns four, you will be able to send them to school only if their birthday falls before a certain date. If they are not four before that date, they will have to wait a whole year before they go into primary 1.

It is a function of delivering the policies, and it makes things manageable for local authorities, because they know how many children will be coming into the system over the year. Of course, some local authorities have used discretion and will fund a child's ELC place from their third birthday, while others have chosen not to do so. I am sure that my Conservative colleague will be supportive of ensuring that such local decisions are made according to local priorities and that those powers are not taken away from local authorities.

I also emphasise that children in Scotland who are particularly vulnerable—the eligible two-year-olds who make up about 25 per cent of children in Scotland—are funded from the age of two.

Sandesh Gulhane: This is different from a child going to school, because the funding goes over 52 weeks. In other words, if your child is born in February, their place will be funded for the six months up to August. However, that is not the case for a child born between March and August. That is different from what you set out in your answer. Why is that?

The Deputy Convener: I think that we are radically drifting off topic. Perhaps the minister can give a brief answer, because I would really like to move on.

Maree Todd: It is simply a function of the delivery of education in Scotland. Local authorities can exercise flexibility; many, but not all of them, do.

The Deputy Convener: Stephanie Callaghan has questions on proportionate universalism.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Thank you very much, convener—we got there. I thank the witnesses for attending.

In evidence, we have heard about the effects of proportionate universalism and about the inverse care law—the fact that the people who are most in need of our services are often the most likely to miss out on them because they do not turn up for tests, X-rays or hospital appointments. Is the minister supportive of the concept of proportionate universalism? How is Professor Sir Michael Marmot's work influencing her approach to tackling health inequalities?

Maree Todd: Yes, I am supportive of the concept of proportionate universalism. I agree with Professor Sir Michael Marmot's position that action to reduce health inequalities must be proportionate, with more intensive action lower down the social gradient. However, action also has to be universal to raise and flatten the whole gradient.

We already deliver a number of services in that way. For example, we are currently refreshing our tobacco action plan and considering other initiatives, such as the role of minimum and maximum pricing in tobacco, as well as initiatives such as the New Zealand phased approach to a smoking ban, which could be developed. Such action is universal and would have an impact right across the population. Every citizen in Scotland would benefit from those policies.

However, we also target services. We provide £9.1 million a year to health boards to fund smoking cessation services that are targeted at the most deprived areas, because that is where smoking rates are significantly higher. As Carol Mochan regularly points out in the chamber, there is a huge difference in the numbers of people who smoke depending on socioeconomic background. It is something like 6 per cent to 7 per cent for people on the highest income and up near 30 per cent for those on the lowest income.

Stephanie Callaghan: That is really helpful. Stigma and trauma have a huge impact on the most deprived people. In his evidence, Dr Peter Cawston spoke about safety netting, which was interesting. He also spoke about the chance 2 change project group, which is now working alongside the Scottish Government to help people to help each other to make a difference to their health and wellbeing. Do you have any comments on that? Can you give us a bit more information on it?

Maree Todd: Absolutely. The Government recognises that adverse childhood experiences can blight the entire lives of our citizens. There is no determinism about it, but there is a lot of evidence that the more adverse childhood experiences a person has, the more likely they are to suffer ill health in adulthood, the more likely they are to smoke and the more likely they are to drink heavily. A lot of work is going on around that. There is also a lot of work on developing trauma-informed services.

It is not an obvious policy—I think that this is one of the things to which you are alluding, but chip in if I am wrong—but, when I think about safety nets, I think about the policy of extending free bus travel to children and young people up to the age of 21. The growing up in Scotland data shows that one of the things that is protective for children who are having adverse childhood experiences is the ability to travel. That might seem like it is not directly related to tackling adverse childhood experiences but it is actually a powerful policy for relieving them.

I was quite blown away when I first came across that link but, when I stopped and thought about it, I realised that, if someone is able to travel, they are able to get out of difficult life circumstances should they need to escape. They are also able to access public services in a way that people who do not have access to public transport cannot. Such policies, which are universal, are definitely having an impact on some of the most vulnerable people in our society.

I will ask Michael Kellett to say a bit more about Chance 2 Change.

You talked about communities helping themselves and how we support them to do so. Just last week, I met with a group of Gypsy Travellers. There is a remarkable piece of work going on, facilitated by MECOPP—the Minority Ethnic Carers of People Project—in Edinburgh, to train community health workers, and those workers are now having a profound impact on their own community. Members of that community are much less likely to come forward for things such as cervical smears. Smears are a powerful preventative tool for maintaining good health, as they catch cancer before it even develops.

Hearing about that work gave us an insight into the impact that people can have in their own communities. Some communities are marginalised and find it hard to trust people outside the community—of course they do, as they have had a lifetime, and sometimes millennia, of abuse and discrimination. Finding and identifying those people in a community who can help others in the community to access healthcare is important. There is powerful work going on, and we heard powerful testimonies and case studies in that meeting last week.

I will bring in Michael Kellet.

Michael Kellet: I am happy to provide further information, if the committee would like it, on the Chance 2 Change group. From my perspective, our key focus is on supporting communities, in particular those that suffer most from deprivation, to support themselves to tackle health inequalities. That is a fundamental part of the place and wellbeing programme, alongside the work on anchor institutions that I spoke about earlier.

We are seeking to learn from best practice, and there is a range of initiatives. I work closely with Inspiring Scotland, which works with grass-roots organisations in a number of communities across Scotland to build local social capacity to support communities to support themselves.

Part of the challenge is that that work tends to be episodic. Quite often, the funding is not maintained in order to produce long-term impacts on tackling health inequalities. We have talked about that, and it is a challenge. As part of that programme, therefore, we are thinking about how we share best practice better and ensure that funding and support is sustainable and mainstreamed in a way that will work in the longer term.

That focus on community-based support is important to us, and we are taking it forward under the place and wellbeing programme. I can provide more details about that programme too, if that would be helpful.

Stephanie Callaghan: Thank you. Convener, it would be great to have some more information, and perhaps some written information, on the Gypsy Traveller work. That would be fantastic.

Maree Todd: I would be delighted to share that.

The Deputy Convener: Emma Harper has a supplementary, after which I ask her to move on to our next theme, which is health in all policies.

Emma Harper: I want to pick up on what the minister said about Gypsy Travellers and cervical cancer. I know that there is a reduced uptake of, or reduced participation in, cervical cancer screening not only in areas of higher deprivation, but among black, Asian and minority ethnic women. I know that research on self-sampling for human papillomavirus and cervical cancer is currently being undertaken; NHS Dumfries and Galloway is part of that work. If we can move the self-sampling process forward, will that help to tackle the reduced level of uptake for cervical cancer screening?

Maree Todd: Absolutely—self-sampling will help. There are a number of reasons why people

do not engage in the cervical screening programme. Sometimes there are disability issues, which make it very difficult for women to access somewhere that they can actually get a smear. There are sometimes cultural issues that make it less likely that women will come forward for a smear, and more likely that they would do it at home. A big factor, which we do not often talk about, concerns women who have experienced sexual violence and how hard it is for them to undergo such an invasive test. Of course, we know that many women in society have experienced sexual violence.

There are a number of reasons why women do not come forward for cervical smears. I absolutely believe that self-testing at home will improve the situation, but it is not the entire solution. For example, our bowel screening programme is all done at home, and it is easy to do and not invasive, but we do not have 100 per cent uptake for it. We have more work to do to make it easy for people and to help them to understand why it is so important.

We now have an opportunity to eradicate cervical cancer because of the advances in smear sampling and in vaccination. The World Health Organization is very keen on developing a programme of work on that, and I am very keen that Scotland should participate in that. I would love to see cervical cancer eradicated.

10:15

Tragically, however, one of the associations that we see is that the very people who are less likely to participate in the vaccine programme are those who are less likely to come forward for a smear. That makes it very difficult. I am seeing that in my work on blood-borne viruses too. We have to work extra hard to understand why some people do not participate, and we have to go to extra lengths to reach them. Eradicating blood-borne viruses and hepatitis C, and the transmission of HIV, is within our grasp, thanks to advances in technology. We just have to work hard to find those people and ensure that we get them into treatment.

Emma Harper: Thank you for that, minister.

I have a couple of quick questions on the theme of health in all policies. In a previous session, I asked about health inequality impact assessments being included in planning, for instance. Again, that involves looking across portfolios. Can the minister describe what work the Scottish Government is doing to include health inequality impact assessments in all policy areas?

Maree Todd: The Scottish Government continues to advocate for the use of HIIAs as part of our health in all policies approach to policy teams across Government and public bodies, and among wider stakeholders, supporting colleagues to embed the assessments in practice and to ensure that the potential impacts of policies and programmes on health inequalities and the wider determinants of health are fully considered.

The HIIA guidance was last updated in 2016, and Public Health Scotland will be updating it later this year. We are also working closely with the Glasgow Centre for Population Health and Voluntary Health Scotland on developing a new tool to measure the impact that major housing and transport projects can have on improving health and wellbeing and reducing health inequalities across the Glasgow city region.

Ultimately, we would like to see the use of HIIAs within a health in all policies approach. There is a great deal of learning to be taken from countries such as Wales, which made the use of HIIAs a statutory requirement for public bodies when the Public Health (Wales) Act 2017 was passed by the Welsh Senedd. I am interested in taking that approach in Scotland.

The Deputy Convener: Gillian Mackay has questions on public services.

Gillian Mackay (Central Scotland) (Green): Good morning to the panel. Last week at committee, I asked Dr Peter Cawston, of GPs at the Deep End, whether services are trauma informed. He highlighted that

"Tackling ... stigma involves every person who works in a health and social care setting ... having a better understanding of how trauma impacts throughout a person's life, and how it affects ... behaviour."—[*Official Report*, *Health, Social Care and Sport Committee*, 21 June 2022; c 30.]

He went on to say that, although trauma-informed training is more widely available, there is still much work to do.

What is the Government doing to promote the importance of services being trauma informed and to ensure that all health and care staff undergo trauma-informed training?

Maree Todd: That is an important point. I have talked about how the Government well recognises and understands the impact of adverse childhood experiences on somebody's entire life course. It is important that our public services are trauma informed, and it is disappointing that there are times when we feel that people who are presenting looking for support from public services are further traumatised by what they meet there. We really have to work hard to get that right.

In November 2021, the Deputy First Minister told the Finance and Public Administration Committee:

"we need our public services to wrap around ... people and to be person centred, holistic and responsive to their

needs, instead of expecting people to fit around what public services offer and to navigate complicated systems from positions of vulnerability and need."—[*Official Report*, *Finance and Public Administration Committee*, 30 November 2021; c 2.]

We are backing that up with actions, one of which is to increase the availability of training in trauma-informed practice. We are also trying to simplify—although the task is almost impossible—the way in which some of our services are delivered. Again, Michael Kellet might wish to say more on that.

As members will know, with regard to our children and young people, we talk regularly about GIRFEC, or getting it right for every child. For our adult population, we now need to think about GIRFEA—getting it right for every adult—or GIRFE, which is about getting it right for everyone, every time. We have not quite decided on an acronym, or at least I have not settled on it yet, but I am campaigning for it to be GIRFE.

We need to think about the people who present to services. An important example involves the work that Angela Constance is doing on drug addiction. One of the challenges in that area is that it is quite hard for people to get into treatment and very easy for them to fall out of it. We need to make it easier for people to present and to get treatment quickly when they do so, and we need to make it hard for them to come out of treatment. We need to be trauma informed and to understand where the individual is on their journey to recovery, and we need to catch them and hold on to them until we can get them better.

There needs to be a reduction in stigma in those services, and there needs to be dignity in everything that we do. That is a classic example of how we can transform those services. It takes a lot of work, but we are absolutely on it, and we are working on that aspect. That is just one little microcosm.

I have responsibility for a lot of chronic illnesses, and the last thing I want is for individuals to feel like they are a collection of conditions. I am really keen to ensure that people are able to access holistic person-centred care and that they do not have to present for several weeks running at different clinics for blood letting and other things. I want them to be able to present at one place and get holistic person-centred care. That will make their lives easier and make them more productive economically, and it will save money for the NHS. Why would we not do it? It is a bit trickier to achieve in reality than it is in our imagination, but we are definitely recognising the benefits not only for us, but absolutely for individuals who are trying to access public services.

Michael Kellet: I have a couple of things to say on GIRFE, or GIRFET—getting it right for everyone together—which is another example. The minister and others will decide what the best acronym is.

The focus on how we wrap our services around an individual to understand them and best meet their needs is building on the GP contract. It is the central focus of the preventative and proactive care reform programme that the minister talked about earlier. That is about building a multidisciplinary team, which is sometimes called the principal care team, to ensure that care goes beyond health, into housing and other support. That is important.

I will cycle back to Gillian Mackay's question about trauma-informed training. The committee is probably aware of this, but it may be useful for me to highlight that, since 2018, the Government has invested more than £5 million in a national trauma training programme. A total of £3.2 million in funding has been distributed to local authorities, to enable them to work with community planning partners to further that agenda. Our commitment is that by April next year, we will publish a long-term delivery plan for the next phase of the national trauma training programme.

To go back to Emma Harper's earlier question, I recently saw—you may not be aware of this, minister—a fantastic programme that the Meadows clinic is developing. The Meadows clinic is a facility in NHS Forth Valley that supports women who are the victims of sexual violence. It addresses all their healthcare needs, including at the acute point after an attack.

In one of the initiatives that the Meadows clinic told us about, it supports victims of sexual violence to access cervical smears, and it does so on a trauma-informed basis. It has had early success, because of its way of working; it works with the women in order to build trust and, in doing so, has been able to persuade and encourage those who, for reasons that will obvious to the committee, have refused to go through the cervical smear process. One of the discussions that we had was about how, with the programme being successful in its early days, we could roll it out nationally to ensure that victims of sexual violence across Scotland were supported in that trauma-informed way. I thought that it would be useful to share with the committee what was a really inspiring project.

Gillian Mackay: Absolutely, and thank you both for those answers.

Dr Shari McDaid told us that

"if there is just a one-off training session in the trauma-informed approach, people will be expected to go back to their systems of working and try to remember what they learned during that one-off ... programme."

They emphasised the need for "on-going reflection" and said:

"Embedding reflective practice is the next step that needs to accompany the training programmes and education in the trauma-informed approach."—[*Official Report*, *Health, Social Care and Sport Committee*, 21 June 2022; c 31.]

What action is the Government taking to ensure that reflective practice accompanies trauma-informed training?

Maree Todd: Many health and social care professionals—and certainly those in the regulated professions—already embed reflective practice in their development. I take on board your point about ensuring that it becomes part of the trauma-informed package, because I know that that goes out to a much wider staff pool than simply the regulated health professionals. It would be well worth my going back to check that it is there.

However, reflective practice is about not just an individual's practice but changing the system to make it more person centred, flexible and holistic in the way that it is designed, built, delivered and implemented. If we focus only on individual practice, we will not achieve our goal and we will also run the risk of having an extremely weary workforce who feel that it is their fault that things are not working when it absolutely is not. We did not build these systems deliberately—they evolved over time to meet needs—but most people will acknowledge that some of our most vulnerable citizens have to navigate a really complex and bureaucratic system on a day-to-day basis simply to get help that they have a right to. That is not good enough, and we need to reflect on that and build things better.

Gillian Mackay: That is great.

The Deputy Convener: We now move on to questions about the role of community link workers. I call Tess White to lead the questioning.

Tess White: Minister, in 2016, the Scottish Government set the target of recruiting 250 community link workers by the end of the parliamentary session. However, in your area of the Highlands and my area of Aberdeenshire, we still do not have any. I accept that you were not the minister then, but you are now. What work are you leading on to ensure that the target is delivered?

Maree Todd: We have, of course, delivered the target for Scotland, with more than 300 community link workers now employed across Scotland through the primary care improvement fund. From this year, we will build on their successes with the introduction of the new multidisciplinary mental health and wellbeing teams in primary care, which will include new community link workers and put an emphasis on social support and social prescribing, where that is appropriate for the person.

In 2021, we commissioned Voluntary Health Scotland to establish the community link worker network to strengthen that role and increase wider understanding of the contribution that link workers make to tackling health inequalities. We are also embedding welfare rights and money advice services across 150 primary care settings over two years in deprived communities across Scotland.

10:30

Tess White: Minister, you have not answered the question. Unless my figures are wrong, not a single link worker has been appointed in Aberdeenshire or in your area of the Highlands. Can you assure us that you are leading on action to fill those posts?

Maree Todd: Yes, I can. I will take action and come back to you on that.

The Deputy Convener: Gillian Mackay has a supplementary question. I will then bring in David Torrance.

Gillian Mackay: A lack of joined-up care has been highlighted to the committee, with some patients falling off the cliff edge once they have been discharged from services. For example, patients are not always connected with community care once they have been discharged from hospital. How can we ensure better links between acute and community care, and what role can link workers play in that regard?

Maree Todd: Link workers can be a really important and powerful tool for the holistic care that I talked about, given their understanding of the social determinants of ill health and their work on maximising income and ensuring that people do not fall through the net.

We also have to reflect on the systems that lead to that sense of people falling through the net as they move from secondary to primary care. I think that everybody will acknowledge that, at every interface in the health service—and there are many—there is a risk of communication failing and of folk being lost to follow up. As we build the social care system, we are looking very carefully at that and at how we can improve communication between health and social care. There is a recognition that such communication, even within health, is challenging at times, but we think that there are digital solutions that will make it simpler to transfer information from one area of the health service to another and potentially to areas outwith the health service—to social care and so on, and perhaps, with the individual's permission, to third sector organisations. That said, we are definitely still a little distance away from such solutions.

Something else that might arise from those solutions is people being in charge of their own

information, which would be an empowering experience. I have no doubt that, if he were here, my colleague Kevin Stewart would be talking eloquently about the many people whom he meets who are retraumatised by having to tell their story time and again. They cannot understand why, their story having been told once to somebody in the system, it does not follow them the whole way through. We are very aware of the issues, and we are working hard to improve matters and resolve them.

One of the ways in which we will build those systems better in the future is by putting lived experience at their heart. If lived experience is at the heart of policy development, we will be much more likely to get the policy right. That also holds us to account with regard to policy implementation, as we are more likely to find what is sometimes a gulf but is often a gap between what we have intended and what is actually happening on the ground. I think that the best way of ensuring that we achieve our policy aims is to be held to account on the basis of lived experience.

Does Michael Kellet have any more to say about that?

Michael Kellet: No, minister. I think that you have covered it.

The Deputy Convener: I call David Torrance.

David Torrance (Kirkcaldy) (SNP): Good morning, minister and Mr Kellet. Can you expand on the success of community link workers in the most deprived areas? How do we ensure that they have the resources to engage with other key sectors, such as the third sector, which is really important? Moreover, how do we get the information back from the third sector to show that they are having that success?

Maree Todd: Data collection is a challenge right across the board, is it not? However, it is important to show how effective these policies are.

Community link workers are at the forefront of our efforts to tackle the consequences, and the determinants, of health inequalities. They work directly with individuals to help them to navigate and engage with wider services. We know that they are invaluable in supporting people with issues such as debt, benefits advice, social isolation and housing. They are important in connecting individuals to community resources—for example, in helping to ensure that individual folk find out about food banks and are able to take the first step to get that support, or in helping people into mental health provision—and they also provide people with on-going emotional support.

That is all quite hard to capture. We can say that we have employed X community health workers and that we have achieved the national aim but, as Tess White pointed out, that does not necessarily mean that we have national coverage. Therefore, we need to keep going back and looking at the data and the outcomes. We need to look at the differences around qualitative data rather than quantitative data and see whether we can capture the impact that community link workers are having.

Michael Kellet: To build on that, I think that there is real power in the community of community link workers. The minister recently spoke at a reception in the Parliament for the Scottish Social Prescribing Network; members of the committee may have been there too. The point about capturing qualitative evidence is important. There was real passion from members of that network, which is a self-organised association of community link workers. They told a couple of stories at that event, one of which was about a young man living in Wester Hailes who was supported by a community link worker. He was a veteran who had disengaged from society—he was living in a house without electricity or heating, and he got his water in a billy-can; it was that type of scenario. His mental health was in a really difficult position. The community link worker told us the story of her engagement with him—of how, over time, she built trust with him, connected him with housing services and got his electricity reconnected.

Those colleagues tell such stories time and again. The power of those community link workers and the social prescribing approach is profound. Again, as part of the care and wellbeing portfolio work, we in Government are looking at how we can further support social prescribing and community link workers to improve health and wellbeing and tackle some pretty profound health inequalities.

Maree Todd: I must admit that those people were a very impressive bunch, and I absolutely got the impression that there is a passionate army of social justice warriors out there, doing their best for Scotland. The presentations that they gave were really powerful. I met them shortly before the event, and I know that they are doing impressive work. They are really getting alongside people and helping them to flourish.

The Deputy Convener: We come to questions on systemic inequality. Sandesh Gulhane will lead on that theme.

Sandesh Gulhane: Before I get into my questions on systemic inequality, I wonder whether the minister would join me in asking anyone who is available for any screening programme to attend it.

Maree Todd: Absolutely—I could not agree more. We have really effective screening programmes that are well evidenced and largely

easy to access, and it is important that people attend and participate in them. Most of the programmes are about early detection of problems that, as everyone knows, are much more treatable if they are caught at an early stage. The screening programme for cervical cancer is unique in that it catches changes before they even become cancer. It is not about catching cervical cancer early—it is about preventing it. For me, that is a powerful reason to participate in the programme.

Sandesh Gulhane: Thank you, minister.

I move on to my questions on the theme. Do you feel that there is systemic racism within the Scottish NHS?

Maree Todd: I think that there is systemic racism in every aspect of society—to be frank, it would be foolish to deny that. Over the past couple of years, the Black Lives Matter movement has shone a light on systemic inequalities. In addition, the experience of the pandemic highlighted that members of black and minority ethnic communities were more likely to work in jobs that meant that they were exposed to the virus, more likely to live in housing that meant that the virus spread through their families, and more likely to live in poverty. Those are all systemic issues to which we cannot close our eyes—we have to acknowledge them.

That does not mean that those issues are easy to tackle. Every society has to focus on ways of tackling the systemic inequalities that have built up over centuries and sometimes—in the case of women—millennia. There is not one society in the world that does not have a challenge with inequality for women. We have to acknowledge how difficult it is to tackle those things, acknowledge that they are there, and have our eyes and minds open to ways to improve the situation.

Sandesh Gulhane: The systemic racism in the Scottish health service, which you have said does exist, is a problem for not only the staff but the patients. I will set aside the staff issue for now. One of the big issues that patients have is accessing healthcare because they do not feel that it is for them. How can we address that issue and improve the situation?

Maree Todd: You are absolutely right. When people experience systemic racism, they feel that society is not built for them, so it is very hard for them to access public services. An acknowledgement of that issue and an endeavour to improve the situation are really important.

I go back to the work that we are doing with the Gypsy Traveller community, which I met recently. That is one example of how community health workers from within the community were able to make a significant difference to the health of their community. That issue is worth exploring.

It is important that we have good data to guide us, and it is always difficult to find data for people who are outside the system. We can do better, and we have been doing better. The vaccination programme was among the first in which we collected ethnicity data at the time of administration. That has been really helpful in focusing our efforts on outreach programmes. We ensured that we put in special programmes to reach minority ethnic communities that were less likely to take up our offer of the vaccine. Extra efforts were successfully made with the Polish, black and Pakistani communities.

It is much more difficult to capture people who are not participating at all. The Gypsy Traveller community talked to me about how difficult it is for members of that community to register with a GP because they are not in one location. They move around all the time so, by definition, that makes it almost impossible for them even to get into the healthcare system. It is very difficult to capture data on people who are completely excluded from the healthcare system.

Finally, there is an issue relating to research and studying. For example, women have suffered from this being a man's world. The fact that much of the medical research of the past century has focused on men, who are much more likely than women are to participate in clinical trials, for understandable reasons around pregnancy and childbearing, means that our medical understanding of men—largely white men in the developed world—is far greater than our medical understanding of women, men from ethnic minorities and, in particular, women from ethnic minorities. There are real gaps in our understanding, and we can see them played out in real life.

The impact of ethnicity on maternity and birth outcomes has been the subject of academic studies in England, one or two of which have reported recently. Although those are English studies, I am absolutely sure that there will be lessons for us to learn from them, because there is solid evidence of black and minority ethnic women suffering severe health inequalities as they pass through maternity services. We need to look at that, understand it, learn from it and implement changes in Scotland.

10:45

Sandesh Gulhane: You are right in what you say, because black and minority ethnic women are more likely to die when they are pregnant.

I will illustrate my final question with two examples, the first of which seems very simple

and small: it involves sticking plasters and Band-aids. When I had a cut, I would put on a sticking plaster and a Band-aid. I did not realise that they were supposed to be skin coloured. When they were produced in different colours, it made a world of difference. When you put on a sticking plaster, it is not big and obvious; it does not show that something has happened. It is things like that that really matter. It is only when I saw that that I noticed how awful it was.

My other example relates to the Indian community, which includes Sikhs and Hindus. There are no information leaflets available in Hindi in the NHS Greater Glasgow and Clyde area. Public Health Scotland produced a report that talked about the Muslim community, the Polish community and the black community, but there was nothing in it about the Indian community or Hindus and Sikhs. Why was that the case? Why has that rather large community been excluded?

Maree Todd: I would need to ask NHS Greater Glasgow and Clyde that question, and I will do that.

You are absolutely right about tiny things making a big difference. As a woman, I absolutely recognise that I live in a man's world—I have daily reminders of that—and I think that it is exactly the same for black and minority ethnic people. Small reminders that this world is not their world will have a profound effect on them—to be frank, such reminders will have a far greater effect than whether they got a plaster on their cut. You are right to say that small things make a big difference. It is important that we take care of those small things. Frankly, it is incredible that we have not done so thus far.

I am sure that NHS Greater Glasgow and Clyde makes sure that health information is available in multiple languages, and I know that it has access to translators. The NHS Greater Glasgow and Clyde area has the greatest ethnic diversity in the whole of Scotland. Ensuring that resources are available in different languages might not go far enough. There might have to be other alternatives, whereby information on a website, for example, can be easily translated.

We need to go a little further than just ensuring that information is available in different languages. We need to make sure that our work is culturally sensitive to whomever we care for. I hear that time and again from people from minority communities. I am sure that almost all members of the committee will have heard it reported recently that members of the LGBTQ+ community feel—and there is evidence to support this—that alcohol services are not meeting their needs.

What I am saying is that we need to go further than going through a tick-box exercise of ensuring that information is available in different languages. Although we absolutely need to ensure that information is available in different languages, we need to go further and have person-centred services that get alongside people and which are sensitive to the culture that they are from. We must ensure that we deliver care that is sensitive to their cultural needs and which does not make them feel as though they are outside the community.

The Deputy Convener: We will move on to discuss our final theme this morning: the pandemic and the cost of living crisis. What is the Scottish Government doing to ensure that those who are already vulnerable and who have been affected by health inequalities are not further disadvantaged during Covid recovery and the cost of living crisis?

Maree Todd: The cost of living crisis is impacting on every household in the UK, and the Scottish Government will continue to do everything in its power, within its fixed budget, to ensure that people, communities and businesses are supported as much as possible.

In the 2022-23 budget, the Scottish Government has allocated almost £3 billion to a range of supports that will contribute to mitigating the impact of the increased cost of living on households, including a £150 payment for those living in Scotland who are in receipt of council tax reduction and those in council tax bands A to D. That will support 1.85 million households. A further £10 million has been allocated to the fuel insecurity fund, which will help households at risk of severely rationing their energy use or self-disconnecting entirely.

Investments have also been made in a range of measures that are unique to Scotland. A payment of £520 was made for around 144,000 school-age children from low-income families through bridging payments in 2021-22, and nearly 82,000 unpaid carers have received £491.40 of additional support this year through the carers allowance supplement. Eight Scottish benefits, including best start grant payments, have been uprated by 6 per cent to ensure that those essential payments keep pace with rising costs. Moreover, 92,000 households have been protected from the UK Government's bedroom tax, a policy that affected people with disabilities, in particular, and action has been taken to protect a further 4,000 households, 97 per cent of which have dependent children living in them, from the UK benefit cap, which reduces benefit awards by an average of £2,500 per year.

The Deputy Convener: Thank you for that summary of the actions that the Scottish Government is taking. The cost of living payment employs the strategy that the UK Government

employed for council tax, and there will be people sitting round this table who will have received that £150. Does the minister feel that there are better ways of delivering such support to people, perhaps through a more focused approach to those most in need in particular? In this inquiry, we are interested in inequalities and in trying to protect people from those inequalities being exacerbated.

Maree Todd: When she announced the payment, Kate Forbes made it very clear that she was balancing the tension between getting it to the right people and focusing on the people who need it most, and the speed required to get it out the door and into people's hands.

The Scottish Government is frustrated, because as a result of the pandemic it has discovered that there are not always easy mechanisms in place to get money into people's hands. I am sure that the Government will reflect on that. The mechanisms will improve with the growth of the social security system, but it is not always easy for us to identify the individuals who need the most help and get the money to them. Kate Forbes was very frank about the compromise to be made in getting the money to the people who needed it most and fast while knowing that some people who got it would not need it.

The Deputy Convener: My next question, which relates to some of my previous ones, is about support for local government. Local government will be at the forefront of the impending cost of living storm, which will be evident in services such as welfare rights and money advice. In all public health approaches, local government needs to do more, but it has been asked to do more with less; indeed, the Accounts Commission has pointed to a 4.2 per cent real-terms cut to local government budgets. Do you feel that it is sustainable for local government to deliver what we want to achieve with such cuts to budgets?

Maree Todd: There absolutely are challenging times ahead. I am thinking, for example, of the cost of fuel and energy price rises, and their impact on public services. The cost of heating a nursing home, a hospital or even a sports hall is higher, as is the cost of running a swimming pool. All those things were, largely, not calculated for when budgets were being set just a few months ago. That inflationary increase in energy costs alone is having an immense impact on people's ability to deliver public services.

There is also inflation in capital costs. I was recently chatting to a sports organisation that had managed to get a great deal of money to renew its ground, but it had realised that, within a year, £1 million had become £0.9 million. That is how high inflation currently is, and how fast the pot of money is going down. These are challenging times for absolutely everyone, and they are particularly challenging for those who are required to deliver public services. It is a challenge for the Scottish Government, for local authorities and for our NHS boards.

What is required in order to rise to and meet that challenge is innovation, creative thinking and careful prioritisation on what it is that we need to do. It comes back to what was said very early in the evidence session about the need to work collaboratively in a way that might not be particularly natural for us. The fact is that, in order to achieve some of the outcomes that we want to—and have to—achieve in Scotland, we will absolutely have to work together and pool our efforts. There is no way around that. Financially, things are currently really difficult, and it will be necessary for us to collaborate to an extent that we never have before.

The Deputy Convener: Do you accept, though, that because of year-on-year cuts to services—I say this as someone who served for 10 years as a councillor in a local authority—many of the services that we really need do not exist any more, and innovation and collaboration often cannot take place because we do not have the people or the skill sets in local authorities to be able to do them?

Maree Todd: I guess that you and I will absolutely agree that the austerity politics that came in in 2010 has been severely detrimental to our local authority colleagues and to Scotland as a whole. Policy decisions have been made to cut the Government budget and, in turn, the Scottish Government budget. Some of those cuts have had to be passed on, but actually, when I look at the numbers, I see that local authority services have been largely protected from a lot of the cuts in comparison with local authorities in England, some of which have found themselves in a really precarious situation.

All of us—well, not all of us, but certainly you and I, deputy convener—will agree that austerity politics has been really harmful. I go back to David Walsh's testimony to the committee, in which he said that we are paying the cost of the tragic consequences of decisions that were made some time ago. We went into the pandemic in 2020 on the back of 10 years of austerity politics, and there is absolutely no doubt that we would have fared better in the pandemic had we not been in that situation when it hit.

The Deputy Convener: You and I could go back and forth on that, minister, because I think that the feeling on the ground in local government is that Scottish Government decision making, and the choices that have been made, have also had a huge impact. I am thinking in particular of the underfunding of Scottish Government-led

initiatives, some of which we have discussed this morning. Nevertheless, I am very conscious of the time allowed to the committee this morning. As I have said, we could have a further discussion on funding, but I think that we have both made our points and they are now on the record.

I know that Gillian Mackay has a supplementary on this theme, so I am willing to give her the last word.

Gillian Mackay: Thank you, convener. In its submission, the Health and Social Care Alliance highlighted that people with long-term conditions have been particularly impacted by the deterioration in their health and wellbeing due to the cost of living crisis and because they have to use different healthcare aids and supports. What actions is the Government taking to support those people or give them access to support from other places, and to address those issues as a whole?

11:00

Maree Todd: There is an absolute recognition that people with disabilities or long-term conditions will be more impacted by the cost of living crisis. If we think about it on the very human basis that you have highlighted, those people often have equipment that requires electricity, and the cost of charging and running it will be significantly more today than it was this time last year. If people are at home all day—and, following the pandemic, almost all of us have an insight into that situation—there is also the cost of heating their home to a liveable standard. I can move around and put on more layers, but that is not an option for some people with profound disabilities—and it is not an option that I would want them to face.

As you will expect, work is going on in Government to assess the situation and to see what we can do to meet those needs. Michael Kellet might want to say a little more on that and we can write back to you on the support that might be offered to those who are particularly vulnerable as we face this cost of living crisis, which we know comes on the back of other crises—Brexit and an epidemic. We are now right into a cost of living crisis in which food is costing more and energy prices have risen. It is a really difficult time for society and the Scottish Government is trying hard to ensure that our attention is truly focused on the people who need our care the most.

Michael Kellet: I do not have much to add to that. The Health and Social Care Alliance is a key partner and a very good advocate for the people it represents, and we work with it very closely.

The member makes a good point about the unequal impact on people with disabilities. We are working really hard in the short term to look at what further support we can put in place. In the longer term, the national care service will be hugely important and has been welcomed by the alliance and other groups in relation to ensuring consistent social care of high quality right across the country. However, I recognise the point that Ms Mackay makes about short-term support. If we can provide more detail to the committee, we will be very happy to do so.

The Deputy Convener: That concludes our questions. Thank you, minister, for your contributions.

Subordinate Legislation

Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 (Supplementary Provision) Regulations 2022

11:03

The Deputy Convener: Our third item today is consideration of an affirmative instrument. The purpose of the regulations is to ensure that environmental health officers are able to issue fixed-penalty notices in respect of the offence of smoking in a no-smoking area outside a hospital building and the offence of failing to comply with signage requirements at entrances to hospital buildings, regarding the no-smoking areas outside those buildings.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 21 June 2022 and made no recommendations in relation to the instrument.

We will have an evidence session with the Minister for Public Health, Women's Health and Sport and a supporting official on the regulations. Once we have had all our questions answered, we will have the formal debate on the motion.

I welcome again to the committee Maree Todd, the Minister for Public Health, Women's Health and Sport. I also welcome Jules Goodlet-Rowley, head of the healthy living unit in the Scottish Government, who is accompanying the minister online. I invite the minister to make a brief opening statement.

Maree Todd: Thank you for inviting me here to discuss the regulations, which make supplementary provision to the legislation that created the no-smoking perimeters around hospital buildings. Today, I seek your agreement to giving designated officers of local authorities the power to issue fixed-penalty notices in respect of two new offences relating to the ban on smoking outside hospital buildings.

There are three new offences relating to the ban. Without this Scottish statutory instrument, local authority officers such as environmental health officers would be able to issue fixed-penalty notices only in respect of one of those three offences. The regulations will enable local authority officers to issue fixed-penalty notices in respect of the other two offences, too.

As the committee previously noted, the prohibition on smoking outside hospital buildings requires effective enforcement to ensure compliance, especially during the introduction of the 15m boundary. It was the intention that local authority officers would lead on the enforcement of the ban, much as they led on the enforcement of the indoor smoking ban. However, as drafted, the provisions for enforcement of the ban do not fully reflect that intention. That issue was identified only after the Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 were made earlier this year.

The ban on smoking outside hospital buildings will come into force on 5 September 2022. On that date, section 20 of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 will amend the Smoking, Health and Social Care (Scotland) Act 2005. The 2022 regulations will also come into force.

The 2005 act, once amended, will contain three new offences relating to the new ban: knowingly permitting people to smoke in a no-smoking area; smoking within a no-smoking area; and failing to conspicuously display no-smoking notices at the entrances to hospital buildings. The 2005 act will also give the police and local authority officers such as EHOs powers to issue fixed-penalty notices in respect of those offences. However, only the police will have the power to issue fixed-penalty notices in respect of all three offences. EHOs will have the power to issue fixed-penalty notices only in respect of the first offence: allowing people to smoke in a no-smoking area.

As the intention is for EHOs to lead on enforcement, it is critical that EHOs also be able to issue fixed-penalty notices in respect of the other two offences, particularly the offence of smoking in a no-smoking area. Giving EHOs that power will ensure effective enforcement of the perimeter ban.

I am sure that we all agree that hospitals should be places of health promotion where healthy ways of living are demonstrated. They should be environments in which people are protected from harm and supported in making positive lifestyle choices. The sight of people congregating near doorways to smoke outside our hospitals is incongruous to that. The no-smoking perimeter will reduce the risk of exposure to second-hand smoke near entrances and windows. It will prevent smoke from drifting into hospital buildings and protect people who use hospitals, particularly the vulnerable.

The regulations that we are discussing will help to deliver the effective enforcement of the ban that committee members called for during passage of the Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 earlier this year. They provide local authority officers with the same enforcement powers as are granted to Police Scotland, which has indicated that it would be operationally difficult for the police to be solely responsible for enforcement.

This is a team effort. We have been working with health boards, local authorities, Police Scotland and others to bring the ban to fruition. Without the additional powers, we limit the effectiveness of the restrictions even before they come into force. I urge the committee to pass the regulations and help us to stop smoking near Scotland's hospitals.

The Deputy Convener: Thank you, minister. I invite questions from committee members on the regulations.

Sandesh Gulhane: As a doctor, I am obviously supportive of the idea of not smoking around the entrances to hospitals. I have seen people smoking outside the children's hospital in Glasgow, with the smoke going up to the children inside.

I have a few questions. NHS Forth Valley has been trying to enforce no-smoking areas. It has introduced big cross hatches, and somebody goes around telling people not to smoke. That person gets an awful lot of abuse. I understand that we will allow environmental health officers to issue fixed-penalty notices, but how do we prevent such abuse?

Maree Todd: That is a challenge in healthcare environments across the board. It is really important that we think about the cultural impact of such legislation. It gives clarity and certainty to people in Scotland. They will know that hospitals do not allow smoking within their perimeters. I think that that alone will reduce the level of conflict in implementing the ban.

There was a lot of concern in advance of the smoking ban about how the ban would be implemented. Before the ban, there was often friction around how no-smoking areas were implemented. The smoking ban brought clarity to the situation. People know that they are not allowed to smoke and that there will be consequences if they do so. It is not simply a matter of appealing to their good nature; there is the potential for issuing a fine should they not comply with the legislation. That brings clarity and reduces conflict.

Sandesh Gulhane: For clarity for everyone, will you define smoking? Obviously, using cigarettes is smoking, but does smoking include use of heated tobacco and vaping? Some people would say that there is no nicotine in their vape, so they should be allowed to do that. Can I have some clarity on that, please?

Maree Todd: The use of nicotine vapour products is not affected by the regulations. We do not have the power to include NVPs in the regulations, because they were not included in the 2016 act. The permitting of NVP use within the perimeter of hospital grounds will continue to be at the discretion of each health board. I know that that is likely to lead to a lack of clarity.

The evidence on the safety or otherwise of second-hand exposure to vapes is not yet clear. I think that vapes are potentially a useful tool for smoking cessation, and they are likely to be less harmful than smoking tobacco is, but I am deeply cynical about the efforts of tobacco companies to market them widely and to ensure that they find a replacement market with the reduction in smoking. We need to go very carefully with our use of vaping products in health promotion.

I would not rule out looking at vaping products should the evidence firm up that second-hand exposure is problematic. I would not rule out including them or considering future legislation on that. It seems to me that new primary legislation would be required, given that the 2016 act does not give us the ability to regulate.

Sandesh Gulhane: I am sorry, but I have a final question about vaping, minister. I agree that vaping can be quite an effective tool to help the cessation of cigarette smoking, and it probably has a significantly lower risk than smoking. However, when I walk into anywhere, to be honest, but especially a hospital, I do not particularly want to be faced with a cherry-smelling—or whatever-smelling—cloud. That is what happens with a vape. Even though there might not be evidence about second-hand harm, I urge you to look at vaping and include it in the legislation so that we have absolute clarity that people cannot smoke at all around a hospital.

Maree Todd: I am certainly willing to take on board your view on that. We will be looking at issues around vaping. We have had a consultation on the regulation of vaping, and we will look at some of those issues later in the year. I am willing to take on board your view on that, but, as I understand it—perhaps Jules Goodlet-Rowley can come in on this—primary legislation would be required, because the original act, which allowed me to bring the SSI before the committee, did not include vaping. We would be required to look at primary legislation on vaping, and that would be an altogether larger task. However, I am certainly willing to keep that on the radar and include such provision should the opportunity arise in future.

We try hard to make all our legislation evidence based. The evidence on second-hand harm from vaping is not particularly solid or clear yet, and I think that it would be hard to introduce primary legislation on that front right now. However, I ask Jules Goodlet-Rowley whether she has anything further to add on that. She is more familiar with the 2016 act than I am.

Jules Goodlet-Rowley (Scottish Government): At the moment, we do not have the

powers to regulate NVPs within the regulations, and permitting the use of NVPs within the perimeter of hospital grounds will continue to be at the discretion of each health board.

Maree Todd: In a perfect world, we would have foreseen that technology when we wrote the original legislation.

The Deputy Convener: Thank you for that helpful exchange.

11:15

Emma Harper: I remember an anaesthetist telling me that people used to smoke right under the windows of the ear, nose and throat ward so, when she woke from her anaesthesia fog after a tonsillectomy, she smelled cigarette smoke. I therefore welcome the instrument.

As the co-convener of the cross-party group on lung health—and a nurse—I am keen to hear what measures are being taken to help health boards, local authorities and health and social care partnerships to educate people about the legislation, so that it is easier to enforce as we move forward.

Maree Todd: You are absolutely right to talk about how smoke drifts into hospital buildings from outside. For 20 years, I worked as a hospital pharmacist. I have asthma and am one of those people in the workforce who would wheeze as I accessed areas of my workplace where smoke was. Our air conditioning literally pulled smoke in from the smoking area and pumped it into the ward. That is not unusual.

We need to think about the exposure to second-hand smoke that such things cause for staff, patients accessing care and everyone who visits the hospital. That is why the measure is really important. When it comes to raising its profile, today is a busy news day, but I suspect that it will make the news when it is introduced, and be covered by our national news outlets. I also expect the signage at hospitals to be clear.

The two-week run-in—which was not our intention—gives a little time for awareness to be raised about the change on smoking around hospitals, before people face fines for breaking the rules. That is probably helpful. I would hope, therefore, that there will be absolute clarity to everyone that people cannot smoke near hospitals.

Emma Harper: Will you confirm again the go-live date? Did you say that it was 8 September?

Maree Todd: I think that it is 5 September and that two weeks later—on about 20 September—the SSI will mean that environmental health officers can use fixed penalty notices.

The Deputy Convener: I have a brief question about the financial effects. Previously, I asked the cabinet secretary this question, on the funding for environmental health officers to carry out the measure. I appreciate that the paragraph on financial effects states:

"Local Authorities are already funded to undertake tobacco ... work".

I am conscious that there may be a higher number of hospitals in the city of Edinburgh and Glasgow city than in other local authority areas, so there will perhaps be a corresponding pressure on those teams. I suppose that I am just looking for an assurance that, if costs are exorbitant or add pressures for particular departments, that will be monitored by the Government and any adjustments will be made if required.

Maree Todd: Absolutely. I expect the instrument to be effective in preventing the problem, but you are right: if financial costs arise that have not been predicted, we would be more than happy to hear from local authorities.

As a Highlander, I have to say that, although Edinburgh might have more hospitals, a lot more travelling distance would be involved in monitoring the hospitals in the Highlands and Islands. Those are just the challenges that our local authorities and health boards face.

The Deputy Convener: That is fair, and it is good of you to remind me of my central belt bias, which often accidentally slips out.

Given that there are no further questions, we move to item 4, which is the formal debate on the made affirmative instrument on which we have just taken evidence. I remind the committee that members should not put questions to the minister during the formal debate; and officials may not speak.

Minister, do you wish to say anything further on motion S6M-04798, before I invite you to move it?

Maree Todd: No, thank you.

The Deputy Convener: I invite contributions to the debate.

Sandesh Gulhane: I just reiterate that it is important that we include all products including vaping.

Stephanie Callaghan: In response to Dr Gulhane, I want to make a wee comment about vaping. As someone who has given up smoking and currently vapes, I have personal experience. Statistically, you are twice as likely to give up smoking using vaping as you are using nicotine gum. The nicotine is pretty harmless in that form and you do not get the carbon monoxide and so on. Therefore, I think that there is a balance to be struck, as well. We do not have the information

and evidence to back it up yet, but the consensus across the NHS and elsewhere seems to be that vaping is much less harmful than smoking cigarettes. On a balanced approach, having more people vaping and more patients who have been long-term smokers switching to vaping could have a really positive impact overall.

Sandesh Gulhane: I agree. I said earlier that I agree that vaping has an important potential role to play in the reduction of cigarette smoking. I do not know of many things that could be worse than cigarette smoking when it comes to harm, quite frankly.

We know that vaping will cause less harm, but the point that I am trying to raise is that vaping produces a big cloud of smoke. You might not be one of the people who does that in certain areas but, if I am walking up to a hospital, through hospital doors or in the grounds, I do not want to be faced with that big plume of smoke. Even though we do not have a lot of evidence about its effects, I would not like to be walking through that. If everyone is vaping outside the entrances, that is absolutely not what I would like to see.

I think that we could have a balance. We heard from the minister that we cannot put vaping in, because that needs primary legislation—that is absolutely fair enough—but we should be looking for a way of ensuring that there is clarity that people should not smoke on hospital grounds and that they do not vape there, either, because I just do not want to be walking through a cloud of smoke.

The Deputy Convener: As there are no further contributions, I ask the minister to sum up and move the motion.

Maree Todd: I am not sure that I have much to contribute on the vaping debate. It is clear that, for people who are choosing vaping as a means of smoking cessation, it is less harmful than smoking; there is absolutely no doubt about that. However, there are some concerns around the contribution to health inequalities and the attractiveness to children and young people, and there are real concerns around the role of vaping in the future, which we need to consider carefully.

The Scottish Government has a commitment to a tobacco-free generation, in contrast with the Government down south, which is committed to a smoke-free generation and is actually very pro-vaping. At the moment, I am quite open-minded, but sceptical and cynical about the role of the tobacco industry and how those cessation needs are portrayed. That is the Scottish Government view on vaping.

I move,

That the Health, Social Care and Sport Committee recommends that the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (Supplementary Provision) Regulations 2022 be approved.

Motion agreed to.

The Deputy Convener: That concludes consideration of the instrument. I thank the minister and her officials for attending.

National Health Service (Charges to Overseas Visitors) (Scotland) Amendment (No 2) Regulations 2022 (SSI 2022/213)

Public Health etc (Scotland) Act 2008 (Notifiable Diseases and Notifiable Organisms) Amendment Regulations 2022 (SSI 2022/212)

11:24

The Deputy Convener: The fifth item on our agenda is consideration of two negative instruments, which were laid on Thursday 16 June and came into force on the same day. The Delegated Powers and Law Reform Committee considered the instruments at its meeting this morning. It decided to draw them to the attention of the Parliament on reporting ground (j) for failure to comply with laying requirements in section 28(2) of the Interpretation and Legislative Reform (Scotland) Act 2010. However, the DPLRC is content with the explanation provided by the Scottish Government for failure to comply with the laying requirements.

The first instrument is the National Health Service (Charges to Overseas Visitors) (Scotland) Amendment (No 2) Regulations 2022. It ensures that certain NHS services for any overseas visitor who requires diagnosis or treatment for monkeypox are provided without charge to that overseas visitor.

No motions to annul have been received in relation to the instrument.

As no member has any comments, I propose that the committee does not make any recommendations in relation to the instrument. Do members agree with that?

Members *indicated agreement.*

The Deputy Convener: The second instrument is the Public Health etc (Scotland) Act 2008 (Notifiable Diseases and Notifiable Organisms) Amendment Regulations 2022 (SSI 2022/212). These regulations will trigger duties on registered medical practitioners to share information with health boards where they have reasonable grounds to suspect that a person they are attending to has monkeypox. That information

must then be shared onwards to the Common Services Agency and Public Health Scotland.

The regulations will also have the effect, if monkeypox virus is identified by a diagnostic laboratory in Scotland, that the director of that laboratory must provide information to the health board in the laboratory's area and to the Common Services Agency and Public Health Scotland.

No motions to annul have been received in relation to the instrument.

As no members have any comments, I propose that the committee does not make any recommendations in relation to the instrument. Do members agree with that?

Members *indicated agreement.*

The Deputy Convener: This is the final meeting of the committee ahead of the summer recess. Further details of our next meeting will be published towards the end of August.

That concludes the public part of our meeting.

11:26

Meeting continued in private until 12:07.

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