OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 21 May 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 May 2024

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

16th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Pete Cheema OBE (Scottish Grocers Federation)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Sheila Duffy (ASH Scotland)
John Dunne (UK Vaping Industry Association)
Neil Gray (Cabinet Secretary for Health and Social Care)
Stephen Lea-Ross (Scottish Government)
Dr Garth Reid (Public Health Scotland)
Paula Speirs (NHS Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 21 May 2024

[The Convener opened the meeting at 09:15]

Decisions on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 16th meeting in 2024 of the Health, Social Care and Sport Committee. I have received no apologies. Ivan McKee has now resigned his position as a member of the committee, and James Dornan is joining us remotely as a substitute.

The first item on our agenda is to decide whether to take items 7, 8, 9 and 11 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Healthcare in Remote and Rural Areas

09:16

The Convener: The second item is an evidence session with the cabinet secretary and supporting officials as part of our inquiry into healthcare in remote and rural areas. I welcome Neil Gray, the Cabinet Secretary for Health and Social Care; Stephen Lea-Ross, who is the deputy director of health workforce planning and development at the Scottish Government; and Paula Speirs, who is the deputy chief operating officer of NHS Scotland.

Before we begin, I invite the deputy convener to say a few words about the committee's visit to Skye last week as part of the inquiry.

Paul Sweeney (Glasgow) (Lab): Last week, several committee members took part in an external visit to the Isle of Skye as part of our inquiry. We were based in Portree. On behalf of the entire committee, I thank the staff of Broadford medical practice and Broadford hospital for meeting us. We are incredibly grateful to those national health service staff for taking the time to discuss the myriad issues that are impacting delivery of services across the island, as well as the unique challenges that come with recruitment and retention of staff in remote and rural areas.

We are also very grateful to those on NHS Highland's board who, behind the scenes, helped to plan the agenda for the visit and ensured that things ran smoothly, and for the committee clerks' work in supporting the visit.

I also offer our thanks to the Skye and Lochalsh Mental Health Association for allowing us to use its facilities for a set of evening engagements. The committee members were keen to hear from service users and local stakeholders, and we are really grateful to the significant number of people who came along to meet us and engage with us, often travelling long distances in the evening to do so.

The points that were raised during the visit will certainly be taken into consideration alongside the evidence that is received throughout the inquiry, and it will be invaluable in helping to inform the recommendations in the committee's concluding report.

The Convener: Thank you very much, deputy convener.

We move straight to questions. Cabinet secretary, I want to focus initially on the national centre for remote and rural health and care that was launched last October. When the then

Cabinet Secretary for NHS Recovery, Health and Social Care wrote to the committee, he said:

> "I have been clear that the Centre must focus on deliverables and impact".

To what extent in the development of the centre has the focus been not only on strategy development but on actions, delivery and that impact?

The Cabinet Secretary for Health and Social Care (Neil Gray): First, I am pleased to hear that the committee was in Skye last week. Initially, there was a suggestion that I might have joined you there for that evidence session, but I am very pleased to be here this morning and grateful for the opportunity to discuss what is a very important issue for me, having been born and brought up in Orkney.

Like other colleagues around the table, I understand well the importance of delivering health and social care services in rural and island communities, and I also recognise the challenges therein. I am very much looking forward to seeing more of the work that comes through from the committee, and I am very grateful for the work that you are doing.

I will bring in colleagues on the progress that has been made off the back of the centre's establishment, which has had financial support from the Scottish Government.

The centre has also led to the development of a rural and island workforce recruitment strategy by the end of this year, because the Government recognises that, for all elements of the health and social care service, but particularly in rural and island communities, the workforce is critical to ensuring that we can deliver services. Having that strategy is critical, and I believe that the task and finish group is meeting right now to discuss continuing that work. I do not know whether colleagues wish to add to that.

Stephen Lea-Ross (Scottish Government): On the question about practical developments, the activity that has been given the most focus since the launch of the centre has been developing and delivering some education and training initiatives, principally to rural advanced practitioners. The rural advanced practitioners programme for paramedicine is a practical medicine programme that is designed to support advanced paramedicine practice in remote and rural settings. There has also been some work to develop multiprofessional training sessions for primary care multiprofessional practitioners, to support the continued roll-out of multidisciplinary teams in remote and rural settings.

In addition, the centre has made formal links with the centre for workforce supply, which we established in 2021. During the past two years, it has focused on supporting international recruitment activity, principally of nurses, into health boards across Scotland, including into remote and rural settings. It is currently shifting its focus into hard-to-fill medical recruitment in remote and rural settings, with early work focusing on challenges with psychiatry in remote and rural boards.

The final thing that I will note is the centre's focus on the development of the credential in remote and rural medicine, which is the first of its kind in the United Kingdom. Roll-out of training delivery activity is on-going. That credential is now listed with the General Medical Council and it is in the final stages of preparation for delivery.

The Convener: That was a helpful update. For the committee's information, what is the reporting and monitoring structure of the national centre?

Stephen Lea-Ross: We meet monthly with colleagues from the national centre in connection with their work on developing the centre's work programme and on the structure of the remote and rural workforce strategy. Through that arrangement, there is a governance team, with oversight by colleagues from Scottish Government, through primary care and other areas under the director general for health and social care. At the moment, we use that process to monitor delivery according to the centre's agreed work programme. We also proactively monitor delivery of the centre's work programme as part of one of NHS Education For Scotland's agreed deliverables, through our sponsorship function in the health workforce.

Paula Speirs (NHS Scotland): To supplement that answer on the work that the centre has been doing, the sponsorship of the centre comes through the primary care directorate, so reporting of governance goes through that. As part of wider planning, delivery and strengthening work across Scotland, we have been bringing the centre's work into NHS Scotland. Although there is a governance route into the primary care directorate—which is where the funding comes from—it is important that the work that the centre is doing and its priorities, particularly around the rural credential that Stephen Lea-Ross referenced earlier, is monitored.

As you are probably aware, the rural credential is about looking at the rural general hospital model and at what safe care looks like. We are bringing that into the work of NHS Scotland's planning and delivery board. I suppose that that is less about governance and more about ensuring that the priorities are in line and that they are coherent, so that they can deal with the challenges that are currently being faced.

David Torrance (Kirkcaldy) (SNP): Good morning, cabinet secretary. How does the Scottish Government work with rural integration joint boards, local authorities and health boards to monitor the implementation of the national workforce strategy?

Neil Gray: Obviously, local health boards and integration joint boards are responsible for their own delivery, and we have clear expectations that they will ensure that services continue to be sustained and delivered. We work closely with them, particularly on the workforce. We have instituted the areas of work that Stephen Lea-Ross and Paula Speirs have already set out, but there are others, such as the ScotGEM—Scottish graduate entry medicine—programme for rural general practitioners, that ensure that we continue to support new entry into rural and island areas.

We have the highest fill rate in the UK for the priority foundation areas, which is a good thing when it comes to filling the vacancies in rural and island areas, The fact that we are competing well against the rest of the UK is a good thing and shows that the work that we are doing with IJBs and health boards is coming to fruition. Obviously, challenges remain, and issues are clearly outstanding in certain areas, but the progress is there. The work that Stephen and Paula have already set out will, I hope, continue to support local areas in developing their workforce strategies.

David Torrance: In the evidence session last Monday on the Isle of Skye, we heard from NHS Grampian about the huge cost of locums and agency workers and the effect that that has on the board's budget. What are you doing nationally to try to reduce that cost to all NHS boards across Scotland?

Neil Gray: That is a major concern for me. Since coming into post, one of the areas that I have had the greatest concern about is the rise in agency and locum costs. In some areas, that cost is unavoidable, and we need to invest to ensure service continuation. However, I want to take a longer-term approach, and I hope that some of the reform discussion that we will have later this month and, going into the rest of the year, the reform and improvement work can focus on how we make sure that we have the culture and management structures in place that allow greater flexibility for workforce so that we are attracting and retaining staff.

We have a number of areas of intervention including bursaries and golden hellos to try to attract people to rural and island areas in particular on a sustainable basis, so that we can avoid the need for locum and agency cover. That cost increase over recent years is a major concern for me and one that I wish to tackle.

David Torrance: Last Monday, we heard evidence about trying to recruit staff in a care home on the Isle of Skye. It is only half filled because it cannot get staff, which is blocking a 24-bed hospital where some of the people are there for the long term. The same situation exists across all tourist destinations. Housing is critical. There is just no housing at all, because the houses have been bought as second homes or as Airbnbs. However, NHS Highland has a lot of land. What encouragement is there for the board to build its own housing supply so that it can bring in students and staff? When I asked the board about that, it said that it does not have the experience to build its own supply. How can we encourage it to do that?

Neil Gray: That is a pertinent question on the wider issues that are beyond the control of the health and social care service in rural and island communities in being able to attract and retain staff. Mr Torrance rightly points to the issue of housing. I know from the most recent conversation that I had with NHS Highland about the situation at Portree that it is looking at what it can do from a housing perspective to support staff with their housing needs.

Wider measures such as the Scottish Government's investment in the rural delivery plan and the emergency services key worker housing funds that we are bringing forward are designed to give local areas the ability to invest in ensuring that the social infrastructure is there to support people living and working in those communities and that those communities continue to be sustainable.

There are also wider political issues around attracting and retaining social care staff in particular. Mr Torrance and the committee will be aware of the recent decision of the UK Government to make it harder for social care staff to come to this country to work by stopping the dependants of those social care workers from being able to travel. Obviously, we are not in control of immigration and the decisions that are taken for us are having a detrimental impact on our ability to attract people to come and live and work here. Everybody is well aware that the impact of Brexit on our social care workforce was a near 10 per cent reduction in our social care staffing, almost overnight.

09:30

All of that strikes at the heart of the ability of social care providers to provide the services that we need them to provide, which has a knock-on impact not just on the people who we need to be providing those services for but on the rest of the health service, because there needs to be a clear flow through the health service and, if one part is

under significant pressure, in this case social care, it has an impact elsewhere.

Paula Speirs would like to come in on the back of that.

Paula Speirs: There is more that we are looking to do with the boards and the IJBs to support the improved sustainability of services. An important issue with regard to the sustainability of remote rural and island care is how we work across the public sector. Transport is an example of one of the areas in which we do that and, yesterday, we had a session with colleagues from Transport Scotland and regional transport partnerships to look at health transport planning in a way that we have not done before.

There are operational issues, but what we need to do is plan in a much more strategic way. Housing is another obvious area where that is an issue and there is a need to plan strategically how we work with and support people with regard to community planning, economic development and so on. That is a role for us. We have been engaging with colleagues who are engaged in wider public sector reform.

One area that I would highlight to the committee is the single agency model that is being developed. It presents us with huge opportunities to address some of those slightly wider challenges, which is important, because the issue does not just sit with health; it is a much bigger issue.

The Convener: Before I invite Ruth Maguire to ask her questions, I should draw members' attention to my entry in the register of members' interests, which notes that I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Ruth Maguire (Cunninghame South) (SNP): Good morning. What is the single agency model that was just referred to?

Neil Gray: It is the single island authority model. We are looking at what is possible with regard to local government and health boards working more closely together. Advanced discussions are going on with the island groups, with various levels of interest being expressed by those authorities.

Ruth Maguire: I would like to dig into the housing, childcare and infrastructure issues. Addressing them would help across the board, in terms of public servants moving to rural and island communities. When I have asked during evidence sessions whether boards are having conversations about housing with local authorities, I have found that that does not seem to have been happening. I totally appreciate the challenging fiscal environment that we are in at the moment in terms of capital, but is there a role for the Scottish Government in providing guidance or a framework that would enable public bodies—local authorities, health boards and so on—to pool their resources, such as the land and buildings that the NHS has, and perhaps bring in private investment, too, to develop housing solutions and childcare solutions that would serve the communities and help with sustainability?

Neil Gray: There are frameworks in place around the integration of health and social care that should allow for some of those discussions to take place. Where there is an understanding on the part of IJBs and health and social care partnerships that there are particular workforce challenges in the communities that they are looking to serve, those discussions can start there and spread to other forums. However, of course, where we have that convening power or, indeed, where we can provide that guidance, we will continue to do so. There are good examples of some of that work being done already, and we need to build on those and try to provide that advice on a wider basis.

Ruth Maguire: Could you provide an example of that, particularly in relation to building? We will be aware of lots of good examples of joint working, but I am not sure why things are not progressing; you might have more information on that. We have had the integration for a number of years now—for a decade, even.

Neil Gray: I would be happy to follow up on that in writing, and Paula Speirs wishes to come in on that.

Integration has happened at a different pace in different parts of the country. There are some good examples of integration working well, as I was able to see, for instance, in Shetland, where there has been very strong integration in health and social care across all levels of public sector delivery, which allows decision making to be informed on the basis of service delivery. I point Ms Maguire and the committee to that very good example. There are other areas where levels of integration could definitely be better, however, and that is part of the reason why I believe that the national care service is the right thing for bringing things forward from a service delivery perspective.

I am conscious that Ms Maguire is looking at the wider issue of service delivery around social infrastructure, housing and childcare, for instance. I believe that that comes from the discussions that are taking place on an integration basis. Where we can improve on that, obviously we will.

Paula Speirs: To give another example, work was done at a care home in the Western Isles last year, I think. The health board has been working with the IJB and the council there to utilise that care home for accommodation purposes. That is just a brief example, but we recognise the real

challenges around housing in the Western Isles. It has been possible to attract and recruit consultants in the Western Isles, in accident and emergency, for example, but those roles have been turned down because of a lack of access to childcare. We have been working with colleagues on that, and we have been trying to develop a sense of the framework through the task and finish group, which is meeting for the first time today, identifying the enablers and conditions for success—if I can call it that—that we need to have in place but which might not yet be in place because we have not considered that from a wider-Scotland perspective.

Ruth Maguire: That would certainly be helpful. It is not a matter of asking for additional resource; it is about using what is there. If we could have those examples, that would be really helpful for the committee.

The Convener: Sandesh Gulhane has a supplementary question.

Sandesh Gulhane (Glasgow) (Con): I make a declaration of interest as a practising general practitioner in the NHS.

Good morning, cabinet secretary. I was listening carefully to your answer to David Torrance's question—you are not taking any responsibility for social care, and it is all the fault of Westminster and Brexit.

Neil Gray: No—I have not said that. I was talking about the issues that we face regarding the workforce challenge. It would be remiss of anybody not to acknowledge the impact of making migration to the UK harder and the impact that Brexit has had. Indeed, I think that Mr Macaskill, who represents social care providers, would make those very points, too. Of course we have a responsibility to continue to deliver for social care, and we will continue to do all that we can, which is why we are looking to implement the national care service so that standards can be raised and can become more consistent—both for those working in the service and for those we are providing it for.

When decisions are made for us that are not in our interests and that are detrimental, of course I have to point those out, and Mr Gulhane will understand why I would need to do so. There was a 10 per cent drop in our workforce off the back of Brexit, and the new migration rules will make it much harder for social care providers to employ social care staff. It is understandable that I would wish to make such a comment.

Sandesh Gulhane: You mentioned the NCS. When are we seeing the amendments?

Neil Gray: We are working with the specialist advisory group at the moment on the stage 2 amendments, and we will be providing them to the committee as soon as we can.

Sandesh Gulhane: Do you know roughly when that will be?

Neil Gray: I could not say for certain, but the work is on-going.

Sandesh Gulhane: When the 2018 GP contract was put in place, did the Scottish Government feel, at that time, that it would have a negative impact on rural general practice?

Neil Gray: No. We consulted the British Medical Association and others directly on the implementation of the 2018 contract. It is obviously very difficult to bring forward something that takes a one-size-fits-all approach, while understanding that there will potentially be an impact of that.

That is partly why we are working to ensure that we have multidisciplinary teams coming through; looking at the primary care improvement plan; and providing investments so that we continue to see further investment in primary care in rural communities. It is also why we are continuing to support initiatives such as ScotGEM, which is about encouraging people who are going through medical training to specialise in rural general practice. We recognise the need to ensure that we continue to support rural general practice.

As I said, I was born and brought up in Orkney, and I recognise the role that general practitioners play in rural communities. Those general practices are anchor institutions, and they are a critical element of the sustainability of those communities. I am passionate, therefore, about ensuring that we continue to support rural general practice so that it is sustainable, and so that we continue to have a primary care service in rural and island communities to prevent further ill health among people who might otherwise end up in secondary or acute care.

That is part of the reform and improvement discussions that I hope to bring forward later this month. I will be looking to work with all parties, and others who are represented around the table, to ensure that we take forward the best ideas for how we can put the NHS on a sustainable, improved and recovering footing as we move forward.

Sandesh Gulhane: I am glad that you said that, because it relates to my next question.

Scottish Conservatives have produced a 26-page document, "Modern, Efficient, Local—A new contract between Scotland's NHS and the public", which looks at how our NHS can be improved. I would be keen to hear your feedback on that.

There was a promise of 800 more GPs, and I have heard you say multiple times that we are on track to have that number. Is that the case? How

many of those 800 GPs will be in rural communities?

Neil Gray: I have already given the example of ScotGEM, where we have people coming through a training system that is dedicated to serving remote general practice. We are improving the situation with regard to GP numbers, which I think are up by 256, or 257, in recent years, and we have a record number of GPs—1,200—in training. I recognise that we need to go faster in order to meet the target. That is why, over recent years, we have added new GP training places to the system. I hope that, through the record level of GPs in training and the work that we are doing with ScotGEM—as Stephen Lea-Ross and Paula Speirs outlined, and as I highlighted—a large number of those new GP entrants will go into the rural communities that we wish to see continue to be sustainable.

Paul Sweeney: I thank the panel for joining us today. I want to ask about the anticipated focus of the forthcoming remote and rural recruitment strategy. Can you elaborate on its key objectives and its focus?

Neil Gray: It is about making sure that we continue to see a sustainable workforce for our rural and island communities. It is in development; we have already set out the fact that some of the work is very much live. The focus is on ensuring that we continue to see a supportive and encouraging workforce strategy that ensures that we have a strong recruitment and retention policy for rural and island communities.

Paul Sweeney: Could you outline the scope of the professional roles that the strategy will cover? Is it simply restricted to NHS clinicians, or will it cover the social care and third sector workforce more broadly?

Neil Gray: I believe that it is for the social care side as well.

Stephen Lea-Ross: Yes, that is right. The intention is that it will be a holistic remote and rural recruitment strategy that covers NHS professionals, as well as recruitment and retention priorities for social care and social work services, in recognition of the fact that, in such communities, we are drawing from a smaller band of professionals overall.

09:45

So far, there have been two specific discrete focuses for the development of the strategy, one of which has been on remote and rural recruitment practice. That involves looking to improve the embedding of practice across all our rural and island communities in relation to some of the existing support services and mechanisms that are not necessarily fully utilised 100 per cent of the time. In the context of recruitment and retention, we are talking about things such as premier support for housing and so on.

The second focus is on drawing closer strategic links between remote and rural recruitment practice and the broader suite of initiatives that are taking place across Government, for example through the rural delivery plan. As things stand, those are the two broad areas of focus.

Paul Sweeney: Will the work on the strategy intersect with the work of the nursing and midwifery task force and other similar pieces of work?

Neil Gray: Yes. I co-chair the nursing and midwifery task force. There are areas of work that it is clear that colleagues on that group are keen to expand on, and given that recruitment and retention is obviously a very strong and live area, there will be a crossover between the work on the strategy and the work of the task force.

To follow up on Mr Sweeney's question whether social care will be covered by the strategy, the advisory group includes the Convention of Scottish Local Authorities, Scottish Government officials and health board representatives, so social care will be covered.

Paula Speirs: In considering the recruitment and staffing models, we are looking at a slightly wider element—the issue of what is a sustainable model of health and care in our remote, rural and island areas. We must not look at those things separately. That piece of work involves looking not just at our staffing model, but at what a sustainable model of care is, given that our services are particularly fragile. That is not the case only in remote and rural areas. We are making some immediate reforms in a number of areas. The cabinet secretary referred to the need for longer-term reform, but we need to do the planning for that, because if we do not plan, services could become even more fragile.

The remote and rural implementation group, which is where the national centre came from, discussed a revised staffing model for the rural general hospitals. We have certainly found that there are more GPs, in particular, who are keen to work in the hospital environment. Part of what we need to do now is look at how we deliver not only more primary care in communities, but more acute care in primary care settings. That might include diagnostics or oncology, for example. As we look at our workforce, we need to look not just at our GP workforce and our allied health professionals, but at how we can bring in our acute clinicians as well.

Paul Sweeney: I mentioned that, when we visited Skye last week, we went to the Broadford

medical practice. The GPs there said that some of them work shifts in the adjacent hospital, but that they find that complex and difficult to do because they need to have two different contracts, and it can be quite a faff, as they described it, to organise that.

Is any attempt being made to make it easier for GPs to have a hybrid work pattern that includes working in a GP practice setting and working in a rural hospital setting, especially when those settings are located in close proximity?

Neil Gray: I would be very interested in hearing more about the direct experience that you have been able to pick up. I presume that that will come through in the report, but if there is anything that the practitioners in Broadford would be able to feed straight in, I would be keen for us to look at that as part of our reform and improvement work. We are keen to look at how we can blur the lines of health boards and ensure that we maximise the operational capacity through better working arrangements for our staff.

However, I am cognisant of the fact that, although such an arrangement might work for many people, there are others who would prefer to have a fixed-point contract that involves working in a fixed-point place. Therefore, we would need to handle that carefully, but I would be very interested in hearing more about the experience that you picked up in Broadford.

Paul Sweeney: An important point of context is that the practice was directly managed by the health board, as opposed to it being an independent contractor model. That seems to be an increasing trend in NHS Highland.

Neil Gray: In rural areas, there are more examples of that coming through.

Paula Speirs: If it is okay, I will add to that.

As part of sustainability, we need to join the different components together. On the example that you gave about our employment contracts being a challenge, part of what the task and finish group is trying to understand is the large amount of work that has been done over the years on what an optimal model looks like. We now need to try to understand what the levers are for making that change happen—for example, addressing some of the employment contracts. It might be that, for some areas, the practices in the health boards are working.

We are trying to get underneath some of that. As I said, the question is how the optimal model works in relation to rural general hospitals in particular. It is not just about the hospital workforce. It is right across the piece. We have not yet got into some of the enablers. That is exactly the sort of work that we are doing over the next few months. It is being done over the next few months because we recognise that some services are fragile.

Paul Sweeney: I will make a point about some of the feedback that we got from the emergency department at Broadford hospital. There was a tragic incident in Portree at the weekend, just as we arrived. There was some reflection on that. One of the points that was raised was that rural emergency medicine is simply not attractive to a lot of people, because they see perhaps one or two cases a week and so professional development is constrained. A different approach needs to be taken on GP-led emergency care, perhaps. Are you considering that as part of the strategy?

Neil Gray: Obviously, I am conscious of the need to ensure that we have as equitable access to health provision across Scotland's geography as possible. Mr Sweeney points to an important conundrum on recruitment and retention. Typically, accident and emergency clinicians look for a fast-paced, ever-changing environment. That is what they thrive on. When I shadowed some accident and emergency shifts, that is what many of the A and E consultants told me. That is what drove them to go into accident and emergency, as opposed to any other specialty.

I have friends and family who use the Balfour hospital in Kirkwall. Far fewer people go through the accident and emergency department there than any of the accident and emergency departments in the central belt, for instance. That will have an impact on the attractiveness of the department. That is part of the reason why we have come through with the initiatives that Stephen Lea-Ross spoke about, to try to get people to specialise in remote, rural and island healthcare as early as possible. That means that they will probably take a more multidisciplinary approach to their training and will understand what they are going into. I hope that they will be more willing to stay in a remote and rural setting, understanding the fact that it is a very different environment from an accident and emergency department elsewhere.

I am also cognisant of the situation in Portree, which was a sad incident. My condolences go to the family of the person who lost their life. We are working with NHS Highland on bringing back 24-hour urgent care to Portree as quickly as possible.

Paul Sweeney: Another issue that was raised in the visit was the hospital's design. The hospital was a relatively recent investment by NHS Highland but a lot of the clinicians felt that their feedback had not been listened to in the development of its design. Much of that was down to time constraints because they did not feel able to leave the day job to contribute to consultations.

In the development of the consultation on the workforce strategy, are you looking to tackle some of the practical constraints that mean that people find that they cannot access consultations?

Neil Gray: I can speak to a more local example that I am aware of. I declare an interest in that I am recused from Government decision making on the new Monklands hospital. However, from a constituency perspective, I am very aware of the close involvement of clinicians in that hospital's design.

If that has not happened to the same degree in Broadford on Skye, I would be keen to know about that to ensure that NHS Highland and others can learn from that experience, so that we have projects that are informed by clinical experience to ensure that we get them right.

Paul Sweeney: Just in terms of the recruitment strategy—

The Convener: We need to move on.

Paul Sweeney: Okay.

Ruth Maguire: I will ask about education and training. Obviously, for the sustainability of a workforce, growing your own is helpful, and certainly the folk who we have spoken to in rural areas have pointed to that. As I ask this question, I am conscious that some of the solutions would address issues across the country and not just in rural areas.

First, I want to ask about the work on NHS apprenticeship roles. We have heard about roles in dietetics, occupational health, physiotherapy and radiography. It would be helpful to hear more about the development of those apprenticeship roles.

Neil Gray: I will bring in Stephen Lea-Ross, as I am not as familiar with that issue, although I am familiar with the incredible work that NHS Education for Scotland does and, in particular, the way in which it is helping to inform some of the initiatives that we have already spoken about, such as ScotGEM and the rural fellowships. I will bring in Stephen on the specific examples that you asked for.

Stephen Lea-Ross: Broadly speaking, over the past 12 months, we have provided about 788 new apprenticeships or apprenticeship exposure opportunities across our rural, island and mainland boards. They cover the range of specialties that Ruth Maguire outlined. Clinically, we have focused on nursing and midwifery support roles and on AHP support roles, including radiography and access-to-theatre nursing roles.

One thing that we are focused on is the transition between apprenticeships and qualified working practice, either as a nurse or an AHP. To date, the most successful pathway for that is the Open University earn-as-you-learn pathway—we currently have 466 students enrolled on that pathway nationally, with around 72 in rural and island communities. That is supporting the transition to degree-qualified education and supporting sustainable progression through a career path in rural and island communities.

The next step in our anchors programme, which is focusing on apprenticeships and access to NHS careers, is to broaden the range of opportunities in those existing professions, focusing on band 2 to 4 support and entry-level roles across nursing, midwifery and AHPs—

Ruth Maguire: I am sorry to interrupt, but I would like to jump in. How are the numbers of apprenticeships available to each health board decided? Do boards have a certain proportion that they are allowed to support? How does that work?

Stephen Lea-Ross: The number that I mentioned is just an aggregate number. Boards are not limited in the number of apprenticeship opportunities that they provide, other than in relation to capacity and available funding. As with our pre-registration training, from a Government perspective, we are looking for a supportive training and development environment. We want to ensure that, through the apprenticeships leads—every board has an apprenticeships lead co-ordinator—there is quality training and then onward retention. We also encourage partnerships between health boards and third sector organisations, including the Prince's Trust, to try to do some of that early employability engagement.

Boards are not formally circumscribed in any way in their offer—it is based on their local workforce planning.

Ruth Maguire: That is helpful. I am sorry that I interrupted you. Do you want to continue on that previous point?

Stephen Lea-Ross: No, it is okay.

Ruth Maguire: My other question is on how the Scottish Government can encourage universities to support more flexible training opportunities. Most of our references are to Skye, as the committee has just been there. Would it be possible to deliver access to nursing in Portree, for example? We heard from an advanced nurse practitioner that they had offered to deliver that, but had not been able to do so. Obviously, I do not know the full details, but what work can be done to make the most of such opportunities?

10:00

Neil Gray: Again, that goes back to the discussion around the nursing and midwifery task force and looking at how we make sure that we

are set up to take advantage of the existing opportunities that are available in higher education institutions. The training places that we have available are not fully subscribed, so for those considering a potential career or a career change, look at the opportunities in your local university. There is also the nursing bursary to help to support a transition to or an entry into nursing.

Stephen Lea-Ross referenced the helpful example of the Open University work. I am very keen to look at what more can be done—the discussion is happening at the task force—around the earn-as-you-learn pathway and whether there are more opportunities for that, so that people can either shift within the health service or come into the service.

To get directly to Ms Maguire's point about training being delivered as locally as possible, we will continue to work with higher education institutes to see what more is possible, particularly for remote and rural areas. I was at Robert Gordon University last week and saw some of the fantastic work that is being done there around nursing and paramedic training. There is real enthusiasm among nursing students for what they are embarking on and where they are looking to serve their time.

I hope that we can continue to provide that opportunity to others, particularly, for the benefit of this discussion, in remote and rural areas, so that we continue to have people to serve in the areas where we need service provision.

Carol Mochan (South Scotland) (Lab): I thank the cabinet secretary for the information on this important issue. I am aware that one of the key issues in relation to AHPs is the link with universities and the provision of a flexible model. Have you had any discussion with universities or other portfolio holders that might help with that?

Neil Gray: I have not directly discussed the issue in relation to AHPs, but I am more than happy to take it away for Ms Mochan and report back. Indeed, I should probably be having such a discussion, so Ms Mochan's suggestion is useful.

Gillian Mackay (Central Scotland) (Green): We have explored some workforce issues. How does the work to support the workforce link in with the wider need for reform?

Neil Gray: It is absolutely central, because we cannot have a sustainable and improving health service without a sustained and improving workforce. I am very proud of our incredible workforce. In the past 14 weeks, I have been able to see some of it in action. As health secretary, and previously as a user of the health service, I have seen the fantastic work that our workforce delivers.

On interaction with the workforce around reform, I am keen to hear directly from the workforce, its representatives and the trade unions on setting out how we move forward in a sustainable way and how we make sure that we continue to see improvements. I am keen to hear from the workforce about its ideas for changing how the health service works to make it more responsive to the needs of the people of Scotland and to make sure that it continues to be sustainable.

Having discussed the issue with people over the past few months, I know that that must be about making sure that we prevent ill health. The public health work that we are doing is of critical importance in making sure that we have a healthier population, in stopping the continued escalation in demand that we have on our health service and in making the shift on the flexibility of our employment patterns. We have seen some of that in the implementation of changes under agenda for change over recent weeks. That is where we will need to go, but that has to be informed by discussions with the workforce, which I am committed to having as part of the reform discussions.

Gillian Mackay: On preventative healthcare, given budgetary pressures across the board in all services, but particularly in health services, how is the Scottish Government ensuring the financial sustainability of health services amid rising costs? What resource allocation strategies are being employed to balance immediate acute needs with long-term planning and a shift towards preventative healthcare, particularly in remote and rural places that are facing the challenge of demographic changes in the workforce and patients?

Neil Gray: Ms Mackay strikes right at the heart of the clear challenge that we are facing in the health service and in how we move forward with reform. If resource was aplenty, of course I would be looking to invest far more in primary care services to help with the prevention work and in community and voluntary sector organisations that are doing incredible work across all disciplines.

As part of mental health awareness week last week, I saw some of that work from a mental health perspective in Aberdeen Football Club Community Trust's work on the changing room extra time initiative. That is incredible work to prevent more acute presentation. If resource was aplenty, we would go there.

Ms Mackay is right that we have to continue to sustain services, but we also need to drive change. That is where I hope that we will all be able to come together to discuss how we move human and financial resource to ensure that we are improving people's health in the first place.

That will be most acutely felt in rural and island communities. Paula Speirs talked about the fragility of some services, because sometimes they are provided on a small team basis and, if one person moves on or retires, the service is compromised. We need to continue with the workforce planning perspective, but we also need to look at prevention. Supporting people through hospital at home in rural areas, for instance, is an important innovation. The community care model that treats people as close to home as possible has better outcomes, but it also prevents further deterioration in their health that requires greater intervention in the acute settings, which is what we want to avoid.

Gillian Mackay: I am pleased that the cabinet secretary mentioned the third sector and the voluntary sector. They were among the people whom we spoke to on our visit to Skye, but I have also spoken to some who operate across bits of rural South Lanarkshire. Those organisations face logistical issues such as when they hear about funding. Some of them even referred to basic things such as not getting emails back from people in health boards and local authorities about how and where to access funding.

What more can the Scottish Government do to ensure certainty for organisations that are delivering vital services, whether it be in mental health or in other areas of health and social care? How can they have certainty about the most basic things, such as knowing more than a month in advance that they are going to get funding for the next quarter, for example?

Neil Gray: It increasingly sounds as though the session on Skye was incredibly productive, and I am ever more regretful that I was not a part of it so that I could hear directly from the colleagues that Ms Mackay refers to.

We are in a situation where we do not have the luxury—although I do not think that it is a luxury, actually—of being siloed; we cannot afford that. We need to use the capacity that is available, regardless of where it comes from. There must be much greater collaboration between public sector agencies. The integration agenda is about much greater collaboration between our health and social care partnerships, or IJBs, and our statutory partners, as well as the community and the voluntary sector. As Ms Mackay rightly said, that sector often provides services that statutory providers cannot provide to the same level of funding. We have to see much greater collaboration there.

We must also utilise the expertise and innovation that are coming through from the private sector. If we can harness that, we have an opportunity to stay true to the principles of the NHS being publicly owned and free at the point of need and delivery. We need to harness some of the products that are being delivered by the academic and private sector to free up clinical capacity for the care that clinicians and health service staff give. We have an opportunity to take forward much greater collaboration, if we can, to continue to improve and reform our health service for the better.

Tess White (North East Scotland) (Con): Good morning, cabinet secretary and panel. What consideration is being given to reviewing urgent care and accident and emergency provision in remote and rural areas?

Neil Gray: That is under active consideration, as Ms White will understand, given what happened on Skye recently. Sir Lewis Ritchie undertook a review of the services on Skye; with him, I met NHS Highland, and I expect to have a delivery plan from the board for how that review and its recommendations can return to implementation. The review was implemented for a period, but there were issues with sustainability, for the pertinent reasons that we have heard around attracting and retaining staff in rural and island communities. I am keen to ensure that Highland can deliver on that.

That is a microcosm of what we need to see to a much greater extent across the country. We are working with our rural boards in the areas that I have set out, which include supporting our workforce and supporting the work that NHS Education for Scotland is doing to provide education and training so that urgent care services in remote and rural areas can continue to be sustainable.

Tess White: Sometimes—well, often—incidents pressure test a system. We have heard about the tragic situation in Portree.

Last week, in my area, a little girl called Ivy Mae Ross tragically died; I know that the thoughts of all of us are with her family. That incident highlighted an issue, in that a specialist operations terror attack unit had to be deployed because ambulances were not available to attend the scene. That was not just a single situation—it has been going on for months. At that time, many ambulances were stacked outside the hospital. On that occasion, there was no negative impact directly from that, but it set alarm bells ringing. Given the unrelenting pressures on the Scottish Ambulance Service in my NHS Grampian area, in particular—although those pressures are not unique to Scotland—will you, as cabinet secretary, review contingency planning for serious incidents such as the ones that I mentioned?

Neil Gray: Like Ms White, my thoughts are with the family of the little girl to whom she referred. Those incidents are tragic examples that we wish

to avoid, and everything that we do as a Government, and as health boards and services, is to try to prevent such situations from happening.

Ms White is correct about the pressures on the Ambulance Service and about those pressures not being unique to Scotland. Unfortunately, we have seen the type of ambulance stacking that we saw at Aberdeen royal infirmary elsewhere in the UK, too. That is partly due to the significant increase in demand that we have seen. We are seeing a clear increase in demand on our ambulance services. We also need to have those services in the right place to respond to incidents such as those that Ms White spoke about.

We have made a significant investment in our Ambulance Service to support an increase in the number of practitioners and paramedics working within it to respond. We are also working with boards on how they can make sure that the flow at their hospitals is working better.

That goes back to the point that I mentioned about the importance of social care to our health service. It is important that we get our social care services working for the people who need them, but delays in social care also have an impact that goes all the way back through the hospital, right up to the front door, where ambulances are stacked outside because of the pressure in the hospital. That pressure is not necessarily in accident and emergency, although that is sometimes the case; it might be about accessing beds in the hospital.

We are making investments in all areas of the system to relieve that pressure. We can see that that is working, but it needs to move faster in order for us to see continued improvement in the services that we have available to us.

10:15

Tess White: To follow up on that, it is—as you recognise—a huge issue that there are failings in the system and that some hospitals are better than others. However, stacking—for example in the north-east, where half an ambulance fleet is stacked outside the hospital—puts pressure on the system, so it is clear that there is a failing in the wider system. Will you be tackling that as a matter of urgency?

Neil Gray: We are in discussions with NHS Grampian on the point to which Ms White referred and the particular example that she highlighted, which she has also raised in the chamber. We have been working with NHS Grampian to look at what it is doing. That includes work to improve the flow through the hospital so that we are not seeing ambulances stacked up outside.

The national centre for sustainable delivery is doing work to look at how we ensure that those who are in our hospitals actually need to be there and at how we can improve the delayed discharge picture so that we have hospital beds available. Ultimately, that is at the heart of why we have had delays, certainly in Scotland. I cannot speak for the rest of the UK, but that is certainly what I am picking up here. If we are seeing delays in ambulances being able to turn around at hospital, that is largely because of a lack of availability of beds.

We are using the centre for sustainable delivery to identify patients who can be discharged and get them discharged as quickly as possible, and thereby bring down the average hospital occupancy time. We are also working on that with our local government partners. I work closely with Councillor Paul Kelly of the Convention of Scottish Local Authorities, and we have agreed on work that is to be done across Scotland on giving people patient discharge dates, discharging before noon and weekend discharge. We are looking at everything that we possibly can to get people to where they should be, which is either at home or in the community, rather than in hospital.

We are also doing more focused work with our health and social care partners in Grampian on whether anything further can be done to improve the delayed discharge picture and to improve integration in NHS Grampian. I would be happy to update the committee on that work.

Emma Harper (South Scotland) (SNP): Good morning, cabinet secretary. A couple of different points have come to mind while I have been listening to all the questions and responses. I am interested in issues around digital technology and innovation, and in how remote and rural areas can or cannot benefit from that.

During Covid, we saw that the use of NHS Near Me and the attend anywhere service was beneficial. How can we harness what we have learned so far from the use of digital technology in order to support remote and rural healthcare?

Neil Gray: That points to some of what I was referring to in response to Ms Mackay.

The use of innovation in our health service is going to be critical. Some of that is already in place—Ms Harper spoke about Near Me, which is currently in use—but there is more that we could do to ensure that we continue to utilise some of that innovation to a greater extent.

We also need to look at some of the innovations with regard to digital technology and the advances—if they are ethically used—in artificial intelligence. Critically, we need to ensure—as Ms Harper was driving at in her question—that that is done in not only an ethical way, but an equitable way, so that those who are in remote and rural areas can benefit from such innovations if they

choose to do so, and take advantage of that way of working.

I am very keen to use innovation—as I have set out, it will be central to our being able to see reform and improvement in our health service in a way that maintains capacity and the opportunity for caring by those—the medical professionals and staff who work across our health service—whom we task with supporting patients coming through the system.

Emma Harper: With digital connectivity, the resilience of the network, cyberresilience and cybersecurity come to mind. There have been recent issues with NHS Dumfries and Galloway experiencing a cyberattack. Is that more of a challenge in remote and rural areas, or is that the same no matter which health board we are thinking about?

Neil Gray: I do not think that there is a particular issue in respect of ensuring that we have greater cyberresilience in remote and rural areas. Having grown up in an island community, I know that when a system fails, physically going to a clinic or hospital service is more challenging, because of travel time, transport connections and so on but, from a cyberresilience perspective, I do not think that rural or island communities are any more likely to be targeted by criminal gangs, such as the one that targeted Dumfries and Galloway, than other communities would be.

Paula Speirs: On the wider question of the challenges experienced by boards in remote and rural areas in implementing digital innovation, we are certainly seeing some challenges, as those health boards are typically smaller, and they therefore might not have the same level of capacity or capability as some of the larger boards in areas such as digital. Boards and their digital leads are working together, however. For example, the north of Scotland innovation group met yesterday, and the west of Scotland has similar arrangements for bringing the digital leads together. We can deliver several things at once. Those groups are looking at how to use Consultant Connect, for example, and other innovations.

Innovation is actually coming through much more in remote and rural areas than in urban areas, as people in the more remote areas have had to utilise such solutions. As we go around the country we see some really good examples, which should be spread out much more widely. Ms Maguire made a point earlier about considering some models of care, not just for remote and rural areas but more widely.

Emma Harper: You have mentioned travel and transport. The Highlands and Islands have a travel scheme whereby patients get travel and accommodation provided for free in order to access healthcare. In other remote places such as Dumfries and Galloway, patients are means tested for travel reimbursement purposes. Is there a plan to review the Highlands and Islands travel scheme to see whether there is potential to apply it to other remote and rural areas where patients are being means tested, as I have described?

Neil Gray: As Ms Harper will be aware, there are particular challenges around those in island communities being able to get to the mainland to access services. That means that they often need to travel by plane, which is incredibly costly and requires quite a bit of logistical planning. Ms Harper asked a direct question on whether we would review the situation for people in other rural areas, such as Dumfries and Galloway—the area Ms Harper represents—and the Borders. I am always happy to keep the arrangements under review.

I am cognisant of the financial challenges that are being faced by patients at the moment amid the UK cost crisis and, when it comes to being able to provide any extra funding, Ms Harper will understand the financial fragility that we are living with in government. I am always happy to continue to consider the situation. If Ms Harper has individual examples of where things have proved to be problematic I would be happy to hear about that, in order for us to have an informed review.

The Convener: We have six minutes left for this evidence session, and three members have supplementaries. If members and the panel can be concise, we will probably get them all in.

Sandesh Gulhane: On the theme of what you were saying earlier about wanting equitable access to digital and to the innovations that are coming through, what are you putting in place for rural communities for them to be able to access fast internet, fast broadband and mobile technology, which is essential to the future working of the NHS?

Neil Gray: Mr Gulhane will be aware of the Scottish Government's reaching 100 per cent—R100—programme that invests in broadband and supplements digital connectivity as an area of UK Government responsibility. The roll-out is going well and rural communities are being connected in a way that they would not have been had it not been for the Scottish Government's investment. Work is also being done on mobile connectivity by some of the service providers.

I am racking the back of my former economy briefing brain, but I would be happy to ensure that colleagues in the economy portfolio furnish Mr Gulhane with more information on some of the work that is being done with service providers in rural and island communities to improve the

availability of mobile internet connectivity. He is absolutely right that making sure that those areas are able to access digital services is critical, especially when that innovation will be most needed by and will be most appropriate for some of the rural areas.

Ruth Maguire: In response to Tess White, you spoke about people who are in hospital when that is not the right place for them. An issue that has struck me both in my local area as well as during our visit to Skye is the number of folk who are in hospital because of legal complications, if you like—no one has a power of attorney, so decisions about their care are challenging. Is there more that can be done about that? Do we need to raise awareness of the requirements for families to have powers of attorney and other arrangements in place, or does something need to be done in respect of the power of attorney process?

Neil Gray: A significant number of people who would be considered to be in the delayed discharge category are adults who have incapacity, which is an incredibly complicated area. I will take up Ruth Maguire's invitation and encourage people to ensure that they have power of attorney arrangements in place, as well as arrangements that allow for people to get access to the health and social care services that they need. As a Government, we are looking to introduce legislation on adults with incapacity in order to make sure that we are improving the system and the services for it. My colleague Jenni Minto has responsibility for that bill and we are looking at it during this parliamentary term.

Paul Sweeney: I have a quick clarification on my last question. I know that we discussed the capital investment consultation. My question was specifically about the remote and rural workforce recruitment strategy and the design of the consultation for it. I do not know whether you have any comments on how that will be designed to ensure that clinicians and other stakeholders do not feel that they are unable to participate in the consultation due to time constraints.

Neil Gray: To answer some of your other questions and bring it back into one answer, for the strategies and plans to be effective, stakeholders have to be consulted on them. In order for us to have an effective and sustainable health service and if we are to have a workforce strategy that means anything, the workforce and trade union representatives must be consulted and must be part of the discussion. They will absolutely be part of the discussion.

The Convener: I suspend the meeting to allow for a changeover of witnesses.

10:28

Meeting suspended.

10:29

On resuming—

Subordinate Legislation

National Health Service (Scotland) Act 1978 (Independent Health Care) Modification Order 2024 [Draft]

Healthcare Improvement Scotland (Inspections) Amendment Regulations 2024 [Draft]

The Convener: Our third agenda item is consideration of two affirmative instruments.

The first instrument is the draft National Health Service (Scotland) Act 1978 (Independent Health Care) Modification Order 2024. The purpose of the instrument is to enable Healthcare Improvement Scotland to regulate independent clinics where services are provided by pharmacists and pharmacy technicians; to amend the definition of "independent medical agency" to cover services that are provided by dental practitioners, registered nurses, registered midwives, dental care professionals, pharmacists and pharmacy technicians, which will include wholly online services in Scotland; and to enable Healthcare Improvement Scotland to cancel the registration of independent healthcare services that fail to pay their continuation fees.

The second instrument is the draft Healthcare Improvement Scotland (Inspections) Amendment Regulations 2024. The purpose of the instrument is to allow inspectors who are authorised by Healthcare Improvement Scotland under section 10K of the National Health Service Scotland Act 1978 to inspect medical records. The policy note further states that the current list of professions restricts who HIS is able to draw upon to inspect medical records as part of its inspections. Currently, the ability to inspect medical records as part of inspections that are undertaken by HIS is restricted to medical practitioners, registered nurses, pharmacists and registered dentists.

The Delegated Powers and Law Reform Committee considered the instruments at its meeting on 7 May 2024 and made no recommendations.

Today, we will have an evidence session with the Cabinet Secretary for Health and Social Care and supporting officials on both instruments. Once we have had all our questions answered, we will proceed to a formal debate on the motions.

I welcome to the committee Neil Gray, Cabinet Secretary for Health and Social Care. He is accompanied by Scottish Government officials. Lorraine Alcock is team lead in safety, openness

and learning; Kirndeep Kaur is a solicitor in the legal directorate; and Robert Law is a senior policy manager in safety, openness and learning.

I invite the cabinet secretary to make a brief opening statement.

Neil Gray: I appreciate the opportunity to speak to the two Scottish statutory instruments relating to the regulation of independent healthcare in Scotland.

First, the inspections regulations will allow any suitably trained inspector who is authorised by Healthcare Improvement Scotland to inspect medical records. Currently, the regulations state that Healthcare Improvement Scotland can draw on medical practitioners, registered nurses, pharmacists, and registered dentists to inspect medical records during an inspection. That change will enable Healthcare Improvement Scotland to be more flexible in its approach to conducting independent healthcare service inspections.

The second SSI is the modification order, which has three distinct purposes. First, it will widen the definition of an independent clinic, so that Healthcare Improvement Scotland will regulate clinics where services are provided by pharmacists and pharmacy technicians. That will not include pharmacies that are already regulated by the General Pharmaceutical Council or services that are provided under NHS contracts.

Secondly, the order will amend the definition of "independent medical agency". That provision will now include services that are provided by dental practitioners, registered nurses, registered midwives, dental care professionals, pharmacists and pharmacy technicians. The updated definition will also regulate wholly online services that are based in Scotland. I believe that to be a particularly urgent and important change.

The final purpose of the modification order is to enable Healthcare Improvement Scotland to cancel the registration of independent healthcare services that fail to pay their continuation fees. The inability of HIS to remove services from its register means that, at present, services that repeatedly fail to pay their fees can continue to operate in Scotland. Making that change is likely to have a positive impact on the willingness of providers to pay the fees that they owe and the provision is intended to be used as a last resort.

We have engaged with stakeholders and the wider public throughout the development of the modification order and our public consultation received support for the changes.

The SSIs that are being considered today will ensure that HIS continues to have the power to effectively regulate independent healthcare providers in this growing sector.

The Convener: Thank you for that statement, cabinet secretary. Sandesh Gulhane has a question.

Sandesh Gulhane: I refer members to my entry in the register of members' interests, which states that I am a practising GP.

I welcome HIS being able to inspect to a greater extent than it is doing at the moment and to have some more powers in that regard, because, ultimately, we want healthcare to be provided in a safe and efficient manner. However, I point out that a strand of healthcare is being provided by non-registered doctors and nurses—in fact, by beauticians. I am talking about non-surgical procedures such as fillers.

Those procedures can have significant side effects and, when they go wrong, it costs the NHS a lot of money to rectify them, but there is no regulation and HIS has no ability to go and look at sites to see whether they are safe and clean. Ultimately, those people are doing what I consider to be medical interventions. How can we ensure that that area is included in the legislation?

Neil Gray: The orders do not cover that area, but we are looking to introduce legislation that would cover it, because I share Dr Gulhane's concern about it.

The orders will widen the scope of regulations that are already in place, but we are looking to expand what is covered through legislation, as my colleague, Jenni Minto, has already outlined to Parliament.

The Scottish cosmetic interventions expert group's phase 2 recommendations include the introduction of legislation to regulate the administration of non-surgical cosmetic procedures. Following the 2020 consultation on the regulation of those procedures, our initial priority, from a clinical safety perspective, was to consider regulating the administration of dermal fillers. As we are aware, if they are administered incorrectly, they often cause long-term damage that can be reversed or limited only by the urgent administration of specific prescription-only medication.

Because of the number of non-surgical cosmetic procedures that are now available, we are working with our stakeholders to consider the potential scope of further regulation that is needed within the area. The stakeholders include: healthcare professionals who represent the British College of Aesthetic Medicine and the British Association of Cosmetic Nurses; hair and beauty industry representatives; environmental health officers; and HIS. Their input is hugely valued.

It is also worth noting that part of the phase 3 recommendations of the interventions expert

group was to consider independent services that are provided by other healthcare professionals who are not currently included in the "independent clinic" definition. Our work today to add pharmacists and pharmacy technicians is an important step forward, but I absolutely share Dr Gulhane's concern. We are working to expand some of that regulation to take in the areas of concern that he set out.

Sandesh Gulhane: Cabinet secretary, will you look at ensuring that such procedures can done only by people who are already registered, such as doctors and nurses?

Neil Gray: That goes beyond what is in the orders that are before us today, but I would be happy to have a further conversation with Dr Gulhane about the on-going work that we are doing on expanding regulation of cosmetic procedures, including the detail that Dr Gulhane is looking for, which is part of the consultation and discussions that we are having with stakeholders.

The Convener: Other members of the committee would also find that detail helpful.

Neil Gray: I am happy to share that with the committee.

The Convener: I have had no indication that anyone else wishes to ask a question on the instruments, so we move to item 4, which is the formal debate on the instruments on which we have just taken evidence. I remind the committee that officials may not speak during the debate. I ask the cabinet secretary to speak to and move motions S6M-13020 and S6M-13021.

Neil Gray: I have nothing further to add than what was discussed in the debate.

I move,

That the Health, Social Care and Sport Committee recommends that the National Health Service (Scotland) Act 1978 (Independent Health Care) Modification Order 2024 be approved.

That the Health, Social Care and Sport Committee recommends that the Healthcare Improvement Scotland (Inspections) Amendment Regulations 2024 [draft] be approved.

The Convener: Thank you. Sandesh Gulhane wishes to speak.

Sandesh Gulhane: Although I support the motions that are before us, as I said in my questions, it is important that we understand that, because some people who carry out procedures are not in one of the groups that are being regulated, we have almost a cowboy market, where anyone can do whatever they want with no checks or balances. Patients can suffer significant side effects and significant costs are incurred by the NHS. Therefore, although I am happy that we are seeing some movement from the cabinet secretary, I feel that it is a shame that nothing has been put in place since the 2020 consultation to protect citizens who are looking to get things such as fillers done.

Neil Gray: I am happy to reiterate what I set out earlier: I share Dr Gulhane's concern and the work is on-going. The regulations take us a step forward, but it is imperative that we continue our work to widen regulation of that area. I am happy to come back to the committee with more information on the on-going work on that.

Motions agreed to,

That the Health, Social Care and Sport Committee recommends that the National Health Service (Scotland) Act 1978 (Independent Health Care) Modification Order 2024 be approved.

That the Health, Social Care and Sport Committee recommends that the Healthcare Improvement Scotland (Inspections) Amendment Regulations 2024 [draft] be approved.

Healthcare Improvement Scotland (Fees) Regulations 2024 (SSI 2024/130)

The Convener: The next item on our agenda is consideration of one negative instrument. The purpose of the instrument is to enable Healthcare Improvement Scotland to prescribe the maximum fees that it may impose in respect of independent medical agencies, to raise the maximum fees that may be imposed on all independent healthcare services in respect of applications for registration or cancelling of registration of independent healthcare services, the annual continuation of any such registration, and applications for the variation or removal of a condition of registration.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 7 May 2024 and made no recommendations. No motion to annul has been lodged.

Given that no member has indicated that they wish to comment, I propose that the committee make no recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement.*

The Convener: I suspend the meeting to allow for a change of witnesses.

10:41

Meeting suspended.

11:04

On resuming—

Tobacco and Vapes Bill

The Convener: The sixth item on our agenda is an evidence session as part of our scrutiny of a legislative consent memorandum on the Tobacco and Vapes Bill, which is United Kingdom legislation. I welcome to the committee John Dunne, who is the director general of the UK Vaping Industry Association. We were also expecting Dr Pete Cheema OBE, the chief executive of the Scottish Grocers' Federation, but he has not yet joined us. We will move straight to questions.

Paul Sweeney: Are the witnesses satisfied that the UK Bill adequately reflects Scottish views?

John Dunne (UK Vaping Industry Association): The bill is flawed in many ways. One of the key issues that we have with it is that it does not address the importation of illegal products, which means that it will still allow the importation of disposable devices into the country. It also does not change the way in which products are currently authorised for sale. The Medicines and Healthcare products Regulatory Agency, which approves products for sale, does not consider the packaging, its design or even the design of the products. A lot of products that are geared towards children are imported into the country. The bill fails in those areas.

The other area that we are concerned about is that the bill does not address how young people are getting the products, so the association has put forward measures for licensing. Scotland has a registration process that is unique in the four countries, which is a great thing, but we would like it to be further enhanced. We need to punish retailers that are caught selling to minors and/or selling illegal products. Right now, the fines are too small. Even the fines that are being suggested in the legislation do not come anywhere near where they need to be. The industry is calling for £10,000 per instance fines for anybody who is caught selling to minors or selling illegal products. The Government in Westminster is suggesting £200 on-the-spot fines—frankly, that is a joke.

The bill does have some good things in it. Addressing the packaging of the products so that they are not overtly youth-appealing is a good thing, and it is the same for flavour names. The industry has been calling for that. The UKVIA has its own conduct rules for members to say that they do not use such things. If the MHRA were to look at packaging design and the naming of the products as part of its approval process in the first place, it would not be up to trading standards to try to play whack-a-mole when the products are put on the market. It is a little bit backwards, but the process could be improved.

Paul Sweeney: You mentioned some examples. Is there anything else that is not in the bill that you would have liked to have been addressed?

John Dunne: One of the problems is that we are looking at it from the wrong angle. Although nobody wants to see young people vaping or smoking in the first place, there is a very fine line between stopping that and upsetting the fine balance for smokers who are transitioning from smoking into vaping, which is now the most successful way that adults—in Scotland and in England, Northern Ireland and Wales—give up smoking. That is pure fact.

The problem is that there is so much misinformation out there. We would like to see robust education programmes and robust public awareness programmes that talk about the benefits of vaping as a smoking cessation tool. I fear that the legislation will confuse smokers even more, because it is conflating those issues with the vaping products themselves and they are at least 95 per cent less harmful than their combustible counterparts that kill one in two users. If the legislation goes too far the wrong way, it will make the misconception even worse.

Paul Sweeney: I want to touch on the demographic trends. Are there any aspects that are unique to Scotland that you would like to have seen addressed in the bill?

John Dunne: I do not think that Scotland is unique; smokers are smokers. However, one of the key differences is that Scotland still has a rather high smoking prevalence rate, so it is important that adult smokers are given all the encouragement and tools available to make a switch to a less harmful product if they cannot quit by any other means. That could involve gum patches or vaping products. Personally, I do not care—I just want to see smokers stop smoking.

Paul Sweeney: Do you have any information about what percentage of consumers in Scotland who purchase vapes are existing smokers, as opposed to young people who start with vaping?

John Dunne: I have national numbers, which come from the latest figures provided by Action on Smoking and Health. The majority of users of vaping products are adults. Fewer than one in five young people have ever vaped, according to the latest numbers that have just come out from ASH. While youth vaping trial has increased—up to about 7.5 per cent—the number of young people who are vaping on a regular basis and who did not previously smoke is still relatively low, at about 3.5 per cent.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

Thank you for your statement. What evidence do you have to show that vaping is the most effective form of stopping smoking?

John Dunne: There are a number of reports, from both here in the UK and abroad. The Royal College of Physicians has looked into it, as has the NHS, and even ASH, with its own data, will back up that statement.

Sandesh Gulhane: We shall ask about that when representatives of ASH come before us.

Emma Harper: Good morning to you—and I see that we also have online engagement this morning.

I declare an interest: I am a registered nurse, and I am the co-convener of the cross-party group on lung health in the Parliament.

I am interested in the data. If you are suggesting that vaping is how people quit smoking, I would comment that I know people who have been vaping for 10 years. Is there a tail-off in some of your data? My understanding is that vaping is not good for the lungs. It causes asthma and chronic obstructive pulmonary disease. Nicotine is addictive—it is bad for you and it can cause hardening of the arteries. There are some issues around blood pressure increase and so on. I would be interested to hear about data on how long people vape for once they stop smoking cigarettes.

John Dunne: You have made a couple of different points there. First, nobody is saying that vaping is 100 per cent safe; there are risks, but nothing that we do in this world is 100 per cent safe. We know that, for a smoker who moves from smoking, vaping is far better for them than smoking cigarettes.

On the point about hardening of the arteries and increased heart rate, nicotine is a stimulant and stimulants do that. That is the effect that they have on individuals. While it is addictive, nicotine itself is a rather benign substance. It does not cause cancer, and it does not cause all the problems that smoking combustible cigarettes does. What kills people is the combustion in cigarettes, not the nicotine consumption.

You made another point that I have not yet covered. There are two types of people who vape. There are those who wish to consume nicotine in a less harmful way and there are those who wish to quit smoking and give up nicotine altogether. That is where we see the two different tracks coming into play.

Emma Harper: The notes in front of me say that "The UK-wide consultation on the legislation excluded 307 respondents".

What are your thoughts on that? A conflict of interests is what comes to my mind, but what are your thoughts about the exclusion of 307 respondents?

John Dunne: First, I think that the consultation itself was very poorly managed. The questions were crafted in such a way as to lead to one answer only.

Secondly, although we are not always aligned on everything that we do, I commend the Scottish Parliament for allowing the industry to come and speak today, unlike your Westminster counterparts, who specifically sought not to engage with the industry. It is really disheartening that the Government at Westminster would exclude so many different views when coming to its decision. That was a very poorly planned situation.

11:15

Emma Harper: We hear feedback about young people vaping before they ever have a cigarette. For young people it is not about quitting smoking. We are seeing pink, blue and green Puff Candy, candyfloss flavour and all that. That seems to be direct targeting of young people so that they start taking nicotine into their lungs.

John Dunne: I agree that there are young people vaping who did not previously smoke, and that is not a good thing. That is one of the reasons why we have been pushing for licensing. The issue is at the point of purchase, when a young person is getting the product. The flavours have been around for well over 15 years. The issues that we are having with youth vaping occurred when the new style of disposables came on the market just over two years ago. That is when we started to see the increase. Before that, youth uptake was very low and disposables were only about 5 per cent of the market and were declining from a share of about 10 per cent. There is a direct relationship there, I think.

That is why we are calling for increased fines. We want all the products to be managed from the point at which they enter the country. All the distributors would be licensed and would only be allowed to carry licensed products that are approved by the MHRA—when they consider packaging design, flavour names and so on—so as to ensure that the fidget spinners and Skittles of the world are not getting into the supply chain. The retailers can then buy only from registered and licensed wholesalers. Part of the licensing has to include robust age verification training, similar to what we do with alcohol. We feel that those measures would help to squash how young people are getting the products.

We are a responsible industry and we are here to service adults. There are still 6.5 million smokers in the UK who need to make healthier choices in their lives, whether that is using vaping or other means to get off smoking. That is our core market. We do not need to target young people and, as an industry, we do not do that. In fact, UKVIA is the only trade body in the country that voluntarily tests the age verification processes of our own members four times a year. We report that back to trading standards to look at where the loopholes are and where the system is falling down. We have a success rate on those tests of around 80 to 85 per cent and improving. We feel that such measures could be built into the licensing scheme.

Secondly, for the most part, trading standards offices in the UK are massively underfunded. We reckon that the licensing scheme would generate in the region of £15 million per year from fees alone. That could be ring fenced very simply for use by trading standards to enforce the law in our area. On top of that, fines would penalise the retailers who are doing the wrong thing while allowing the responsible retailers who sell the products only to adults, for whom they are intended, to trade in a sensible way. We think that those are sensible solutions that have not even been looked at by the UK Government.

The Convener: A number of members have supplementary questions, but I will first ask for a point of clarity. Who does UKVIA actually represent?

John Dunne: UKVIA is a coalition of about 106 members at the moment. We represent everyone from a single store retailer through to the supply chain. We have label manufacturers, box manufacturers and major retailers, one of which is a retailer here in Scotland, as well as manufacturers and distributors of the products, not only here in the UK but abroad.

The Convener: That is a broad range right across the industry. What responsibility do you take for the packaging that your members use, which no doubt is bright and colourful and attractive to young people, and for that range of flavours that Emma Harper was referring to—bubble gum, candyfloss and so on—which a lot of very well-established vaping retailers carry?

John Dunne: I am 57 years of age; I like bubble-gum-flavoured gin, for instance, and I have candyfloss-flavoured vodka in my home. Adults like flavours just as much as young people do. As I said earlier, the flavours are not new—they have been around for 15 years. The problem with young people vaping has been around for two to three years.

The Convener: Well, I tend to disagree. I will come back to you with some research.

John Dunne: Absolutely; you can look at ASH's numbers; they will back that up.

The Convener: Actually, I am going to come back to you with University of Glasgow figures. First, however, I will go to Paul Sweeney and then to James Dornan.

Paul Sweeney: I note that around 90 per cent of the world's e-cigarette and vape production is based in Shenzhen in China. There are about 2 million employees across 1,000 factories. How practical is it, therefore, to monitor product safety, given the concentration in that geographical area? What practical measures would you like to see to improve product safety so that we do not have additives such as vitamin E acetate, which has been responsible for respiratory-related deaths?

John Dunne: First, vitamin E acetate is not used in nicotine e-cigarettes—it is a binding agent that is used in the United States in illicit THC devices, which caused the Uvalde situation in 2019. That substance is not in e-cigarettes as we know them in this country. In addition, many of the compounds that are used in other countries are not used here. You need to be very careful when you are using data from outside the UK—

Paul Sweeney: How can we surveil all imports to the UK in a practical sense?

John Dunne: Pardon?

Paul Sweeney: How are we able to provide that certainty about imports? It is not practical to inspect every batch that enters the UK.

John Dunne: The MHRA approves all the legal nicotine-containing products here in the UK. We actually want that process to move to covering non-nicotine versions as well. That is where the illegal products getting into the country are an issue, because they do not go through the same scrutiny with the MHRA.

One area that we are concerned about with regard to the current MHRA process is that it does not actually do batch testing of the products—it relies on data from laboratories on what is in those products. That could be improved.

As an association, while we do not represent all the companies, I spend quite a bit of my time speaking with the association in China. I go out there four times a year and speak with the chief executive officers in those companies to ensure that they understand that they need to follow the rules and regulations of this country.

We are pleased to see that the Chinese Government has made changes to its domestic regulations to ensure that, if companies violate laws in other countries, they are held to account in

China. I can tell you that that has been extremely successful in the past eight months.

The other area—

The Convener: Sorry, we need to move on. We are quite tight for time and we have a lot of questions, so if you can keep your answers brief, that would be helpful.

John Dunne: No problem.

The Convener: I go to James Dornan.

James Dornan (Glasgow Cathcart) (SNP): It is far too early to talk about the health benefits or otherwise of vaping. I accept that it might well help in the initial stages of trying to wean people off cigarettes; anything that does that is a good thing. However, surely we cannot be defending something where we know that there is damage being done by it and we are not sure what the long-term consequences of it are.

John Dunne: Well, we do know. Public Health England has been vocal on the subject. It knows that in comparison with smoking, in the short to medium term, vaping is far better for you than smoking. Nobody is saying that vaping is 100 per cent safe. What we know is that, if people continue to smoke, one in two of those users, if they use the product as intended, will die. We know that. If they cannot quit smoking by any other means, vaping is a good alternative, and a safer alternative, for them to use than combustible tobacco.

James Dornan: Can you confirm, then, that you are saying that the only reasonable use of vaping should be as a smoking cessation product? It should not be targeted at all at young people who have not started smoking.

John Dunne: I do not think that the products should be targeted at young people at all. They are an adult-age-gated product. However, one of the problems is that the laws in this country around the age verification for the products are not being enforced. That is one of the problems with further legislation—if we cannot effectively enforce the current legislation, how do we think adding new legislation will make the situation any better? That is why things such as licensing are the way to go.

James Dornan: The issue is not so much the age; it is about the fact that vaping should be a smoking cessation product. You say that anybody who is over a certain age—16, 18 or whatever it may be—should use it, and that you should be promoting it, despite the fact that you know that it is an unhealthy product and you do not even know what the long-term consequences of it are.

John Dunne: I think that adults are entitled to make decisions for themselves. They are entitled to consume products that may not be the healthiest for them. We consume alcohol in the same way. According to the World Health Organization, there is no safe level of alcohol consumption. We eat sweets and drink caffeine, which is another stimulant. All of those are—

James Dornan: You drink bubble-gum flavoured gin, so I get what you are saying.

However, that is not the issue. The issue is that you are promoting a product while not really knowing what damage it will cause.

John Dunne: I am no scientist, but we know that, in the short and long term, it is far better for people to use vaping products than to smoke cigarettes. The majority of the data shows that that is the case in the short to medium term. We have had these products in the market for almost 20 years. Yes, we do not know the long-term effects over 50, 60 or 70 years, but we have a massive amount of data on the short to medium term.

James Dornan: I will come in with one more point. You talk about the products being targeted at young people as almost a new thing. My grandkids are now in their mid-20s, and they told me about school friends of theirs at 15 years of age—that is 10 years ago—who were vaping for no reason other than that they thought it was cool. That is not a new problem; it has been going on for some time, and it has not been dealt with by the people whom you represent.

John Dunne: I agree—we have been pushing for licensing for well over five years. We have been highlighting the issue for a long time. In fact, I can still remember going to the press and talking to them about the increase that our members were seeing in young people trying to buy the products. It took me about three months to get a story on the subject published in a national newspaper.

We are not hiding behind that—we have been pushing it for many years. Unfortunately, however, the Government's legislation has not caught up, and it has not been effectively used to target those people.

For instance, it has always been illegal for anybody under the age of 18 to vape—

The Convener: We need to move on—we have a lot of questions.

John Dunne: I am sorry.

The Convener: I ask you to keep your answers short, please.

I call David Torrance.

David Torrance: My question is for the Scottish Grocers Federation, on the smoking age and the ban on selling tobacco to anybody who was born after January 2009.

What evidence is there that an age-related ban on purchasing tobacco products will be effective? How practical will it be to enforce that ban?

Dr Pete Cheema OBE (Scottish Grocers Federation): Good morning, everyone, and thank you for the opportunity to speak to the committee.

There are several problems with regard to the unintended consequences of having a ban. As a nation, we are not prone to carrying identification; that is the first issue. Identifying people who are well past the age of consent now, and trying to say to them, "Look, you can buy a bottle of spirits, but you can't buy tobacco," is going to be an issue. It is going to be a problem, and it will cause problems for staff as well.

The one thing that neither committee members nor John Dunne have discussed is the illicit trade, which is going to increase. The illicit trade in vapes is increasing as well—

The Convener: We have actually discussed that, Dr Cheema—we did so before you joined us online.

Dr Cheema: Right, okay—sorry. I was not aware of that.

The Convener: Does Mr Torrance have any further questions?

David Torrance: No, I do not.

Sandesh Gulhane: Before I ask my question, I want to address one point that John Dunne made. Nicotine is a highly dangerous and addictive chemical. It can increase your blood pressure, raise your pulse, increase the flow of blood to your heart and cause narrowing of the arteries. It is not a benign product, as has been said. It is very important to have that on the record.

My question is similar to what David Torrance just asked. It is obvious that someone is eight or 16, but, in 20 or 30 years' time, how are we going to stop people who are eight or 16 now from purchasing cigarettes? Will people always have to show ID when they want to buy cigarettes?

11:30

Dr Cheema: There is a big problem with crime in relation to getting people to produce identification—we have a real issue with that, which is why we were in favour of the introduction of the Protection of Workers (Retail and Age-restricted Goods and Services) (Scotland) Act 2021. People just do not carry ID in this country, and they can become aggressive when they are asked for those forms of identification.

We have constantly said that that will be one of the unintended consequences of the introduction of the bill. How are we going to be able to manage that issue? I really cannot answer that question, but I know that it will be difficult, because we just do not have a history of carrying identification. In the States, for example, if you are buying alcohol in a bar, you have to produce identification. You can only buy one drink for one person or, if you are buying drinks for three people, you have to show identification. In this country, however, we just do not have that history.

Gillian Mackay: Good morning. I am pleased that the committee so far seems to be taking a public health approach to the issues. Mr Dunne, I want to challenge you on a couple of points.

You said that your organisation takes the safety of children very seriously. Having had a quick Google of a few of your members, I must ask, what are you doing to address the fact that some of your members are selling flavours that are clearly targeted at children? One of them in particular is selling a flavour called Super Mix, which everyone round this table who has any young people in their lives will know is also a variant of Haribo—something that children are given as a treat. How does that square with what you said about being serious about products that target children?

John Dunne: We have a guidance document that we have issued to all our members in relation to that, encouraging them to change their flavours and packaging. Some of our members have already taken action on that and have removed the child-friendly names and put out blander packaging without some of the colour. We can provide our members with guidance, but it is up to them to take action.

Gillian Mackay: If no one is actually taking up the guidance that you are issuing, you will forgive us for feeling that that aspiration rings hollow.

On top of that, you said that you are concerned about vapes coming in from China in particular. One member of your organisation is a medical biotechnology company based in Shenzhen, and another is the China Electronics Chamber of Commerce. How do you square the concern about vapes coming in from elsewhere with the membership of your organisation?

John Dunne: We have among our members a number of manufacturers of these products that are based in Shenzhen. The Electronic Cigarette Professional Committee of the China Electronics Chamber of Commerce—ECCC—is the Chinese trade association that represents 950 of the manufacturers in China. We have been working closely with it to get its members to change the ways that they do things. We have set up meetings between the ECCC and the MHRA and we are in the process of setting up meetings between it and His Majesty's Revenue and

Customs in relation to the new duties that have been announced. The ECCC has been very helpful in stemming some of the illegal products coming into this country, and works with the Chinese Government to shut down factories over there that are producing those illegal products.

Gillian Mackay: Price is also a major issue that we have heard many concerns about with regard to the accessibility of the disposable vapes to young people. Some of your members are selling vapes with 20mg of nicotine in them for as low as £4.99—that is about the price of a Tesco meal deal; it is children's pocket money. What are you doing to ensure that the prices of vapes are outwith the reach of young people? Would you support a form of minimum pricing per milligram of nicotine or something similar to make sure that they were outwith young people's price brackets?

John Dunne: The simple answer to that question is that I do not buy the price argument at all. The biggest areas for smoking in this country are the most deprived areas.

Gillian Mackay: Forgive me, but my question was specifically framed around children and young people.

John Dunne: You are trying to make the argument that pricing just affects children. These products are designed to encourage adults to make the switch away from cigarettes. Many of those adults are smoking roll-ups or illicit tobacco products. They need a low entry point if they are going to try vaping. That is why disposables have been around since day 1—they have always been that entry point into vaping.

On the issue of price, we suggested to the Government that it could drop the 2ml tank size argument, which makes no sense at all, and instead go for a 10ml minimum tank size, which would make the device cost £10 or £15, which is out of the pocket-money range that you mention but still offers value to the adult smoker, because, instead of buying five devices, they would be buying only one. That would also have an environmental effect, because it would put fewer lithium-ion batteries into the system. That would have been a more sensible way of taking the products out of the pocket-money range while still adding value for adult smokers.

Gillian Mackay: So, you would acknowledge that price is an issue for children and young people, as we have heard from many parents?

John Dunne: It could be construed that way, but it is also important for adults.

Tess White: Hello, Mr Dunne. There is strong support for the restrictions around packaging, especially given the alarming figure that around a quarter of 15-year-olds in Scotland are using vaping products. Therefore, will the vaping industry work with the Governments across the UK to ensure that changes in standardised packaging are adhered to?

John Dunne: As an industry, we have no problem in toning down the packaging of these products. Many of the products that I see on television at the moment are not even legal to be sold in this country because, for example, they resemble sweet packaging and so on. Those products are already illegal under other legislation but, again, that legislation is not being enforced.

I would be in favour of plainer packaging, but not packaging that emulates a pack of cigarettes. The reason I say that is because smokers are confused enough as it is. If we put these products in the same packaging as cigarettes, all that we are saying to smokers is that they are probably just as bad as the cigarettes that they are smoking, so they may as well continue to smoke. However, I have absolutely no problem with plainer packaging, and some of our members have already switched to that.

The Convener: Sandesh Gulhane has a very brief supplementary question to take us up to 11:40, and it will require a very brief answer.

Sandesh Gulhane: I want to ask about the idea of repealing under-18 offences. Do you not feel that removing the ability to confiscate tobacco and vapes from under-18s, and not making it illegal to sell vapes to under-18s, would increase the number of under-18s wanting to purchase these products?

John Dunne: My understanding is that that regulation applies only to tobacco cigarettes and not to vapes. However, I do not think that we need to criminalise the users of these products. What we have to do is encourage them not to use those products and penalise those who are selling the products to young people. We should criminalise that portion of the issue, rather than criminalising the users.

The Convener: Thank you, Mr Dunne. We will have a brief suspension to change witnesses.

11:39

Meeting suspended.

11:40

On resuming—

The Convener: We will now take evidence from our second panel of witnesses on the bill. I welcome Sheila Duffy, who is the chief executive of ASH Scotland, and Dr Garth Reid, who is a consultant in public health at Public Health Scotland. We will move straight to questions.

Paul Sweeney: I ask both witnesses whether they are satisfied that the bill adequately

addresses Scottish views that were expressed in response to the consultation.

Dr Garth Reid (Public Health Scotland): Thank you for the opportunity to come and talk to you today. The bill represents those views well. The consultation response document shows that comprehensive feedback was provided. I know that time is tight, so I will not break it down, but you can see that in the published consultation response document. It is comprehensive and shows the support for some of the measures, including the ban on disposables, the regulation of flavours and the introduction of plain packaging, which you have just discussed.

Sheila Duffy (ASH Scotland): We fully support the bill. As with anything relating to tobacco, you cannot just take one measure; you have to surround it with other measures. We urge the Government to lay and implement with speed the remaining regulations from the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016, which would complement the measures in the bill. They were reconsulted on in 2022.

Paul Sweeney: Is anything not in the bill that you would like it to have addressed?

Dr Reid: It is important to focus on getting the bill passed, because that would be a big achievement. There are things that we want to do in the future that would also be helpful. For example, we need to consider the availability of products, which you discussed, and we need to think about how we go from the situation now, with lots of retailers selling tobacco and e-cigarettes, to having a smoke-free generation, which will mean that no people smoke and, therefore, retailers will need to sell other products. We will need to bridge the gap between where we are at the moment, with 15 per cent of people smoking, and a smoke-free environment.

Sheila Duffy: I would have loved to see a measure in the bill that focused on product. The measure relating to the age of sale is internationally recognised and will progressively clear retail shelves of tobacco, which is the most lethal addictive product on open sale at the moment. If it had been accompanied—it is not, and we are where we are—by the introduction of very low-nicotine tobacco that removed the addiction factor and/or the removal of filters, which are single-use plastics and have no health benefits, that would have made the bill even stronger and bite even quicker. However, I do not wish to hold up the bill, and we support it going forward with speed.

Paul Sweeney: The previous witnesses mentioned inadequate fines. Do you have similar concerns about that?

Dr Reid: There is no single thing that will make a difference. The bill includes a combination of different actions that work together. We also need to work with retailers to help them to move away from selling such products. I am not sure that having draconian fines is the right message in that context.

We need to try to get retailers to move away from selling those lethal products. We need more focus on the combination of different actions in the bill that tackle smoking and vaping, rather than just trying to look at one thing—for example, licensing. A number of different drivers are maintaining prevalence, and we need to switch all of them off. I am afraid that no one measure will be a magic bullet.

11:45

Sandesh Gulhane: It is now obvious that an eight-year-old should not smoke, and it might also be obvious when they become a young adult, but, in 20 or 30 years' time, how will we enforce that that young person, who will then be in their 40s, does not smoke?

You do not need to press your button, Ms Duffy.

Sheila Duffy: Sorry—I am mucking up the system.

Most smokers started under the legal age of purchase and almost all started by their 20s. As you know, brain development goes on until the age of 24 or 25. In Scotland, we are aiming to put tobacco out of sight, out of mind and out of fashion for the generation that is growing up now and to make it as rare as snuff use currently is: it is not illegal, but it is just not much used. Between now and then, there will be a number of other measures that will reinforce that, and the culture in Scotland will change and move away from tobacco. It is not a beneficial product in any way, and there is no safe level of use. It is time that we recognised that.

Sandesh Gulhane: My question was about how we practically do that.

Sheila Duffy: We do it, by and large, by clearing tobacco from the shelves—putting it completely out of sight and shutting down any visibility of tobacco sales. We need to address the new products that are bringing young people in Scotland into nicotine addiction and raising the risk of their moving on to tobacco. That is the current problem for us to solve in Scotland.

Gillian Mackay: How would the witnesses like any potential health benefits to be evaluated once the bill is passed? Obviously, it might take a while for the impact of some of the measures to show up in the population health data, but do the witnesses have any initial thoughts about how to monitor and evaluate the impact?

Sheila Duffy: With its smoke-free legislation, Scotland set a world-beating standard of research. We looked at changes and were able to show that industry arguments did not follow through into reality and that there were beneficial health impacts. We need to monitor and evaluate carefully.

I am aware that there are not necessarily the budgets to do thorough research. In Scotland, we have seen the gains in reducing tobacco use by and large in youngsters not taking it up. However, I am seriously concerned about the gaps in data on youth vaping, because the reliable widespread data that we have is from 2022, but things change and are fluid. There is a data gap that we should fill to see what happens with not only e-cigarettes but nicotine pouches, which appear to be the next upcoming products that are aimed at the youth.

Dr Reid: It is a great question. With the legislation on smoke-free enclosed public places, we had a range of studies that tackled the issue. For example, there were studies on people working in bars to see what happened to their respiratory health. We also examined what might happen to sales over a longer period and considered other health conditions.

It is necessary to have research on the immediate effects. There would quickly be benefits relating to some of the respiratory problems that you get from smoking. If you quit smoking, you start to see health benefits quite quickly. Of course, there are other conditions, such as cancer, that take a long time to develop.

You want to have an evaluation that has a clear theory of change, and it should look at the immediate impacts and think about the long-term impacts. It would be helpful to have regular reporting so that we can monitor progress. There are UK funding bodies that would, I think, be interested in evaluating such an intervention. It is a world-leading and brave policy to enact, so I think that lots of academics would want to evaluate it.

Gillian Mackay: There are two sides to data collection. There is the collection of data on smoking and increasing age and, as you said, Dr Reid, acute harms from that will show up relatively quickly. For vaping, however, we could be looking for different data, because we have not seen the long-term chronic harms of vaping, particularly for young people who start as young as 10, 11 or 12—eight in some cases.

Refillable products are also still out there, and the industry can reinvent itself and come up with another product that is within the right price range for young people. We need to be alive to any of those evolutions.

On the research into vaping, what do we need to do to monitor the impacts of the disposables ban and to note any further trends and changes so that we can move policy and legislation quickly to react to what is going on?

Dr Reid: That is also a great question. We should be looking at some of the prevalence data to see what is happening with young people who use such products. We should also look at what some of the other impacts might be. We could do qualitative research to see how children understand the products.

We know that research shows that flavours entice children to start vaping. We can also look at the kind of triggers that children are experiencing. Children are walking around our communities and seeing the products displayed prominently and, as the committee has seen and alluded to, they are brightly coloured, so they are enticing for children. If the flavours and the packaging were changed and the product and the packaging were made plain, we could look scientifically at how children respond to that and whether they find them less appealing.

Sheila Duffy: We became aware of the problem of a very steep rise in children's use and underage use through hearing the voices of young people, parents and teachers, way ahead of the research. We are engaging with young people, teachers and youth organisations to hear from them about what is happening out there and how it is impacting them. We are also looking to hear from those who are affected by such products, such as people who feel that they cannot go into the school toilets, for example, because it might trigger an asthma attack.

The research is moving incredibly fast. Up until about a week ago, I was glibly saying that it will take 30 to 60 years to see the serious effects of e-cigarette use, but then I was pulled up by a US professor who said that there is recent research that can tell us about some conditions and not others and that the harm to the cardiovascular and immune systems, for example, is much greater than we thought it would be. The data is not in for serious cancers yet, but we know about carcinogens.

I would like to take issue with a number of points that John Dunne made, including the 95 per cent factoid, which is a zombie estimate from the very early days of e-cigarettes that will not die. I totally disagree with that. The latest research suggests that there is a much narrower gap in harms for some conditions but that there are additional harmful factors with e-cigarettes. The Venn diagram shows that dual use is the worst pattern because it exposes people to the harms of tobacco and the separate additional harms of e-cigarettes. That is the major pattern of use in Scotland, with nearly 43 per cent of vapers also smoking.

I completely agree with Garth Reid that we urgently need to deal with the advertising, the visibility and the targeted appeal to children. We had to argue the case to get rid of tobacco flavours, to put tobacco out of sight and to curb the advertising. That urgently needs to be dealt with, and Scotland can deal with it.

Gillian Mackay: That is great. Thanks.

James Dornan: I was going to pull Dr Cheema up on his comments about ID and how difficult it will be for retailers to stop people from getting cigarettes after the new legislation comes in. Has any young person in this country not grown up having to have ID to show that they are of an age to get a drink, or even cigarettes as the case may be now? I do not really see how that would be an issue. Does the panel agree?

Sheila Duffy: In Scotland we have the Young Scot card, which is free and given out in schools. The photos on the cards can be renewed as young people get older. The card programme runs up to the age of 24. It offers an incentive scheme and is not industry influenced. It is therefore a ready form of ID for young people.

I ask those of us who were there at the time to cast our minds back to the campaign for a smoke-free Scotland. The industry predicted riots and violence, and an NHS crisis centre was set up, but people in Scotland moved on. After six months, they were able to look back and ask, "Why did we think that was normal?"

Dr Reid: In the past, when the age for the sale of tobacco has been raised, we have seen smoking among young people reducing. I agree absolutely with Mr Dornan's point that young people already need to show ID, so that is a bit of a strange argument. Perhaps committee members are not being asked to show ID, but a group of people aged around 18 would be used to doing so as a matter of course. I hope that that answers the question.

Emma Harper: Good morning to you both—actually, it is almost good afternoon. Earlier you probably heard me asking John Dunne about the exclusion of the submissions of 307 respondents to the UK-wide consultation. I am interested in your thoughts on the rationale behind those exclusions. You probably heard me asking about conflicts of interests, for instance.

Dr Reid: I do not know for certain, and I have not looked at the reason for them, but you are probably right to think that the exclusions could have been made because of conflicts of interests. The job of John Dunne, who gave evidence earlier, is to come here to present and defend his industry. Conflicts of interests can affect what people might say about the balance of harms. A good example of that is the 95 per cent figure that Sheila Duffy talked about earlier. Public Health England does not exist any more, so that figure must be really old. As Sheila said, unfortunately, newer research is starting to show that e-cigarettes do cause harm. That is not to say that they are more harmful than smoking, but we need to examine that possibility as the science moves on, and go with that approach.

To answer Ms Harper's question, I would think that the exclusions would have involved a conflict of interests, but why that aspect is so important might need to be explained.

Sheila Duffy: We always look to the WHO, because it is on top of the science in all the various disciplines and it monitors the tobacco industry's international activity. The WHO also presides over the framework convention on tobacco control, which recognises that the aims of tobacco companies are fundamentally and irreconcilably opposed to those of public health bodies. My assumption would be that the responses that Ms Harper mentioned were excluded because of their links with the tobacco industry.

It is easy to assume that the Scottish Grocers Federation represents local retailers and that the UKVIA represents vaping businesses. However, the University of Bath's *Tobacco Tactics* website shows how strongly both organisations lobby against restrictions on e-cigarettes and how the Scottish Grocers Federation has lobbied against the ban on tobacco displays in Scotland and against plain packaging.

12:00

I am astonished by the suggestion that ordinary retailers should be fined £10,000 when so many are struggling to stay in business. They are being visited, weekly or fortnightly, by tobacco company representatives who are absolutely in with the bricks with the UKVIA and the SGF, who are scaremongering and misinforming those retailers. The suggestion that somehow people will choose to change packaging or colouring, for example, but that we ought to fine ordinary retailers £10,000 is outrageous. We need to put the blame, the focus and the onus on the multinational corporations that profit from people's addiction and the health harms that go with it.

Emma Harper: Can I ask another wee quick question? John Dunne said that he supports the introduction of a licensing scheme, but that will not go ahead under the bill. What is the problem with having such a scheme?

Sheila Duffy: Scotland's register of tobacco and nicotine vapour product retailers, which retailers require to be on if they are to legally sell tobacco or any form of e-cigarettes, including those that do not contain nicotine, has been a positive move,

and other nations of the UK regard it with some envy. It is a source of information for researchers to see who is selling where, and it is divided into larger and smaller premises. ASH Scotland has asked whether that register could be made conditional, which would mean that any regulations that were approved by Parliament could then be communicated to retailers on the register.

I have not yet fully understood the UKVIA's request for licensing. However, as is the case with alcohol licensing, I know that such a scheme can be burdensome and cumbersome for local authorities, and it is difficult to bring an effective court case to stop people selling when they have been guilty of selling alcohol to customers who are under age, for example. We need to unpick that.

A certain responsibility for licensing is coming through as a result of previous European tobacco directives. We need to look carefully at what we do, how we do it and what the outcomes are. However, my money would be on using Scotland's register, which I mentioned earlier, and exploring how we could get the best out of it. I know that the Scottish Government is currently putting money into redesigning that register to make it fit for purpose and a good source of information.

Emma Harper: Some retailers now sell vapes to customers who order pizzas to be delivered to them. My understanding is that their age is not verified when vapes are delivered along with the pizza that they have just ordered.

Sheila Duffy: That is definitely an issue. When I have wandered around Edinburgh I have seen adverts mentioning a minimum spend of £30, but it looks as though that is for the fast food that is being delivered to people's doors. I agree that there are real issues there and we need to address them.

Dr Reid: Can I contribute to the licensing point? I support having a licensing scheme. It could be part of the picture, but it should not be at the cost of the other measures in the bill. We could come back to licensing in the future, as part of a package of measures. We will need to consider how we move forward and work with retailers to go from where we are at the moment to having a smoke-free generation in which retailers are not selling the tobacco that is so lethal. I do not think that retailers want to sell it.

Last year, the University of Edinburgh published research that examined the importance of tobacco to footfall in convenience stores in Scotland. It shows a significant reduction in such importance, which is a positive thing that shows that retailers are on the start of a journey to move away from selling such products. If licensing were to be done in a way that was supportive and focused on how we change the environment, but retailers still had other products to sell, that would be okay. However, the bill probably needs to go through as it is and not railroad other provisions that might make the whole thing fall apart.

Paul Sweeney: I want to ask about the balance between regulation and potentially creating additional harms as a result of prohibition. We know from Scotland's drug death crisis that prohibition has been ineffective at reducing public harms, and a recent WHO report has shown that, in Scotland, 23 per cent of 15-year-old boys and 16 per cent of girls of the same age have used cannabis. How do we balance the risk of pushing the market into the black market—that is, into an unregulated space where THC products and so on might be sold? Where do you feel that that balance sits?

Dr Reid: When the age of sale was increased in the past, it was claimed that there would be a rise in illicit sales, but we have not seen that happen. We just need to be mindful of falling into the trap of repeating industry lines.

Because the age-of-sale approach will be quite slow—after all, it will happen only year on year—it will give retailers time to look at what they are doing and change their products and it will give society time to get used to the new context. That is different to the approach of the smoke-free legislation through which, overnight, you were not allowed to smoke in enclosed public places. You will have noticed how the environment at the time in pubs or on buses, for example, was suddenly completely different. Again, the policy aspiration here is to profoundly change Scotland as a country, but the approach will be different, with this incremental year-on-year change. Because it is slow, we will be able to look at it.

Under the bill, there will be £100 million of additional funding for trading standards over time. Therefore, the age-of-sale approach is not the only measure; it needs to work together with more enforcement and cessation. It all works like a jigsaw coming together, if that makes sense.

Sheila Duffy: The prospect of illicit sales has been a go-to argument against every tobacco control measure that has ever been proposed and it always comes up in relation to tax. However, it is a completely separate issue, because "illicit" means criminal. It is not to be in any way endorsed, but stopping it relies on effective enforcement, not on not taking health measures.

Although money is being allocated to trading standards in England, there are still question marks over whether that money will come through to front-line enforcement in Scotland. That said, under the current proposals, there will be excise duty on e-cigarettes and that will bring in customs

and borders control, which is not involved at the moment. Trading standards does not have the same search and seize powers.

We also know of some well-established illicit trade routes that run from Ireland to Scotland and down to the north of England that trading standards cannot touch at the moment. The Chartered Trading Standards Institute estimates that about one in three of the e-cigs used in the UK is illicit. Illicit sales are a problem on their own, however. It is a criminal issue, and we should not let it hamper the introduction of health measures, which are separate and important in their own right.

Paul Sweeney: Nevertheless, I see an interesting intersection here, given our perspective of drugs as a public health issue rather than a criminal issue. I am curious about where we strike the balance. Perhaps that will require a longer piece of work instead of just trying to introduce this particular approach at this point in time.

I do think that a concern is that, in certain communities, the legislation could introduce the risk of the sort of THC-related deaths in America that are associated with illicit e-cigarettes with additives such as vitamin E acetate. I am thinking about the marginal areas of particular deprivation and the exploitation of young people and wondering whether concerns could arise there.

Sheila Duffy: THC vapes are being used by young people in Scotland. I spoke to someone in a Scottish region who had surveyed more than 10,000 young people, and it had come up as an issue.

However, the MHRA does not really test products; it receives information from the manufacturers. It might spot-test a couple, but it puts them on the register. These are not controlled products in the way that medicines are. They are recreational consumer goods, and they are lightly regulated and underregulated.

Interestingly, in a recent piece of research based in Ireland, the notified ingredients and flavours of e-cigarettes were run through an artificial intelligence programme to see what would happen if you heated those chemicals to the temperature that they would be heated to in e-cigarettes, and five of them came out as having really nasty effects that we were not aware of. We have a real issue with illicit and legally sold goods and with non-compliant goods that are not what they say they are.

Paul Sweeney: Thank you. I appreciate those responses.

Sandesh Gulhane: We talk about the use of vapes in smoking cessation, but, ultimately, they represent a very small proportion of those that are used. When I walk into my local Asda or other shops, I see vapes being sold in prominent places. Some have lights on the sides and they have very bright colours. It is literally the opposite of what we have done with cigarettes. Is it fair to say that the industry is targeting children with the way that vapes look?

Sheila Duffy: The massive incremental rise in the number of children and young people who are using e-cigarettes was more or less triggered when the Chinese Government withdrew permission for highly-coloured devices with fruit or other sweet flavours. It did so on two grounds—youth uptake and health concerns—but it did not stop exporting them, and we are now dealing with a problem that it recognised and dealt with.

We absolutely need to close down the visibility of the retail displays in shops, the marketing that is noticed more by children and the flavours that they are more likely to choose. The arguments against doing that are the same as those that were used against reducing fruit and sweet flavours in tobacco or getting rid of alcopops. Some adults like fizzy sweets, but they are not the primary uptake in the real world. E-cigarettes are universally recreational commercially-sold goods; none is available as a medicinal licensed aid.

Dr Reid: I agree with your point about how these products are promoted. It is not a mistake by the industry.

On the issue of cessation, it is important to point out that, in the Scottish health survey—one of our longest-standing surveys—only 21 per cent of smokers reported using an e-cigarette to quit. Therefore, the majority—almost 80 per cent—are using other products. It is a distraction to focus on e-cigarettes as a means of cessation. Other things are far more important. Most people just quit on their own without using anything, and the next quarter use patches and gum.

You asked a great question about the sale of tobacco and the promotion of e-cigarettes in supermarkets. Small convenience stores will need time and support to change, but supermarkets, which are enormous and have made huge amounts of profit, should be showing leadership and starting to change their stores now. After all, there is no reason for supermarkets to sell tobacco, and there is no reason for them to have these big shiny e-cigarette displays that children see and find appealing.

We should not have to legislate every time that we want to see such a change. It would be great if the supermarkets saw what was going to happen with the smoke-free generation and decided to take things into their own hands and take action. We know that discount retailers do not sell tobacco, so, as far as your question is concerned, there is really no reason for supermarkets to advertise e-cigarettes or to sell tobacco at all.

Sandesh Gulhane: I have never seen so many vape shops on our high streets; it seems as though almost every other shop is just a vape shop, and they all have advertising on the outside to get people to come in. However, such a dramatic increase in vape shops—or in sweet shops or any other shop selling vapes—will happen only if there is a huge profit to be made. How do we get on top of that?

12:15

Dr Reid: The bill contains a really good combination of measures. As Sheila Duffy has said, the increase in tax can be used for health purposes or enforcement, and there will be measures to tackle certain flavours that, as we know, encourage children to start vaping. Displays will be covered over, which, again, will help to denormalise the environment that our children are in, and the packets themselves will be plain. That comprehensive set of measures could come together to tackle the different drivers.

It is not the children's fault that they are vaping and it is not their parents' fault, either. It is all to do with how the industry has promoted the products, with children responding to their packaging and appeal. If we could get rid of some of the triggers and drivers for children and explain to them that these are not products for them, we would, I hope, see a change and a reduction in youth vaping.

Sandesh Gulhane: I am glad that we are talking about children, because I am a bit concerned about the repeal of under-18 offences. It will, for example, stop the police confiscating tobacco products from children. Is that something that you want to be put in place?

Sheila Duffy: We welcome the repeal of the criminalisation of the underage purchase of tobacco. The measure came in at the insistence of the Scottish Grocers Federation. It said that if responsibility was going to be put on retailers, responsibility should also be put on underage purchasers.

I share your view that it would be better for these products to be confiscated from children, because they are so harmful and addictive. I would like a clear message to be sent that these products should not be allowed in schools, handed around or sold to children on health grounds. I would point out that, for underage test purchases, the failure rate for e-cigarettes is 20 per cent, while the figure for tobacco is 10 per cent. We need to get on top of that.

As for how we hold the industries to account more, we have to look at a health tax in Scotland or a polluter-pays tax at UK level. We have to start clawing back some of the vast profits. When these cheap, coloured, fruit-flavoured disposables came on to the market—and I have seen these things being sold as cheaply as £1.99—retailers could buy a box of them at wholesale, mark them up by a pound a throw and make a vast profit while still selling them very cheaply. We need to start looking at who is profiting from this and at whether we can impose a health tax on them to discourage them.

We also need to find some way of challenging some retailers who are consistently giving misinformation about, say, the 95 per cent factoid and their role in smoking cessation. One of UKVIA's major members—in fact, its Scottish spokesperson—advertises or has advertised stop-smoking clinics; it was picked up by the Advertising Standards Authority for doing so, because it was really just a try-or-buy thing. It was also recommending heated tobacco products, which no reputable health voice has recommended in any way for cessation. We have to start looking at where the profits are being made and hold those people accountable.

Sandesh Gulhane: Finally, Sheila Duffy, you mentioned children in schools. Does the repeal of under-18 offences mean that a teacher in school cannot confiscate the products, because they can be challenged and potentially get in trouble?

Sheila Duffy: At the moment, it is illegal to sell e-cigarettes to under-18s or to buy e-cigarettes for them. Schools should therefore be able to treat them in the same way as they treat alcohol and tobacco, and that should not change. This will be a decriminalisation of the consumer, not a decriminalisation of underage sales on the part of retailers or through proxy purchase.

Sandesh Gulhane: But if the police cannot confiscate these things, how can a teacher?

Sheila Duffy: I do not know to what extent the police are currently confiscating them, but I think that schools have their own rules. If young people bring in these products, schools should be able to confiscate them just as they can confiscate alcohol and tobacco.

The Convener: I thank the panel for their attendance today. Next week, the committee will undertake stage 2 proceedings for the Abortion Services (Safe Access Zones) (Scotland) Bill.

That concludes the public part of our meeting.

12:20

Meeting continued in private until 12:41.

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